

TO: Director, National Institute for Occupational Safety and Health

FROM: California Fatality Assessment and Control Evaluation (CA/FACE) Program

SUBJECT: A Psychiatric Technician Dies from a Patient Assault at a Forensic Psychiatric Facility

SUMMARY
California FACE Report #10CA009

A psychiatric technician died after she was strangled by a patient at a forensic psychiatric facility. The patient assaulted the victim while the victim was walking alone across the large, open grounds of the facility Secure Treatment Area (STA)). The victim carried a personal alarm that was not able to transmit a signal inside to security personnel or treatment team staff from the STA grounds. At the time of the assault, security personnel were at the entrance to the STA but nowhere else within the grounds. The alleged assailant had been admitted to this facility in 1999 after conviction for violent assault and being declared not guilty by reason of insanity. He had a long, documented history of assault and verbal abuse to other patients and staff. The alleged assailant's unrestricted grounds pass had been suspended by his treatment team on two occasions because of physical and verbal assaults within three weeks prior to this incident. However, the treatment team restored his grounds pass and he was on the grounds of the STA without supervision on the day of the incident. The CA/FACE investigative team determined that, to prevent future occurrences, forensic psychiatric facilities should develop and implement a comprehensive written workplace violence injury prevention program. This program should include the following elements to reduce the risk of violent assaults to staff:

- Security personnel or co-workers should accompany individual employees when walking through open or unsecured areas.
- As part of an emergency response plan, personal alarms worn by employees should be operational throughout all areas of the facility.
- The facility should assign hospital police officers and/or security personnel to locations where they can monitor patients for assaultive behavior.
- The facility should implement policies for issuing and suspending grounds passes for patients at risk of committing violent assault.

INTRODUCTION

On Saturday, October 23, 2010, at approximately 5:30 p.m., a 54-year-old female psychiatric technician died after she was strangled by a patient. The CA/FACE

investigator learned of this incident on October 25, 2010, from a newspaper story about the fatality. On December 1, 2010, the CA/FACE investigation team interviewed the facility Health and Safety Officer and one union representative. On December 15, 2010, a group interview was conducted with seven nursing employees. Telephone interviews were also completed in January 2011 with two additional union representatives and a facility psychiatrist. On February 1, 2011, the CA/FACE investigation team toured the STA and viewed the incident scene. On February 15, 2011, a telephone conference was held between the CA/FACE investigation team and the administrative and management staff of the facility to discuss documents, policies, and procedures relevant to this incident. A copy of the facility Injury and Illness Prevention Program (IIPP), policies on workplace violence and risk assessment, Cal/OSHA citation, and the County Sheriff's Department Incident/Investigation Report were also reviewed.

The victim's employer was a state psychiatric facility that had been in existence for over 100 years. The facility housed approximately 2,400 employees and 1,500 patients in a campus-like setting with the treatment units located on 138 acres.

The victim was a female psychiatric technician who had worked at the hospital for 14 years. The hospital had a written Injury and Illness Prevention Plan (IIPP) that included management and employee responsibilities, safety meeting schedules, training, and general safety procedures for work within the facility. The facility workplace violence program included incident notification, supervisor responsibilities, and policies regarding tolerance of violence. The program did not cover risk of working alone, mechanisms for review of and communication about escalating verbal and/or physical assaults by patients, or activation of personal alarms during a threat from a patient.

The hospital provided most training programs by video and classroom sessions. All employees of the hospital were required to attend a three-day training course on Therapeutic Strategies and Interventions (TSI). These training sessions were designed to teach employees how to intervene and deescalate violent situations and how to shield themselves in confrontational situations. The facility had no documentation to indicate that TSI refresher training occurred on a periodic basis.

As part of its grounds pass policies, the facility issued grounds passes to patients in three levels; the least restrictive Level 3 pass provided unescorted access to the STA grounds for both therapeutic and leisure activities. In issuing Level 3 grounds passes, the treatment team was to consider problematic behaviors such as property damage, possession of contraband, verbal or physical aggression or assaults, sexual aggression, potential for victimization, danger to self and others, substance abuse, and predatory behaviors. The policy required the Program Director to initially approve Level 3 grounds passes with the treatment order written by a physician or psychologist. Grounds passes could be suspended at any time if any staff on duty determined that the patient demonstrated inappropriate behavior. If the treatment team restored the grounds pass within 30 days, no written documentation for this decision was required to be noted in the treatment plan. If the treatment team continued the grounds pass suspension, they had to document the rationale in the patient treatment plan. If the treatment team suspended the grounds pass for more than 30 days, restoration required review and approval by the Program Director.

BACKGROUND

The facility was originally designed as a long-term residential psychiatric facility with multiple housing units spread around a large, campus-like setting. In 1995, the majority of the facility was modified to admit patients referred from the criminal justice system considered not guilty by reason of insanity or not fit to stand trial. Many of these patients have committed violent offenses including physical assaults. These patients are housed for long-term treatment within several locked units within a perimeter fence with one entrance (“sally port”) that controls access. The sally port is located approximately one-third mile from the incident scene.

Hospital police officers (HPOs) are assigned primarily to secure and patrol the perimeter fence and are not stationed within the grounds of the STA. All facility employees working within the STA have personal alarms that, when activated by the employee within a housing unit, transmit an emergency signal to the HPO at the sally port and to staff within the treatment unit. However, the personal alarm signal is not received if activated outdoors on the facility grounds.

In 2006, the U.S. Department of Justice required the facility to develop and implement a model of patient care that included a reduction in physical restraint and seclusion rooms, enhanced medication management, and increased staff supervision of patients. The facility staff stated that this treatment model impaired their ability to impose consequences for verbal and physical threat by patients, thereby increasing the frequency of assaults.

INVESTIGATION

The incident occurred on the grounds of the STA within the facility. On the day of the incident, the victim returned to the facility after taking a break in her car in the parking lot outside of the STA. According to the security logs, she passed through the sally port into the STA at 5:18 pm. Based on patient and co-worker statements, the victim walked alone across the facility grounds to her treatment unit. The alleged assailant was outside on the STA grounds and likely observed the victim as she was walking to her treatment unit. According to statements given to the County Sheriff’s investigators, he approached the victim just outside of her locked unit and forced her into a patio area adjacent to the front door. The victim may have attempted to verbally deescalate the threat of physical assault, but after several minutes was strangled by the alleged assailant on the patio floor. The alleged assailant returned to his locked unit at 6:00 pm. After the victim failed to return to her unit, several co-workers searched the facility grounds and discovered her without pulse and respiration. The co-workers alerted the facility security staff and County Sheriff’s Department, which secured the incident scene. After investigation by the County Sheriff’s Department, the County District Attorney’s office charged the alleged assailant with homicide.

It is not known if the victim activated her personal alarm during the assault. Post-incident testing of her personal alarm within the treatment unit demonstrated that it was operational. The personal alarm was not designed to transmit a signal from outdoors

back into the treatment unit. Security computer logs showed that no signal was received from the victim's alarm on the day of the incident.

Review of the facility incident investigation records indicates that the alleged assailant had been involved in 37 incidents of verbal and/or physical threats to patients and staff between February 13, 2008, and October 7, 2011. Most recently, on October 1, 2010, facility security personnel conducted an incident investigation after a staff person reported that the alleged assailant hit another patient. The incident was closed after the alleged assailant stated that he was aware of his inappropriate conduct. On October 18, 2010, another incident investigation was initiated after a female staff person in the medical clinic reported that the alleged assailant was verbally abusive on October 6, 2010, after she instructed him to leave the area. The alleged assailant stated to the facility security investigator that this female staff person had been verbally abusive in telling him to leave the medical clinic. Interview statements from the staff person and co-workers suggested that the alleged assailant had repeatedly come to the medical clinic without an appointment and made inappropriate and sexually suggestive comments. This incident investigation was closed without further action on October 27, 2010.

The alleged assailant had received a Level 3 grounds pass at some time prior to the physical assault on October 1, 2010. On that date, one of the treatment team members temporarily suspended his Level 3 grounds pass. Staff again temporarily suspended his Level 3 grounds pass on October 6, 2010, after the medical clinic notified the treatment team of the verbal assault on a clinic staff person. It is not known when the alleged assailant's Level 3 grounds pass was reinstated prior to October 23, 2010.

CAUSE OF DEATH

The death certificate listed the cause of death as asphyxia by manual strangulation.

RECOMMENDATIONS / DISCUSSION

Recommendation: As part of their Injury and Illness Prevention Program, managers of forensic psychiatric facilities should develop and implement a comprehensive written workplace violence injury prevention program.

Discussion: This forensic psychiatric facility treats many individuals who have been transferred from the California criminal justice system with a record of violent assaults. Studies of the risk factors for workplace violence in psychiatric facilities consistently show that a prior history of violent assaults is a significant factor in predicting subsequent assaults to staff. Therefore, management of this forensic psychiatric facility should consider this as a high-risk environment for staff assaults. Evidence from successful programs in psychiatric facilities also demonstrates that implementing a comprehensive workplace violence prevention program can reduce the incidence of violent injuries to staff.

In this incident, written documentation and information from staff interviews suggest that many elements of a comprehensive workplace violence prevention program were absent. These elements include addressing the risk of working alone, mechanisms for staff review of escalating verbal and/or physical assaults by patients, and post-incident analysis and corrective action. Had facility management developed and implemented a comprehensive workplace violence prevention program, several elements would have been in place that may have prevented this incident from occurring. These elements include:

- Security personnel or co-workers should accompany individual employees when walking through open or unsecured areas.

In this incident, the victim was walking by herself across a distance of almost one-third mile to reach the treatment unit. The original design of this facility was for a long-term psychiatric inpatient center with treatment units arrayed in a campus-like setting. In converting to a forensic unit in the 1990s, a fenced enclosure was erected around the perimeter without substantial modification of the interior grounds. As a result of this design, patients who have Level 3 grounds passes may be able to position themselves in locations within the STA that are not readily visible to staff. This incident occurred at approximately 5:45 pm on a weekend during a light rain, and evidence suggests that no other staff were present on the grounds of the STA during the assault. The alleged assailant was permitted to be within the STA until 6 pm on the day of the incident. It is not known if the assailant was within the STA as part of a preconceived plan to assault this particular victim, or whether she was victim of a “crime of opportunity.” Regardless of motive, the assailant was able to assault the victim without any witnesses to the incident. If a co-worker or security personnel had accompanied the victim, the assailant may have been deterred from assaulting the victim.

- As part of an emergency response plan, personal alarms worn by employees should be operational throughout all areas of the facility.

In this incident, the victim had a personal alarm that was issued to all staff as part of an emergency response system for staff working within the STA. The facility had a protocol to respond to emergency alarms by notifying treatment team staff and security personnel of the alarm location and immediately responding to the scene. Post-incident testing of the victim’s alarm within the treatment unit showed that it was operational and able to transmit a signal to both security and the treatment team. However, the personal alarms were not designed to transmit a signal from outdoors back into the locked treatment units, and therefore no emergency response was possible in the event of an unwitnessed assault on the grounds. Evidence suggests that the victim may have tried to verbally defuse or deescalate the confrontation with her assailant over a period of several minutes prior to her death. If the victim had activated her personal alarm and a signal was transmitted to security or the treatment team with her location, there may have been enough time to respond to the incident scene and thwart the assault. As part of their emergency response plan, forensic psychiatry facilities should consider purchasing mobile

devices that can transmit high decibel audible alarms and electronic alert signals throughout a large area (both indoors and outdoors) and locate staff accurately. An emergency response plan should include staff training on the use of personal alarms, as well as adequate personnel and operational protocols to respond in a timely manner to emergency alarms throughout the treatment areas.

- The facility should assign hospital police officers and/or security personnel to locations where they can monitor patients for assaultive behavior.

In this incident, the victim entered the STA through a sally port attended by the HPO. Once the victim was inside the STA and walking across the grounds, no security personnel or other witnesses saw the alleged assailant immediately prior to the incident. This suggests that the assailant was able to be on the STA grounds without being seen by hospital staff and may have afforded the assailant the opportunity to assault the victim.

This facility was originally designed and located in a rural environment as a long-term psychiatric treatment center that was distant from populated urban areas. In recent decades, the areas adjacent to the facility have developed into residential neighborhoods with a variety of supporting businesses. When the facility transitioned in the 1990s to house a forensic population, kiosks with security personnel were located at intervals outside the perimeter fence to monitor the risk to the community. No security personnel were assigned at fixed locations within the STA where patients could be monitored for inappropriate or assaultive behavior to staff. If security personnel had been stationed within the grounds of the STA in visual contact with all areas including the treatment units, the assailant may have been less likely to initiate physical contact with the victim, and/or an emergency response would have been immediately initiated to stop the assault. Video surveillance can also supplement the physical presence of security personnel. Video surveillance can provide deterrence, the ability to identify the perpetrator and circumstances of the incident, and facilitate an immediate response to an assault.

- The facility should implement policies for issuing and suspending grounds passes for patients at risk of committing violent assault.

In this incident, the alleged assailant had received a Level 3 grounds pass that permitted him to stay on the STA grounds without supervision for up to two hours at a time. On the day of the incident, the alleged assailant signed out of his treatment unit on three occasions, including during the time of the fatal assault. The alleged assailant had two incidents of assaultive behavior within the month prior to October 23, 2010, with temporary suspension of his Level 3 grounds pass on each occasion. It is not known when or why his Level 3 grounds pass was restored prior to October 23, 2010. The facility policy permitted restoration of Level 3 grounds passes within 30 days based on the clinical judgment of the treatment team, without additional review of risk factors for violent assault or written approval by senior psychiatric or psychology staff. Written criteria governed the issuance of Level 3 grounds passes, but no written criteria governed restoration of Level 3 grounds passes after

temporary suspension. If the treatment team and senior psychiatric staff had been required to systematically review historical and behavioral risk factors, they may have judged that the alleged assailant's unrestricted access to the STA grounds would pose a risk of subsequent violent assault. Alternatively, a policy could require that suspension of a Level 3 grounds pass automatically "demote" the patient to a Level 1 grounds pass with close staff supervision. In either case, the alleged assailant's Level 3 grounds pass would not have been restored and he would not have had access to the STA grounds on the day of the incident. Policies should be specific with regard to time of suspension and consequences for inappropriate behavior and should be reviewed annually with changes documented,

A comprehensive workplace violence prevention program should include methods that the employer will use to prevent workplace violent incidents. These include making high-risk areas more visible; installing good external lighting; providing training on recognizing the early signs of agitation, de-escalating skills, and non-violent self-defense responses; and establishing and implementing reporting systems for incidents of aggressive behavior. In the written program, the employer should specify the methods and means to address each specific hazard identified in the workplace evaluation that may place employees at risk of workplace violence. The employer should design and implement a workplace violence incident reporting system, including a routine process for assessing patient acuity and assaultive behavior and adjusting staffing and supervision as needed; responding to individual violent events and taking appropriate corrective action; identifying commonalities among multiple incidents (such as the same perpetrator(s), high-risk activities or locations, or time of day); and describing on a regular basis the prevalence, severity, and consequences of workplace violence incidents. Employees should be provided with information and training on the risks of workplace violence, including measures employees can take to protect themselves from the identified risks. Training should address specific procedures that the employer has implemented to protect employees, such as incident alert and notification procedures, appropriate work practices, emergency procedures, and use of security alarms and other devices. Post-incident treatment and crisis counseling should be available to all employees to prevent and treat both the physical and psychological effects of violence incidents. The facility should review workplace violence programs annually and document all changes to the program.

The facility should establish a joint labor-management workplace violence prevention committee to implement elements of the written violence prevention program. This committee should be composed of a representative of facility administration who is responsible for overseeing all aspects of the program, as well as health care workers who engage in direct patient contact. This committee should complete periodic violence risk assessments to analyze risk factors for workplace violence and to make recommendations to the facility for program improvements and corrective actions.

Since this incident has occurred, the employer has implemented and has continued to work towards several security enhancements to ensure the safety of their employees.

References:

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Key Elements of a Workplace Violence Prevention Program. New York State Public Employees Federation. Available at <http://pef.org/stopworkplaceviolence/files/PEFFactsheetNYSWPVL2010.pdf>.

Occupational Violence Topic Page. National Institute for Occupational Safety and Health. See <http://www.cdc.gov/niosh/topics/violence>.

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FATALITY ASSESSMENT AND CONTROL EVALUATION PROGRAM

The California Department of Public Health, in cooperation with the Public Health Institute and the National Institute for Occupational Safety and Health (NIOSH), conducts investigations of work-related fatalities. The goal of the CA/FACE program is to prevent fatal work injuries. CA/FACE aims to achieve this goal by studying the work environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact. NIOSH-funded, state-based FACE programs include: California, Iowa, Kentucky, Massachusetts, Michigan, New Jersey, New York, Oregon, and Washington.

Additional information regarding the CA/FACE program is available from:

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