CRITICAL INCIDENT REVIEW

EASTERN STATE HOSPITAL

Forensic Patient Escape of 9/17/09

Department of Social and Health Services
Health & Recovery Services Administration
October 2, 2009

Background:

- This report is the result of interviews of staff members involved in the incident. The interviews were conducted by a multi-disciplinary team not associated with the escape event. Questions were based on “what happened,” “who was involved,” and timelines.
- Staff names, ESH organizational units, and patient names are confidential.
- This review is a collection of facts as best we know them and raises questions that the State Psychiatric Hospital Safety Review Panel will be asked to examine and make recommendations for systemic improvement including public, patient, and staff safety.
- This report covers the facts known at this time and cover:
    1. Timelines of events from the initiation of this field trip
    2. Events at the fair
    3. Events leading to the notification of law enforcement

- Note: Letters designate specific organizational units of ESH
- Note: Numbers designate specific ESH staff members

Selection process for this field trip: Planning for the trip to the Spokane County Interstate Fair began months before the event. Because hospital groups have gone to the fair in past years, this field trip is highly regarded by patients, and they are aware that group members must meet specific behavior and patient security levels before they can be included in the group.

1. 5/26/09
   ESH staff initiated “Supervised Trip Planning Form” to prepare for fair field trip

2. 7/15/09
   ESH Staff Team A discussed fair event and the patients cleared for attendance.

3. 9/2/09
   Sign-up sheet for the fair was posted on the wards for patients to request to participate.

4. 9/9/09

   List of patients reviewed by ESH Staff Team A to review and approve patients who requested to attend.
   - Decision to approve based on Level C’s (A-E scale with A being the least risk and E being the most risk)) and above are eligible, the type of activity, assessment of patient’s behavior and treatment compliance, review of patient rule violations, and staffing needs.

Ward environment before the field trip:

5. 9/15/09
   Individual orders written by ESH Staff Team A for approved patients to attend the fair as a field trip.

6. 9/16/09
   List of patients approved for event attendance reviewed again by ESH Staff Team A to approve patients to attend.

7. 9/17/09: ESH Staff Team A
   - Spokane County Interstate Fair: Events appeared to be normal the day of the fair, and hospital staff did not sense any signals that the day would not be routine. The subject patient's backpack was not searched this day, however, and staff said it would have been searched if it appeared too full.
   - 11-7 shift reported
   - 3-11 shift reported (9/16/09)
   - Ward quiet; all patients slept
   - No unusual behavior noted or reported
   - All patients scheduled for the field trip were reported by staff to have had the usual morning routine, got ready, ate breakfast, and waited until ready to leave for the fair.

8. 9/17/09: 8:30 AM
   - ESH staff reviewed all patients attending the fair to finalize the list of attendees.
   - ESH escort staff generated a list of cell phone numbers and patient assignments with each staff member (3 patients to one staff escort) per current policy. Two of the 11 staff had ESH cell phones and nine individual staff had their personal cell phones listed on the assignment sheet used to notify each other during the field trip. **Backpacks**: patients are permitted to carry backpacks to store their personal belongings and learning/therapeutic materials they receive from various treatment groups.
   - **Backpacks**: prior to leaving for the fair backpacks or purses were not searched. Attendant staff from team A did report they did a visual external search of subject patient's backpack and it appeared empty. Attendant staff from team A reported if a backpack appeared full they would have searched it.

9. 9/17/09: 9:45 AM
   Patients and ESH escort staff left for the fair:

- 1 bus with 25 patients and 9 staff
- 1 van with 6 patients and 2 staff

10. 9/17/09: 10:30 AM
    Arrived at the fair:
    - ESH escort staff explained expectations and notified each patient who their staff escort was.
    - One patient was permitted to attend who had a court ordered 1:1 staff requirement.

11. 9/17/09: 10:45 AM
    - Groups of patients/staff escorts went their separate ways to view exhibits they were interested in.

The Escape: A single staff person was assigned to three patients, including the subject patient who escaped. The operational rule was that the three patients had to do things together and wait on each other when one of them became involved in an exhibit or an activity. Early on things seemed to be proceeding normally.

12. 9/17/09: 11:40 AM to 11:45 AM: **Event**

    - ESH staff escort was positioned by a patient who was smoking and subject patient was about 10 feet away looking in the main building.
    - ESH staff escort looked at the patient who was smoking, then looked back at the subject patient's location and the patient was gone.
    - No other ESH escort staff observed the subject patient leave the location.

13. 9/17/09: 11:45 AM
    - Another ESH staff escort was in the area and was notified subject patient was missing.
    - This staff person monitored the 2 other patients while the subject patient's escort searched the immediate area and bathroom.
    - ESH escort staff reported it took 15-20 minutes to search the area.

Escape Response: Although each staff person had a cell phone at the fair, no one called 911. Instead, staff attending the group talked with each other and reported back to staff at the hospital about the escape. Current policy requires an immediate call to 911 immediately in the event of an unauthorized leave of a forensic patient.

14. 9/17/09: 11:54 AM
    ESH staff escort called another ESH staff escort person who was supervising other patients at the fair and reported subject patient was missing.

15. 9/17/09: 12:01 PM
    ESH escort staff escorting other patients at the fair were notified and concurred with another ESH escort staff person's recommendation to in ther all patients and staff in one location.

16. 9/17/09: 12:05 PM
    Patients and escort staff gathered in central location to return to hospital per Rehabilitation Services policy.

17. 9/17/09: 12:09 PM
    - ESH escort staff did a patient head count.
    - ESH escort staff called ESH switchboard to initiate reports that subject patient was missing.
    - Switchboard transferred call to ESH Administrative Unit B.

18. 9/17/09: 12:10 PM
    - ESH Administrative Unit B notified by ESH escort staff.
    - Description of missing patient was given
    - ESH escort reporting staff stated no indication from patient on acting out prior to unauthorized leave.
    - ESH Administrative Unit B instructed escort reporting staff to notify fair security and follow protocols specific to the Forensics Services Unit.

19. 9/17/09: 12:14 PM
    - ESH escort staff called ESH Administrative Unit C.
    - No answer the first time.
    - ESH escort staff called another phone number in ESH Administrative Unit C and reported subject patient was missing.
    - Call transferred within ESH Administrative Unit C; escort staff was told they did not need to call 911.
    - ESH escort staff at the fair asked 2 times if they needed to call 911 from their location and asked if they needed to return to the hospital.
    - Response from ESH Administrative Unit C was that a ward staff person would do the notice to 911 from the ward.

- ESH Administrative Unit staff C notified another C administrative staff member.

20. 9/17/09: 12:15 PM
    - ESH Administrative Unit staff C notified and instructed staff at fair to stay at the fair.
    - This information was relayed through a different administrative staff member in ESH Administrative Unit C.

21. 9/17/09: 12:16 PM
    - A second ESH Administrative Unit D staff member was called by ESH escort staff from the fair.
    - Initially no answer. Additional call made and connection made.
    - ESH escort staff at the fair were instructed by ESH Administrative Unit staff D to get everyone on the bus and return to ESH.

22. 9/17/09: 12:27 PM

    ESH escort staff at the fair connected with staff on the subject patient's ward and notified ward staff of unauthorized leave.
    - The call to ESH Administrative Unit C made by affiliated staff and the call made to ESH Administrative Unit D made by affiliated staff were made at the same time.
    - ESH escort staff at the fair interpreted that the unauthorized leave process, including calling 911, would be started by staff at ESH and the group could stay.

23. 9/17/09: 12:30 PM to 12:45 PM
    - ESH staff member 1 attempted to call ESH staff member 2 to receive specific instructions for the correct unauthorized leave procedure (12:30 PM).
    - Connection was not made.
    - ESH staff member 1 called ESH staff member 3 and explained the situation.
    - ESH staff member 3 reached ESH staff member 2 (12:33PM).
    - ESH staff member 2 called ESH staff member 1, discussed the situation and sent ESH staff member 4 to cover ESH staff member's 1 duties so this person would be uninterrupted in making notifications to law enforcement (12:33 PM).
    - ESH staff member 2 instructed ESH staff member 1 to contact another ESH staff member 5 to review process on all notifications for an unauthorized leave (12:34 PM).
    - ESH staff member 2 notified ESH staff member 6 (12:40 PM).

- ESH staff member 6 instructed ESH staff member 2 to notify hospital administration (12:40 PM).

24. 9/17/09: 12:45 PM
    - ESH staff member 4 notified ESH staff member 7 who notified ESH staff member 8.

25. 9/17/09: 1:00 PM
    - ESH staff member 8 notified 2 DSHS/HRSA staff members 9 & 10 via phone/voicemail.

26. 9/17/09: 1:10 PM
    - ESH hospital staff 1 called a more experienced ESH staff member 11 to ask for assistance in carrying out the ESH Administration Unit unauthorized leave process correctly.
    - ESH hospital staff 1 was instructed to follow notification on front of medical chart by ESH by ESH staff member 11.

27. 9/17/09: 1:10 PM to 1:45 PM
    ESH hospital staff member 1 made the following notifications:
    - WSP: 1:10 PM
    - Sheriff: 1:15 PM (Dispatch)
    - MLPD: 1:45 PM

ADDITIONAL CONTACTS WITH LAW ENFORCEMENT: Once law enforcement agencies were contacted, ESH turned to other notifications and began providing information to the Sheriff's office when requested for facts, a recent photo and description of what the escaped patient was wearing.

28. 9/17/09: 1:00 PM
    - ESH staff 1 having difficulty faxing to Green Hill (JRA unit that processes ESH warrant requests).
    - ESH staff 1 notified ESH staff C who notified another ESH staff C to notify Green Hill immediately. The call was made by ESH staff C and notification made to Green Hill.

29. 9/17/09: 1:40 PM

- ESH escort staff at the fair contacted by Sheriff's deputy who requested description of the subject patient and other identifying information.
- Sheriff's deputy asked why it took so long for notification to the Sheriff's Department.

30. 9/17/09: 1:45 PM
    ESH staff and patients return to bus for departure to ESH.

31. 9/17/09: 1:48 PM
    ESH staff C notify Victim Witness Program.

32. 9/17/09: 1:49 PM
    ESH staff C was notified subject patient had not been found.

33. 9/17/09: 1:57 PM
    ESH staff C emailed photo of subject patient to DOC.

34. 9/17/09: 2:00 PM
    Green Hill notified by fax by ESH staff C.

RETURN TO THE HOSPITAL: Almost three hours after the escape, the bus and van returned the remaining members of the field trip to ESH.

35. 9/17/09: 2:15 PM

    ESH escort staff and patients arrive at ESH and immediately return to wards.

36. 9/17/09: 2:30 PM
    - Patient meeting called on subject patient's ward to determine whether they had any information regarding subject patient's plans, communication and unauthorized leave.
    - No useful information was gathered to assist with locating the missing patient.

37. A staff member heard later that the subject patient had been planning the escape for over a month; however the remark could not be verified.

38. Subject patient's room had been locked by staff before the escape was reported. A check showed that it was very messy, with clothes, boom box, guitar, and art projects strewn about.

39. DSHS Secretary suspends all forensic group field trips at both ESH and WSH hospitals after she arrives in Spokane on other state business.

40. 9/18/09: DSHS Secretary also suspends all civil patient group field trips at ESH and WSH.