

## District Attorney Braisted reports:

## 54 deaths at Willowbrook 'unavoidable'

By RAYMOND A. WITTEK

District Attorney John M. Braisted Jr. says he has reluctantly concluded that the "accidental" deaths of 54 patients at Willowbrook State School over a five-year period were "unavoidable."

Nevertheless, the district attorney faulted Gov. Rockefeller, the Legislature and others in state government for creating conditions of overcrowding and understaffing when, because of fiscal concerns, they saw fit to spurn pleas for additional funds, effective budget cuts and freeze jobs.

In a four-page report culminating a four-month investigation, Braisted indicated he found a correlation between the death rate and the conditions that developed at Willowbrook in the wake of budget problems.

At the same time, Braisted removed any cloud that may have hung over the head of Dr. Jack Hammond, who served as director of the institution for eight years prior to his transfer to Rome State School last month.

He also defended the institution's ward attendants, calling them "harried and overburdened."

Braisted pinpointed 1970 and 1971 as the years when most of the 54 deaths — 35 — occurred, indicating an alarming trend that reflects an overall deterioration of the institution during this period.

Although not mentioned specifically in the report, Willowbrook was one of the institutions under the State Department of Mental Health that felt the force of a \$15 million budget cut in 1971, and a job freeze imposed in December 1970.

Braisted's report had one ringing note that emerged above all others. The death rate

rose as the number of ward attendants declined, resulting in less and less supervision.

Braisted said he instituted the inquiry at the request of a parents' group at Willowbrook with a view toward determining whether there was any evidence of criminality which could be presented to a grand jury.

"The investigation has not turned up any hardcore substantial evidence of criminality nor criminal negligence on the part of any individual or individuals in connection with these deaths," Braisted said, adding:

"Instead, it has revealed an under-financed, overcrowded condition with an undermanned, overworked staff.

"All these factors, no doubt, contributed to at least some of the deaths. However, there is no one person or group who can be held responsible for any particular death or all of them in general."

Braisted, obviously alluding to the wide news coverage given Willowbrook in recent months, said the investigation made no attempt to concern itself with, or fix responsibility for, the "overall general conditions" at the institution.

The report covered the years 1967 to 1971, with the death rate rising from a low of 3 in 1967 to a high of 18 in 1971.

Braisted defined an accidental death as "any death that occurs suddenly to a patient who is not under active medical treatment."

Broken down into age groupings, the report said 8 of the patients were less than 11

years old, 19 between the ages of 10 and 20, 17 between 20 and 30, and 12 over the age of 30.

As for intelligence, the report continued, all but three of the patients "fell into the bottom two groupings on the intelligence quotient (IQ) scale.

Fourteen, with IQs of less than 36, were regarded as "severely retarded," and 37 with IQs of less than 20 were considered "severely retarded."

The report said 33 of the patients suffered from "seizures of various kinds" and 35 were in need of "total care."

Autopsies were performed in all but two of the deaths and these showed that 38 had died of asphyxia, six of unknown causes and 10 by other causes ranging from heart attack to a fractured skull suffered in a fall.

In 27 of the deaths, the report stated, an attendant was nearby when the patient died. This also was true of 19 of the asphyxia deaths.

"These figures show that the overwhelming majority of the victims . . . were those who needed the greatest amount of care, and that the major cause of death was that of asphyxia or choking," the report said.

Nearly all of the choking deaths, the report pointed out, occurred during or right after meal time and invariably the patient had choked on pieces of food.

On the question of insufficiency of personnel, the report cited statistics that were disclosed at various public hearings which showed wards with 60 to 70 patients staffed

by only two attendants.

Dr. Hammond was quoted as saying that due to the budget freeze and other financial problems Willowbrook was short approximately 1,000 attendants and that at one time the institution had more than 5,000 patients — 600 more than capacity and 2,000 beyond that recommended by the American Association on Mental Deficiency.

The report had this to say on the two logical targets of the investigation, ward attendants and Dr. Hammond:

## ● Ward attendants —

"There is presently existing, therefore, a situation where virtually a handful of trained ward attendants, straining under an enormous workload, are caring for an overwhelming number of patients, many of whom are incapable of performing simple functions on their own.

"Under these circumstances, and in the absence of any substantial evidence to the contrary, it would be not only improper, but grossly unjust, to attempt to characterize the inability of these harried and overburdened ward attendants to keep each and every patient under constant supervision and, in effect, the several places at one time, thus giving rise to any sort of criminal responsibility on their part for these tragic and unfortunate deaths."

## ● On Dr. Hammond —

"Our investigation has not considered or determined whether he performed well or was remiss in handling the situation.

"However, it has firmly concluded that Dr. Hammond could not in any conceivable way be held criminally responsible, either directly or indirectly, for any of the deaths that occurred at Willowbrook during his administration.

"He was forced to operate the institution on a budget that was totally inadequate. It was