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OFFICE OF THE STATE COMPTROLLER

January 29, 2009

Michael Hogan, Ph.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Re: Report 2008-F-28

Dear Dr. Hogan:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution, and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Office of Mental Health to implement the recommendations contained in our audit report, *Office of Mental Health South Beach Psychiatric Center: Facility Security* (Report 2006-S-36).

Background, Scope and Objectives

The Office of Mental Health (Office) operates 27 psychiatric centers throughout New York State. These centers provide care and treatment for adults and children with various types and levels of mental illnesses. The Office operates two classes of psychiatric centers: forensic and civil. As a civil psychiatric center, South Beach Psychiatric Center (South Beach) located in Staten Island, serves patients who entered the system voluntarily or involuntarily. South Beach is obligated to treat patients who are there involuntarily pursuant to court order until the courts and mental health professionals have determined that they can be released.

Our initial audit report, which was issued on August 10, 2007, evaluated whether security measures at South Beach adequately protected patients, staff and the public. Our report identified instances where security measures were not complied with. For example, one patient left the grounds without off-grounds privileges and subsequently died while away. In addition, several other patients who did not have permission to leave the grounds were able to do so. We also observed taxis exiting the facility without being stopped at the front gate to verify that their passengers were either authorized visitors or patients with permission to leave the grounds. In November 2006, South Beach started a multimillion-dollar construction program intended to upgrade the facility's physical security. The Office's New Incident Management and Reporting System was established to compile relevant data on incidents occurring within South Beach and other facilities. This database provides a basis for staff follow-up, analysis and possible action. Our prior audit found that South Beach officials did not report certain security-related incidents involving patient escapes or assaults as required.

The objective of our follow-up was to assess the extent of implementation as of November 5, 2008 of the seven recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

We found that South Beach's officials have made progress in correcting the security issues we identified. However, additional improvements are needed. Of the seven prior audit recommendations, five recommendations have been implemented, one recommendation has been partially implemented and one recommendation has not been implemented.

Follow-up Observations

Recommendation 1

Comply with existing security requirements to control all persons and vehicles entering South Beach. Enhance current policies to include checks of all vehicles exiting the facility.

Status - Not Implemented

Agency Action - South Beach's executive director issued a July 18, 2007 memo to all staff reinforcing the existing security policy, including that "all cars when entering and parked on the grounds must have a parking permit displayed." In addition, the Chief of Security issued a memo on March 11, 2008 reinforcing the policy that all car service vehicles be stopped when they enter and exit the facility to confirm who they are there to pick up and who they have in the vehicle when they leave. We did not see adequate compliance with the overall entry security requirements. For example, on October 2, 2008 we tested compliance with the existing security requirements and observed a large trailer truck entering the facility through the main gate at 8:45 that morning without being stopped. Also, we observed that both the entry and exit barriers at the front gate were in the upright position at 12:45 PM that day. Our review of the memos issued on security by South Beach found that they were restatements of existing policy, not enhancements that would include a check of all vehicles exiting the facility. South Beach maintains that it would be impractical to stop all vehicles exiting the facility as it would cause severe traffic back-ups, especially during peak periods such as lunch time and shift changes, and the majority of people exiting the facility are known to the safety officers. We believe the benefits of enforcing required security measures 24-hours a day are worth any inconveniences that may occur.

Recommendation 2

Investigate the circumstances surrounding the security booth security lapses noted in this report and take corrective action as necessary.

Status - Implemented

Agency Action - South Beach investigated the security lapses related to the security booth cited in our prior report and identified the employee who was responsible for these lapses. The

employee was subsequently provided with counseling, including a written warning stating that additional actions would be taken if the employee's performance did not improve. According to the Executive Director of South Beach, the employee ultimately left South Beach.

Recommendation 3

Repair the fence to correct the potential for security breaches. Until the new fence and other planned facility enhancements are completed, institute periodic security tours to inspect the facility perimeter.

Status - Implemented

Agency Action - South Beach officials repaired the section of fence cited in our prior report. During construction of the new fence, South Beach has made periodic inspections of the current fencing surrounding the facility and has instituted periodic security tours of the perimeter.

Recommendation 4

Periodically review the color-coding on each patient's badge to ensure the appropriate level is assigned.

Status - Partially Implemented

Agency Action - Patient privilege levels are regularly reviewed by South Beach's clinical staff. The results of these reviews are then communicated to the security staff who are responsible to keep current the color coding on each patient's identity badge. Privilege level information on all patients is kept at three security-related locations: the main entrance gate, the Security Office and the Security Sergeant's office. This information includes photographs of all patients and identification card color codes to ensure easy identification of which privileges have been granted each patient. However, revisions to privilege levels are communicated to the security staff no more frequently than monthly.

We selected from the Security Office's patient listing the names of eight patients who on October 1, 2008 were listed as having off-grounds privileges. We reviewed clinical documents for each of these eight patients and noted that six did, in fact, have off-grounds privileges and the proper color code listed at the security locations. However, one patient had a privilege level change on September 3 and no longer had off-grounds privileges on the date of our review. However, since the security locations do not get revised privilege information more often than monthly, the three security locations did not have this updated information. A second patient had off-grounds privileges for only nine specific hours on Sundays for family visits, but according to officials at the Security Office and main gate, this patient's privilege level information did not reflect the limited off-grounds status. The Security Office and other security locations should receive updated and complete privilege information whenever that information is clinically revised in order to better track the movements of patients. South Beach officials have acknowledged that additional measures will be taken to ensure that color -

coding badges reflect the appropriate assigned level and that the facility will be developing an electronic notification system, to communicate changes in privilege level to the Safety Department as they occur. This notification system will become incorporated in the new security system for the facility.

Recommendation 5

Perform a detailed investigation of the circumstances surrounding the missing person incident noted in this report and take corrective action as appropriate.

Status - Implemented

Agency Action - South Beach officials conducted an investigation of the missing patient incident. We reviewed the investigation report and found it was quite extensive, involving ten committees, 12 reference sources including the patient's records, 16 formal interviews, eight informal interviews and a complete review of the patient's history. The investigation found four weaknesses in South Beach's actions that, had appropriate actions been performed, might have made this incident less likely to happen. The report makes four recommendations for improvements.

Recommendation 6

Instruct all facility staff to comply with OMH's incident reporting program, and provide them with training as appropriate.

Status - Implemented

Agency Action - All employees have now been trained and instructed to use the incident reporting system. One module of the annual training is a team review of the identification, documentation, reporting and investigation of individual incidents.

Recommendation 7

Periodically reconcile NIMRS entries to the Safety and Security Office's independent incident blotter to ensure all significant incidents are reported and followed up on as required.

Status - Implemented

Agency Action - We examined the Security Office's blotter and confirmed that incident entries on the blotter were periodically reviewed and signed off as reconciled with the New Incident Management Reporting System (NIMRS). We judgmentally selected one incident reported and entered on to the blotter on each of three dates: July 4, 2008, July 16, 2008 and September 24, 2008. We verified that descriptions for all three incidents were transcribed on to incident investigation reports filed at South Beach to be used to enter into NIMRS. We

also confirmed through NIMRS that all three incidents were, in fact, entered into the NIMRS database.

Major contributors to this report were Stu Dolgon, Jeffrey Marks, Dmitri Vassiliev and Sal D'Amato.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of South Beach and the Office of Mental Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Michael Solomon
Audit Manager

cc: Thomas Lukacs, DoB