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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, effectuate 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 6 of the patients were less than 10 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 a saying that due to the budg freeze and other financi problems Willowbrook wa short approximately 1,000 a tendants and that at one tim the institution had more tha 5,000 patients — 600 more tha capacity and 2,000 beyond tha recommended by the America Association on Menta Deficiency.

The report had this to say on the two logical targets o 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, be 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

documented that he took steps to reduce the patient population while repeatedly making requests for more funds. These efforts failed for the most part.

"Nevertheless, he attempted to remedy the situation in some manner.

"Since Dr. Hammond's efforts to improve matters were largely frustrated, the 'choking' and other accidental deaths must be characterized (distasteful as it may sound) as being unavoidable."

Case histories of tragedy

Two cases of patients who died of accidental causes at Willowbrook State School were described in District Attorney John M. Braisted Jr.'s report as exemplifying "the difficulty in caring for and supervising severe and profoundly retarded patients."

Braisted said, "These patients need constant supervision and can easily be stricken if left alone for even a short period of time."

One case involved what the report called a "typical" choking death. The patient, a 15-year-old boy, was found dead in his dormitory shortly after he had eaten supper.

Continuing, the report said:

"He suffered from profound retardation caused by epilepsy. His IQ was 13. He could not talk and did not show any awareness. He needed complete supervision and care in his daily needs, which included having to be fed by the attendant.

On Oct. 17, 1971, the boy was found dead by the attendant who had gone to get him for his shower. The autopsy revealed the cause of death to be asphyxia in the upper part of the larynx caused by vomitus material.

Another case is that of a 23-year-old patient who was found dead on the floor of a hall in Building 7. Here again, the cause of death was a bolus of food lodged in the throat.

The attendant in charge stated that this particular patient was the first to leave the dining room after eating while she was busy feeding other patients. This youth was unable to feed or dress himself and had an IQ of 19. He was also unable to talk."