After We Lost Andrew

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AFTER WE LOST ANDREW
By Deborah Clark Ebel, R.N.

The phone rang. The children were the only ones who received calls on the pay phones on the unit, so I decided to let it ring. Someone in the office said, “That’s his mother. Andrew’s mother. She was supposed to call him.” I stood frozen, listening to the ring, ring, ring--perhaps 20 rings--and then it suddenly dawned on me. She doesn’t know. She doesn’t know her son is dead. She expects Andrew to answer the phone.

The ringing stopped.

Slowly buttoning my coat, I listened to the conversation in the office. Well, somebody has to talk to her. You know she’s going to call back. What do we want to say? Who’s going to talk to her? We’ll tell her to go to Middlesex Hospital.

The phone began ringing again. I waited a couple of rings, then leaned into the office and asked if anyone was going to answer the phone. Apparently, they still hadn’t decided who was going to talk to Lucinda McClain, because the members of the administration kept discussing who and what and how, looking at each other, waiting for someone to make a move. The ringing continued.

I felt annoyed at their indecision, and at their delay in answering the phone. I realized that talking to her was going to be difficult, but she deserved to know what had happened, and, as the evening coordinator, I certainly didn’t have the authority to talk to her about something like this.

Finally, Program Director Brian Fay stood and went to answer the call. Andrew’s mother wanted to speak to him. She also wanted to know why it took so long to answer the phone.

The conversation was brief. Brian explained that Andrew was not on the unit; that something had happened and there was a problem. Ms. McClain was told to go to Middlesex Hospital, where they would give her more information.

Andrew had been dead for more than an hour, all this activity was going on, and yet his mother didn’t know her life had been unalterably changed. I thought of the bond between mother and child, of the link between me and my own children, and what an empty hole there must be when one loses a child. I didn’t know exactly what her relationship with Andrew had been, and I didn’t care. She was his mother. He was her son.

My phone, at my home in Manchester, had rung a few minutes after 9 that morning, Sunday, March 22 and I had ignored it.

It was my day off, and I was exhausted and there was a late-season blizzard blowing. Working full time in a children's psychiatric unit was a job I loved, but it was also exhausting and my weekends were a time to regroup. I didn't want to see anybody or talk to anybody--my bed and comforter were quite warm and comfortable, thank you very much.

My sleepy teenage son dragged himself into my room and told me it was Donna from the hospital calling. I groaned.

"I am not working today; I'm too tired. Tell her I'm sleeping and I'll call her back later."

Donna was the nursing supervisor and I knew her call meant she wanted me to come in to work. No, I reassured myself, there's no way I'm working today. I pulled the comforter tight under my chin and snuggled deeper into the warmth as Jon returned to the phone in his room.

"Uh, mom…" Jon was at my door again. "She sounds really mad. She said to tell you to get out of bed, that she really needs to talk to you now."

I stumbled to the phone and mumbled a greeting of sorts.

"Debbi? We've got some problems here and we need you to come to work." Donna sounded rushed.

"Uh, do you really need me, Donna? I'm beat and I need a break."

"Andrew McClain went into cardiac arrest during a restraint this morning--the EMTs are getting him ready for transport to Middlesex Hospital now." She paused. "We really need nursing support here. Things are a mess."

Andrew had been admitted during the early morning hours the previous Thursday, and was on the unit when I worked Thursday and Friday. Having met him only twice, I knew very little about him. He was easy to picture, mostly due to his prosthetic eye, but his story was like that of so many of the others--troubled family life, foster homes, and problem behavior.

I agreed to be there as soon as I could. Driving to the hospital, I thought about what Donna had told me, and tried to imagine the scene. There were 26 children on the unit and something like this was sure to have frightened them. At the same time, it was hard to imagine anything really serious happening on the children's unit. I even had a passing notion that there might have been a mistake or overreaction and Andrew would be back by the time I arrived. Oh well, I rationalized, I'm awake now and it'll be a relaxing day with the kids.

I found our nurses' office busy with administrative personnel, staff from other units and our unit's staff from other shifts. Everyone looked stunned; silence filled the nurses' station. People clung to each other and rocked back and forth, seeking strength, seeking comfort. Andrew had been pronounced dead at 10:17 a.m. The inconceivable had happened.

Dead. I turned the word over and over in my mind. It didn't connect.

Karen Slonus, the registered nurse in charge of the unit that morning, and the two mental health workers involved in the restraint, Jen Bryant and Spero Parasco, were in the office. Bryant sat sobbing while the nurse manager, Marcia Pella, sat next to her, gently rubbing her back. She seemed to be trying to make sense of everything. Of something. Of anything.

My heart went out to her. We were both nurses. What would I have felt had I been in her place? Would I have responded differently? What would I have done?

Jen sat cross-legged on the floor, fists clenched. She rocked back and forth, sobbing and moaning, like a wounded being. When a co-worker offered, “It’s going to be OK,” she could not be consoled.

Spero sat alone in a corner, head down, hands visibly shaking. He looked dazed, as if he wasn’t quite sure what was happening. He looked lost.

My own eyes welled. There was nothing that could be said to comfort them. Nothing at all.

I had worked as evening coordinator of the unit for a year and a half. The staff with whom I worked most closely genuinely loved the children on the unit. Gender, race, religion--all were irrelevant. A majority of the hospitalized children had Department of Children and Families involvement; many were wards of the state. Many had lived their childhoods surrounded by abuse and violence and drugs. Many had arrived on the hospital unit with all their worldly belongings packed in a plastic garbage bag.

Our staff tried to create a stable and caring environment for the children. We wanted an atmosphere where deeply troubled children could, perhaps, develop a stronger sense of self and learn better ways of handling the horribly difficult circumstances they lived with outside the safety of the hospital. The staff laughed and played and joked with the children, comforted them, and held them close whenever they needed it.

These are children we on the unit grew to care about and, not infrequently, came to love. These are children who, for a variety of reasons, had problems on the outside, but who found a place in our hearts and who, for many of us, will reside there forever.

Someone said, “Are all the kids off the unit? The police want to come in.” I turned and answered to no one in particular, “Yeah. They’re at the gym and then they’ll be up at the school.”

I watched from the sanctuary of the med room as the Portland Police and the state Police Eastern District Major Crime Squad sealed the entrance to the timeout room with yellow “crime scene” tape. It was disconcerting to think of any part of the unit being a crime scene.

The unit, these rooms, had always been a place where I had been just as comfortable as in my own home. Even on those evenings when the unit was chaotic and one or more kids was out of control--kicking or spitting or biting or hitting or throwing furniture--I knew the routine, the plan, and had a pretty good picture of the outcome. This was different. It felt like a foreign land. It felt unreal.

I thought about the timeout room and wondered if it would look any different now that a child had died there. Would I sense Andrew’s presence and his last moments on earth? Logically, I knew the answer, but everything had changed so much, so quickly.

Senior hospital officials gathered in the nurses’ office, including Robert Everett, the president and CEO, Michael Suchopar, the vice president of operations, and others. Andrew’s chart and medication sheet were pored over and scrupulously studied. Medical data, including his admission history and physical and lab work, were reviewed and then photocopied for closer inspection later.

Then the phone rang. Andrew’s mother was calling her son.

Normally the children walked to the hospital cafeteria for lunch and dinner. This day was different. In order to protect the children from learning about Andrew's death before we had an opportunity to tell them, we kept the children sequestered in the school. The cafeteria prepared tray lunches and wheeled them up to us.

Visiting hours on Sunday were from 1 p.m. to 2 p.m. To prevent the children's visitors from inadvertently going to the Unit, where the police and administrators were, visitors were met in the main reception area and directed to the hospital school.

Most of the children don't have visitors. Ever. Many of the children no longer have any involvement with their biological families, and many times the children are "between" foster homes. Even when there are interested family members, they often have no transportation to the hospital. On that Sunday there were three, maybe four, visitors.

One of the younger boys was visited by both parents. He excitedly told his parents that, "Andrew got sick and had to go to the hospital this morning." His mother patiently explained that this was the hospital and that this was where Andrew was. (I don't believe she knew who Andrew was; she just knew he was another child on the unit.) Her son kept trying to make her understand---"But, but, but…" and "No! Another hospital!"--but she never got it. I sat quietly with one of the mental health workers, watching the kids, hoping the mother wouldn't come over and ask me any questions. She didn't.

I relaxed a little when visiting hours were over. Back In the nurses' office, I started my shift. The office remained hectic, with people coming and going. The evening staff started to arrive, and those who hadn't already heard about Andrew had to be told. Everyone was shocked, but quickly asked where they were most needed. I sent them up to the school to relieve the exhausted day staff.

The nursing supervisor came by and told me to remove Andrew's name from the computer census.

I rapidly moved through all the discharge screens until I came to the areas indicating reason for discharge and to where the patient was discharged. There were about 15 options; this was a procedure I ran through every evening.

None of the options were what I needed. On a routine discharge, I would label the "reason for discharge" as "with maximum benefit," which means that the patient has received as much from the hospitalization as was possible. The next step would be to indicate where the patient was going to be discharged: home, residential treatment facility, state hospital, for example.

I was stumped. The computer program didn't allow for someone to die. I ended up discharging "with maximum benefit" to "hospital."

Around 4:00 that afternoon, the unit's clinical staff arrived to be available when we told the kids. It was important that they learn about Andrew's death from us. I found myself dreading the whole thing.

The children filed in from dinner and were directed straight to the burgundy couches in the center of our community room. This is where, ordinarily, we have group meetings and where the children gather before leaving the building for school or gym. They didn't seem to notice the unusual number of staff people standing around: nurses, mental health workers and clinicians who were not scheduled to work weekends. The children knew everyone's schedule, days and times, and if a staff person was in on the "wrong" day or time, the child usually called it to their attention immediately. This day they made no comment. Maybe they intuitively knew why.

The nurse manager began to speak to the kids, and at that moment I began to battle with tears. My eyes burned, then blurred. I told myself sharply, Now's not the time--take a deep breath--think of the kids, they come first. And somehow the extra strength I needed pulled me through.

We explained that when Andrew had gone to the hospital that morning that he had stopped breathing. That his heart had stopped. That the doctors had worked very, very hard to get it started again but that there was nothing they could do and so he had died. There were a couple of gasps from the group, and some of the children cried. Softly.

Some of the kids were personally familiar with death--it's not unusual these days for a child here to have a relative, even a parent, who has died from drugs, violence or AIDS. Some of the other kids, though, were so young that their concept of death was unclear. We talked briefly about the meaning of death and reassured the kids they were safe. The clinicians, nurses and mental health workers made it clear they were available to any child who needed consoling or just wanted to talk.

One of the children quietly raised his hand. When called upon, he gently asked if we could have a moment of silence for Andrew. In that room of mourning, the silence was deafening.

Later that night, safe at home, I watched the 10 o'clock news. Andrew's death was the lead story. The reality of what had happened overwhelmed me, and I was consumed by feelings I had suppressed all day--sadness, despair, fear, horror, confusion. I began sobbing the first tears of many that would flow for many months. I didn't sleep that night.

On Monday morning the entire unit staff, as well as the hospital school teachers, were telephoned and told of a mandatory 1:30 p.m. meeting. The preliminary autopsy report would be released at 2 p.m.

Nurses, mental health workers, clinicians and teachers gathered around a table in the conference room. The somber formal portraits of the founder and past directors of the hospital stared down at us as the program director, reviewed the previous day's events, and went into more detail for those who had not been present. The sentiment most commonly expressed was, "That could have been me doing that hold." The second was a hope that Andrew's death was due to some pre-existing medical condition and not to the restraint.

There were expressions of support for the staff members involved in the restraint. We all were deeply concerned for the three of them, but our positive statements were as much about our own fears as about our three co-workers.

The director warned us that the autopsy results might not turn out the way we hoped. I knew then that he already knew. He couldn't and wouldn't tell us until the report was officially released.

The vice president of operations, entered promptly at 2. He slipped quietly into a chair near one end of the table and sighed deeply. He looked exhausted. The preliminary report had been released and it indicated that Andrew had suffocated.

Suffocated. It was the outcome we feared most and it stirred all our innermost doubts and fears. Although we were devastated by the death of a child in our care, to think that an action done by any one of us might have contributed to his death was overwhelming. Most frightening was the fact that we all had done countless restraints just like this one.

The single exchange with Andrew I remember was when I had given him his medications on

Thursday evening. He took nortriptyline, an antidepressant, and risperidone, a powerful antipsychotic to help control his behavior. He put the pills into his mouth and gave me a steady, almost challenging, look. “Did you swallow them? Or are you messing with me?” I asked.

Patients not infrequently “cheek” their meds and spit them out when the nurse is not looking. They don’t like the side effects, which can range from dry mouth to lethargy to disorientation.

Andrew held his gaze, but didn’t answer. He opened his mouth and moved his tongue to show me he had swallowed, then turned sideways and watched me with his good eye.

My gut feeling told me he hadn’t swallowed the med, so I told him I wanted him to wait with me at the med room. Eventually the pills would melt and he would have to swallow. I started my usual explanation about meds and the importance of taking them, but Andrew wasn’t listening.

I wasn’t surprised when I read the report of Andrew’s autopsy and noted the “zero” blood level of risperidone, the antipsychotic. Antipsychotics in children are used to treat, among other things, self-injurious behavior and uncontrollable aggression. Andrew went to the timeout room, and was restrained, after threatening another boy and going into a tantrum.

The “zero” risperidone level meant Andrew had been cheeking his meds.

Someone asked me recently what it’s like to work with children in a psychiatric hospital. It is a position that is personal and intimate, because the worker gets to know the patient’s fears, hopes, sadnesses, and a myriad of other feelings that people normally keep to themselves. It’s vital to maintain a balance between the natural desire to ease a child’s pain and the need to keep a healthy professional distance. In many ways, it’s like working within two separate realities at the same time.

On one hand, the child’s history may include severe abuse, either sexual, physical or emotional, or serious behavior problems that include fire-setting, assault, or any number of other behaviors that until recently have been beaten, prostituted, burned or made to witness shootings, and there are children who abuse and kill animals or endanger the lives of other people. Sometimes I think there’s nothing new to shock me. But there is…there always is. Just when it seems I’ve heard or seen it all, a new, brutalized kid comes along.

The child may hit, kick, bite or spit at staff members, or assault them with any item within reach, including chairs, tables or toys. Children can be surprisingly strong when angry, and I have known workers to suffer fractured ribs, broken noses, deep lacerations, and concussions during confrontations with patients. The worker learns quickly to be on constant guard to prevent injury to a child or another staff person.

Workers on psychiatric units are regularly targets of extreme vulgarity, name-calling and threats. The names I have been called by 5-year-old children would not be printable in any newspaper. Experience and professionalism allow these things to roll right off the worker--there’s not the same emotional response there would be if the worker’s own child said or did these things. It’s part of the job.

The hold used with Andrew is called a two-person therapeutic hold. Devised at our hospital, it was taught to all nurses, mental health workers and others with significant patient contact at the hospital.

A staff member crosses the patient’s arms across his chest from behind and grasps both wrists. The patient is then lowered as gently as possible to the floor where he lies face down across his own

arms. The worker holding the wrists may need to apply slight-to-moderate pressure to prevent the patient from rolling over, but should never apply heavy pressure.

A second worker crosses the patient's legs at the ankles to prevent the patient from kicking. The Portland Police Department investigation later found that, in Andrew's case, the hold had been done correctly. The theory of the hold itself was at fault.

That Monday, the heartbreak in the room was palpable. Some sat silently; some sobbed openly. Sadness saturated us. For Andrew, his mother and ourselves. For all the children.

Michael Vaughn left for a meeting to inform the rest of the hospital staff of the autopsy results. Others returned to the unit. Some of us stood silently, embracing, seeking some strength, some solace, from one another. Together, we slowly returned to the unit where 25 children still very much needed us.

The courtesy shown to us that day by the Elmcrest administration--informing the Saybrook Unit staff of the autopsy results privately and separately from the rest of the hospital--was, my opinion, one of the few times proper consideration was given to the serious and disastrous impact Andrew's death had on the staff.

We learned that we were to be observed by staff from Riverview Hospital for Children and Youth, an institution run by the Department of Children and Families. In order to ensure the safety of the remaining children and provide assurances to the appropriate monitoring agencies, observations were to be conducted 24 hours a day, seven days a week. Having to prove to the outside world that we were not going to harm children placed in our care was an uncomfortable, although understandable, situation. It was hurtful, and the daily media reports contributed to our feelings of isolation. Added to this was uncertainty as to whether DCF would remove the remaining state-custody children from our care.

The Riverview staff was extraordinarily compassionate and understanding of our situation. One of the observers even confessed to feeling embarrassed at having to be there--he recognized that we were peers, working for the same thing, and he felt uncomfortable being placed in a "monitoring" position.

Besides these investigators, there were investigators from the Department of Public Health; there were other DCF investigators looking into other, unrelated, allegations; and, in the midst of it all, there was an inspection by the Joint Commission on Accreditation of Healthcare Organizations. During April and May, DCF personnel frequently pulled aside one or another staff person, sometimes questioning them for an hour or more.

We found through talking with the various observers that some of them had been retired from inpatient psychiatry for years. Some had no experience with children other than parenting. Some had no psychiatric experience. Some of the observers were quiet; some followed fast on our heels, taking note of every action or non-action. It was a challenge to function normally when we knew every move we made was being judged.

There was one instance in which a young boy climbed to the top of a freestanding closet, about 6½ feet off the ground. He flailed around, hanging over the side, threatening to jump, then appearing to almost fall off. I told one of the mental health workers to get him down, which he did.

The boy immediately climbed back up and resumed his actions. I was worried that he would fall and be injured, so I again told the mental health worker to get him down and, if he continued to exhibit unsafe behavior, to escort him to the timeout room. As the mental health worker once more got the

boy down, the boy began to hit and kick the mental health worker and ended up in a restraint.

The observer caught me outside the timeout room door and began criticizing my actions, stating that she thought I had “set him up” by making him come down from the closet, that she didn’t think he would have gotten hurt. I turned away, unable to answer. My eyes burned and stuck in my throat were the words: “We’ve gone through hell here, every single one of us. So don’t you dare tell me you don’t think he would have gotten hurt. Nobody thought a kid would die in a restraint either and no one is getting hurt on my time!”

On March 22, the children’s unit housed 26 children between the ages of 5 and 13. The unit was designed to hold 24 children. One year previously, there had been 31 patients in the same space.

During those times when there were more than the approved 24 children, the “extras” slept in beds on the adolescent unit, and were entered on the hospital census records as adolescent-unit patients. With a staffing ratio of 1 to 4, the 26 patients on the unit should minimally have been assigned six staff people. It came as no surprise, however, that the number on March 22 was five; one registered nurse and four mental health workers.

As managed care strives to cut costs, staffing has been cut to bare minimums. This was true on our unit before Andrew McClain’s death and continued with only slight improvement afterward. Following Andrew’s death, we were more likely to be assigned one or two additional mental health workers, yet I continued to be the only nurse on the evening shift until mid-June. In fairness, I must add that the staffing conditions at this particular hospital are infinitely better than at many privately operated facilities.

Violence management is commonplace, as staff must protect themselves. At the same time, staff must be careful to ensure the safety of both the violent patient and other patients on the unit.

Every staff person would prefer to avoid placing a child in a hold. It’s always a critical decision, and the physical and emotional implications must be carefully weighed before committing to such a move. But the growing numbers of patients, the increased severity of diagnoses and the baseline staffing make the use of restraints unavoidable.

The most immediate and obvious reaction of unit staff to Andrew’s death was a reluctance to put hands on a child. We were fearful of doing any sort of therapeutic hold, and often hesitated far beyond what was safe for the child, the other children or the staff. One day, an older boy filled a sock with small toys and ran around the unit swinging and hitting furniture and younger children with his homemade flail. The staff repeatedly used “verbal de-escalation techniques”--calm, reassuring speech and body language--in an attempt to get the boy to put the weapon down, but he would listen to none of it.

Before Andrew’s death, the boy would have been stopped at the outset and escorted to the timeout room. To have permitted him to hit even one child would have been unthinkable. Instead, staff leaned too far the other way and did not take the appropriate action. Indecision was rampant.

Complicating things further was the fact that the children sensed our apprehension and took advantage of it. Although some of their increased agitation was due to staff anxiety, these children were dealing with their own sense of loss and feelings of uncertainty. On those few occasions when staff put hands on a child, it was not unusual to hear a cry of, “Please don’t kill me!” In addition, the presence of the monitors--numerous unknown and unfamiliar persons--asking probing questions made the children feel even more fearful, threatened and unsafe.

The day after Andrew's death we were no longer permitted to use the kind of restraint that had been used on him. Unfortunately, we were provided with neither an alternative nor sufficient staff to compensate, which resulted in indecisiveness. This was not a major problem with younger or smaller children, but, for a time, we had no safe or adequate mechanism to deal with frequently out-of-control adolescents.

The doctors did not escape this uncertainty and indecision. They were, however, reluctant to change over to "mechanical restraints" that we were now permitted to use: the papoose board and the safety coat.

The papoose is a 3- to 4-foot-long padded board with large Velcro straps designed to restrain a small child for his or others' safety. Separate Velcro straps hold the child's hands at his sides. The safety coat, also called a "body bag," is made of heavy-duty canvas with wooden or plastic slats sewn into it to maintain rigidity. The coat covers the patient's body from feet to neck. An out-of-control patient is zipped into the coat, and the coat is secured by four buckled straps.

Shortly after we began using these, I called one of the attending physicians for an order to place a severely out-of-control 8-year-old boy in a papoose. The child had been kicking, hitting, biting and spitting at staff members; he repeatedly banged his head on the floor and bit his hands and arms until they bled. He craved the safety and security the restraint provided. It had served as an external control for behavior he could not control from within. He rarely stopped this behavior until he was placed in a safety coat or papoose.

I explained to the doctor that we had tried verbal intervention and that at this point five mental health workers had been working in the timeout room with the boy for 10 minutes without success. The doctor refused to give the order, stating he wanted to avoid the restraint.

The child continued fighting for another 20 minutes, and I again phoned the doctor to tell him I must have the order. The continued manhandling was more abusive than placing the child in a papoose, where we knew he would calm down. I got the order, we placed him in a papoose and 25 minutes later I was tucking the child into bed.

One of the on-call doctors resigned, followed by a fairly rapid exodus of mental health workers and registered nurses. Many of these were professionals with extensive and valuable experience. One registered nurse said to me in tears, "I just can't take this stress anymore." Another said, "I cried three times before noon today…I have to get out of here."

The environment changed every day: Policies were revised and documentation and expectations changed daily. Sixteen-hour days and six- or seven-day weeks were standard. Requested days off were denied, no matter the reason, and dinner breaks, or even bathroom breaks, were rare. During one visit to a fast-food restaurant located near the Elmcrest, the young man behind the counter spotted my Elmcrest employee badge and said, "Are you one of those people who killed that kid?" This was all in addition to continuing to do the basic and my unit--caring for the kids.

In the first weeks following Andrew's death, none of us anticipated the repercussions his death would have on us, nor how it would forever change so many of our lives. At that point, we were simply trying to keep things together and respond to the situation the best way we could.

In "Critical Incident Stress and Trauma in the Workplace," Gerald W. Lewis, a clinical psychologist who helps organizations deal with employees who have experienced workplace trauma, says the death of a child is one of the most severe "single-victim" incidents for those in the helping professions.

“Employees dealing with such incidents may go through reactions similar to those of actual victims of trauma,” says Lewis, who works on a crisis-intervention team at Boston’s Logan Airport. He recommends that constant accurate information be provided in order to avoid the rumor mill: “If people are not provided with information, they tend to create it out of bits and pieces, fantasy, distortion and fear.”

Hospital managers were so caught up in the responses to the Department of Children and Families and Department of Public Health that they failed to grasp how seriously strained the staff really was.

The staff participated in two brief meetings with an employee assistance counselor from St. Francis Hospital and Medical Center, both during our on-duty and on-unit work time. They consisted primarily of the employees’ complaints regarding increased work-time demands and management’s unrealistic expectations, rather than discussion of the events surrounding Andrew’s death and our own feelings of vulnerability. Two journal articles, one of them by Lewis, on employee trauma were left in our unit mailboxes.

Although Andrew’s death had been ruled “accidental” by the medical examiner, no decision had been made about whether the two workers who used the restraint would have criminal charges brought against them. An indictment of them would have felt like an indictment of us all.

It was difficult to accept the negative and what seemed like unending media reports. Aware that many in the public saw us as under skilled workers who recklessly endangered the children in our care, we removed the Elmcrest employee parking stickers from our cars’ windshields to discourage vandalism. We heard that the “thing to do” was to rewrite our resumes to say we worked for St. Francis Care—Elmcrest’s parent company--rather than Elmcrest. Parents of new admissions frequently asked to see the timeout room “where that boy died” and others made statements such as, “If you people hurt one hair on my kid’s head…”

As someone whose entire career has been dedicated to the care of children and families, being viewed in that light was excruciating. At Elmcrest, we cared deeply and took pride in what we did. Now we were not only dealing with a child’s death and our own emotional reaction to that, but were watching things we believed in and cared about--and knew we were good at--falling apart. No one on the outside knew.

Information about the status of the investigation came in bits and pieces, if at all. A copy of a notice placed in the newspaper by Elmcrest was posted on the unit bulletin board--this, about a month after Andrew’s death, was the first time Elmcrest had publicly notified staff that there had been a delay in the institution of CPR on Andrew. When I read about that delay, I felt as if I had been kicked in the stomach. I was physically ill. There were whispers of delays in getting oxygen containers for Andrew and problems with the 911 call.

We learned the FBI was looking into whether race might have been a factor in Andrew’s restraint and subsequent death. It was not, and it stung to learn that anyone might think it had been.

No one answered our questions.

In May I learned that I had developed a cardiac condition and requested a Monday off for the first part of a cardiac stress test. Despite my doing a double shift on Thursday, being asked to do the same on Friday, and being requested to work on Saturday and Sunday, my request for Monday off was denied. The tension and stress continued to mount. I cried more and more frequently.

As employees resigned, greater demands were placed on the remaining personnel. There was more overtime and more paperwork. More demands and less support. Rather than feeling valued for our dedication and experience, it felt as if our loyalty was taken for granted. Recruitment bonuses of $2,500 were offered for newly hired registered nurses, and temporary agency nurses and mental health workers were engaged at almost double the hourly rate of the regular Elmcrest nurses.

By July, the unit's day nursing staff had deteriorated to two per diem nurses, the evening staff had one temporary agency nurse and a new graduate nurse, and the night shift had one agency nurse. There were no longer any regularly assigned registered nurses.

New carpeting was put on all the units, and the walls were painted with lighter, brighter colors. New furniture was ordered for the unit. Senior personnel solicited staff input on carpet and furniture color choices, though they hadn't asked for our recommendations regarding what would benefit the children or improve the unit's programming. We were told to hang up child-style posters and pictures.

A "patient acuity" system was implemented, which was supposed to determine staffing levels. In reality, many times the numbers were incorrect or manufactured. Even if the numbers had been correct, they in no way reflected the unique needs of the children's unit. A "patient assignment roster" gave the appearance of assigning individual staff members to individual patients, but was really just a piece of paper. Staff would look to see to whom they were assigned and touch base with the patient, but this did not function as a true "primary assignment" in which the staff person gets to know the patient thoroughly. None of these cosmetic moves got to the core of what were serious and significant inadequacies.

In October, The Hartford Courant published its investigation, "Deadly Restraints," that turned up 23 restraint-related deaths over an 11-month period in psychiatric and mental retardation facilities nationally. It's unfathomable that a facility such as Elmcrest wasn't aware of any of these deaths. Even one death attributed to restraint, particularly in cases where staff had used the method also used at Elmcrest, would seem to have warranted some questioning by the hospital's risk management committee.

As employees, we performed restraint procedures as we had been taught by hospital instructors and as required by hospital policy. This technique--which Elmcrest had used for two years--was taught to every Elmcrest employee. We used the holds believing they were safe. The two mental health workers involved in Andrew's restraint were both current on their training, with one of them having completed his annual update just days before Andrew's restraint. It is difficult to realize and accept, that we placed our patients and ourselves jeopardy every time we used this restraint.

It's no cliché to say that America today is truly a nation in crisis. Unless we want these angry children to grow up and become angrier adults, every man and woman in this country should take this situation seriously. All politicians know how to talk the "kids are our future" talk. Unfortunately, we're decades beyond talking and must take action. To the politicians I say, don't waste money on studies that tell us we have a problem. We know that. It's time to get practical and do some real work before it's too late. Our situation didn't happen overnight; it was 30 years in the making. There will be no quick fix.

Although inpatient psychiatric hospitalization is necessary in some cases, I do not believe it benefit's the majority of those who are admitted to such facilities. Admitting a 2-year-old child to a psychiatric unit (which Elmcrest does not do, but which I have seen elsewhere) is ridiculous. A 2-year-old with a behavior problem is obviously a 2-year-old with a parenting problem. Even in those instances in which a child genuinely might benefit from psychiatric treatment, the system as it now exists is

inefficient and often unsuccessful. Short-term treatment (as approved by most managed care companies) rarely provides more than stabilization of the immediate crisis and institution of a regime of medications such as antidepressants or tranquilizers. And once approved insurance benefits have been exhausted, the child is discharged.

I recently had lunch with a friend, a former supervisor at a psychiatric hospital. We talked about the number of outstanding nurses who simply cannot work within the psychiatric system any longer. We talked about how painful the work is and how lonely the work is. It's not the kind of job where you can go home at the end of the day and share with your spouse. They wouldn't understand. Yet the people who work in the system go back day after day to care for the people who no one else cares about. To care for the children no one cares about. Until someone dies. Like Andrew.

I hardly knew Andrew; he hardly knew me. Yet I have carried him with me every hour of every day for nine months. The impact his untimely death had on me cannot be measured. The agony, the tears, the doubts, the unanswered questions. I don't know or understand why Andrew's death and the subsequent events affected me the way it did.

To sit down with one of these kids can be like sitting with any kid. My kid. Your kid. The neighbor's kid.

It can be getting a HIV-positive child to take his numerous medications by encouraging him to toss the empty med cup into the trash can just like Michael Jordan and cheering him on with, "He shoots! He scores! The crowd rises to its feet!"

It can be sitting in a rocking chair, reading two or three or four stories--then continuing to rock long after the stories are over and the child's eyes blink slowly as he falls asleep. It can be realizing that this child may never have been rocked to sleep in his life.

It can be humbly accepting a child's carefully drawn and colored picture or helping a little girl braid her hair. It can be teaching the importance of basic hygiene such as daily bathing, tooth brushing, and clean clothes.

At the same time, it can become charged with emotion when a child breaks down because he hasn't heard from his mother in over a year, or he's been through a dozen foster homes, or he feels responsible for his father dying; or when you realize that you're the closest thing to a family the kid has.

And when the moment comes that the child asks if he can come home and live with you, you swallow hard and explain that you can't do that, that you have your own family and that you're sure his next foster family will be the best and that they will love him very much. But inside, you really wish you could take him home.

We talk, we laugh, we play. They cry to you; you cry alone. And you never know what the next five minutes will bring.

I have walked with Andrew's ghost for the better part of a year now. Gradually the people involved in the situation have moved on and wounds have begun to heal…slowly. Wonderful, caring and extremely talented individuals who used to work with the children are now scattered--working in convalescent facilities, bookstores, home care and flower shops; or not working at all. Through The Courant's investigative work, greater awareness and attention have been drawn to some of the problems in psychiatric hospital generally, and with restraints specifically.

The conditions children face that lead to their placement in psychiatric hospitals and residential treatment facilities, as well as the attitudes that will ultimately spring from their experiences, are far more commonplace than society has acknowledged or would like to believe.

For the most part, society wears blinders when it comes to the atrocities perpetrated on countless children. We become indignant over isolated media reports of abuse, yet thousands of children and teenagers content with maltreatment every day of their lives. It's not something that's easy to think about, so we don't. Turning them into psychiatric patients, complete with a diagnosis, however, is not the answer.

It's time to allow Andrew some peace. I know it's time for me to let go. I'm no longer working with young people, and I don't know what my future holds. All I am certain of is that nothing in my life has touched me or impacted upon me as forcefully as the death of a young boy I met only twice. I have worked with children and adolescents throughout my entire nursing career, and as I have been touched by each and every one of them, I have come to question our country's priorities. We like to speak of being a child and family-oriented nation. But we're not. No society that allows such atrocities, which tolerates the destruction of childhood, which forgets that all children deserve a future, is child-oriented.

To my former co-workers Eric, Hillary, Jackie, Tom, Marcy, Marcia, Leo and Kyle: I love you all and miss you all so very much. It was an honor and a privilege to work with you. Most importantly, the kids knew we cared. Live in peace.

To Andrew, to all that you will miss, and to all who will miss you: Please know that because of you, changes are being made and lives may be saved--and that's the greatest thing anyone can accomplish. Rest in peace, Andrew. Rest in peace.

Deborah Clark Ebel
