STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Testimony of Dr. Joshua M. Sharfstein
Secretary, Department of Health and Mental Hygiene
Dr. Gail Jordan-Randolph, Medical Director, Mental Hygiene Administration
Dr. David Helsel, Chief Executive Officer, Clifton T. Perkins Hospital

Before the Senate Finance and Budget and Taxation Committees

Security at Clifton T. Perkins Hospital

November 30, 2011

Introduction

Thank you for the opportunity to testify today on the recent incidents at Clifton T. Perkins Hospital Center (Perkins Hospital) and the steps that the Department of Health and Mental Hygiene (DHMH) is taking to improve security for staff and residents.

The three homicides at Perkins Hospital over the last 14 months were unacceptable and tragic. In this testimony, we will provide some basic background information about Perkins Hospital, explain actions taken in response to the incidents, and discuss the independent, external review now underway.

Our top priority in all of these efforts is the safety of Perkins staff and residents.

Clifton T. Perkins Hospital

Clifton T. Perkins Hospital Center is a maximum security psychiatric inpatient hospital operated by the Department of Health and Mental Hygiene in Jessup, Maryland. The Hospital is licensed as a special hospital - psychiatric by the Office of Health Care Quality (OHCQ) and is accredited as a psychiatric hospital by the Joint Commission. The Hospital opened in 1959 and was renovated in 1995 and 2010.

Hospital Vision. The Vision of Perkins is to be a premier forensic psychiatric hospital that provides effective and efficient assessment and treatment to psychiatric patients who require hospitalization within a secure environment.

Hospital values. The Clifton T. Perkins Hospital Center values are:

- Patient and staff safety;
- Patient right and commitment to our organizational Code of Ethics;
- Full disclosure of medical errors;
- Staff competency through a commitment to continuous learning and performance Improvement;
- Ongoing patient participation in individualized treatment planning that includes the family;
- The right of everyone to be treated with respect to include patients, staff and visitors;
- Limited use of Seclusion/Restraint.

Capacity. The hospital's capacity is 248 patients. This expanded in 2010 from 218.

Staffing. The hospital staff of more than 450 includes psychiatrists, social workers, psychologists, nurses, and psychiatric security attendants.

Patient population. Patients at Perkins Hospital have serious psychiatric disorders including schizophrenia, schizoaffective disorder and other psychotic illnesses. In addition, nearly all patients have faced serious criminal charges, including homicide, assault, first degree sexual offenses, arson, and robbery with a deadly weapon. More than 95% of patients are court-ordered to Perkins Hospital for evaluation and treatment. This population includes the most challenging patients to treat in the Maryland state psychiatric system.

Levels of care. Perkins Hospital has three levels of care. There are seven maximum security units, two medium security units, and one minimum security unit. Patient assignment to levels of care is based on a number of factors, including response to treatment, interactions with peers and staff, and clinical assessment. A Forensic Review Board must approve a movement to less secure settings. A Forensic Review Board and a judge must approve a conditional release.

Security. A secure environment is the responsibility of everyone at Perkins Hospital. Hospital administration must provide for adequate staffing, policies, and leadership that support a secure environment. Doctors must make challenging judgment calls about which patients are appropriate for which level of care and oversee an effective therapeutic regimen. Nurses must respond to the hour-to-hour condition of patients. Aides must provide 1:1 and other types of surveillance effectively.

Technology supports safety but cannot assure safety. On the maximum security units, patients can lock their doors from the inside. There are alarm buttons to allow staff to call for assistance.

Outside, the facility has a barb wire fence surrounding part of the "maximum security" side of the hospital. In addition, there is a sally port separating the maximum and medium sides of the hospital. All doors between the wards and any common area are locked and accessible only by key card.

The Incidents and Hospital Response

On September 26, 2010, Susan Sachs was killed at Perkins Hospital and another patient was charged. In response to this incident, OHCQ conducted onsite surveys of the facility on September 27, October 21, November 9, and November 29, 2010. The Joint Commission accompanied OHCQ on the October 21, 2010 visit.

The investigation revealed that the victim's bedroom door was unlocked when it should have been locked and the staff failed to observe that the perpetrator had entered her room. The investigation also revealed that staff members were asleep when they should have been awake and monitoring patients. OHCQ identified a number of deficiencies related to staffing, patient monitoring, and security systems. In response to this review, Perkins Hospital:

- terminated three employees;
- added a hall monitor to each maximum security unit;
- created a female-only maximum security unit;
- made improvements to the security system on the ward;
- updated employee training; and
- implemented random monitoring for compliance with changes.

In addition to these changes at Perkins Hospital, DHMH instituted changes across all state facilities to prevent staff inattention during night shifts.

OHCQ conducted 4 additional on-site complaint investigations of Perkins Hospital between December 2010 and October 2011. There were also approximately 7 administrative surveys performed related to other less significant issues. Two of the surveys found deficiencies relating to the improper use of restraints. None of the other surveys found deficiencies, and none identified problems related to patient safety.

On October 21, 2011, patient David Rico-Noyola was killed, with another patient charged with the crime. OHCQ initiated its review the next day and did not identify any deficiencies related to the incident. DHMH assigned Dr. Gayle Jordan-Randolph to work with Perkins Hospital to conduct a further review of the case and oversee necessary changes to improve security and the environment at Perkins.

On October 27, 2011, patient Rogelio Mondragon was killed by another patient who was also criminally charged. OHCQ noted several deficiencies, including that staff assigned to monitor

the hall where the attack occurred did not see the alleged perpetrator enter the room. OHCQ also noted that while the victim did lock his door effectively, he unlocked the door prior to the attack, allowing the alleged perpetrator to gain entrance. OHCQ suggests further technological enhancements be considered to reduce the chance that the security technology can be circumvented by patients.

In response to these two tragic incidents, Perkins Hospital, supported by Dr. Jordan-Randolph:

- Added a second hall monitor to each maximum security unit;
- Changed procedures regarding hall monitoring;
- Changed the staffing and patient mix on key affected units;
- Directed staff to clinically reassess every Perkins patient;
- Initiated a review of the on-ward security system; and
- Reviewed key procedures with Perkins staff.

Dr. Jordan-Randolph also met multiple times with Perkins employees and union representatives. A number of additional changes were made based on this input, including: developing a plan for reducing mandatory overtime, strengthening the change of shift procedures, and reevaluating the medication list and dosage for every Perkins patient.

In addition, following the traumatic events, Perkins Hospital made support available to all employees and patients and provided information and assistance to family members.

On November 11, the Department announced the creation of a Health and Safety Team with management and employee representation. This group will meet monthly and review data on patient-patient and patient-staff assaults, action plans related to safety, critical incident review, communication to employees, and training techniques.

Comprehensive Review of Security at Perkins Hospital

In addition to the direct responses to the incidents over the last 15 months, the Department has initiated a broad, independent review of security at Perkins Hospital. There is no stone to be left unturned as we look for opportunities to improve safety.

We have hired two of the foremost national experts in forensic psychology and psychiatry, with extensive experience in hospital administration, to lead this review. Dr. Kenneth Appelbaum is a psychiatrist and the Director of Correctional Mental Health Policy and Research at the University of Massachusetts Medical School. He previously worked for many years as the director of the mental health program in the Massachusetts correctional system.

Dr. Joel Dvoskin, a forensic psychologist, teaches at the University of Arizona College of Medicine. He has tremendous clinical experience in maximum security prison and hospital settings, caring for violent offenders with serious mental illness. He previously served as New

York State's Acting Commissioner of Mental Health and is considered a national expert on managing the risk of violent behavior.

These experts will review these incidents and current policies and procedures. They will speak with employees, patients, family members, advocates, and administrators, examine data on patient-patient and patient-staff assaults, workers compensation, seclusions and restraints, and provide an initial report in January and a final report in February.

New Leadership at Perkins Hospital

Dr. David S. Helsel was appointed as CEO of the Clifton T. Perkins Hospital Center on November 2. Previously, Dr. Helsel had served as the CEO of the Spring Grove Hospital Center since 2004. Prior to taking over as CEO at Spring Grove, he worked in various management capacities at the facility for 20 years, including as Clinical Director and Chief of Medical Staff from 1988 to 2004. He is an experienced and accomplished administrator and psychiatrist, and he is the right leader to steer Perkins Hospital through this difficult time.

Since starting at Perkins Hospital, Dr. Helsel has met multiple times with employees and drawn up plans to reduce overtime, hire more employees to focus on safety, and enhance clinical review. The Department will support his plans for improvement at the hospital.

This remains a challenging time at Perkins Hospital. We intend to continue doing everything possible to support safety at the hospital, including explaining our efforts with transparency to the legislature and the public.

Thank you for the opportunity to testify today. We appreciate your interest and welcome your input.