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The death of Rudy Ochoa: no surprises from grand jury

THE grand jury report on the death of Rudy Ochoa contains little that's surprising. Dismaying, disgusting and infuriating, yes; surprising, no.

The grand jurors repeat many of the criticisms leveled by the ad hoc medical panel convened to investigate the Ochoa case — and, for that matter, by a special panel created more than four years ago to examine charges of poor medical care at the county's juvenile facilities.

Ochoa, 13, died March 26 in the county Juvenile Center of a virulent pneumonia that the attending physician and nurses apparently failed to diagnose. The grand jury report reiterates and endorses the statement of the earlier ad hoc medical panel that Ochoa's chances were "hampered by . . . inadequate medical care and inadequate nursing care."

But the grand jurors, like the medical panelists and the 1977 investigatory group before them, stress that the root problem isn't individual incompetence and inefficiency — it is inefficient, negligent, slipshod administration.

"It would be an 'easy out' to conclude that only inadequate medical and nursing care by a few persons led to an unfortunate but isolated incident — the death of Rudy Ochoa," the grand jury report states. "This, however, would not be completely true. *The deficiencies in the administrative control of (Santa Clara Valley Medical Center) for the medical care provided those at Juvenile Hall make it difficult to assure proper medical care for those incarcerated.*"

The jurors underlined that last sentence to emphasize its importance. It should be not only underlined but spelled out in neon and kept flashing in front of the eyes of VMC Director Robert Sillen until he has cleaned up the administrative mess at the Juvenile Center.

The grand jurors accuse the VMC leadership of administrative lapses at the Juvenile Center that would tax credulity if the same things had not been said again and again in earlier reports.

- Nurses at the Juvenile Center infirmary have no operational procedures manual or standing orders. "The Supervising Nurse," the grand jurors report, "stated that she has been in the process of writing a manual for the past nine years."
- "There are no definite lines of authority and control. The distinction between line and staff supervision is unclear . . . the organizational structure does not lead to clear lines of responsibility and control."
- There is no regular inspection of Juvenile Center facilities and operations by high-level VMC administrators. "Routine medical care audits and peer review are not performed. Only one medical staff meeting has been held in the past year."
- There is no ongoing training program for doctors and nurses.
- Lack of "effective administrative leadership . . . program goals and . . . consistent policies" for the nursing staff "results in a situation which might encourage some staff to simply 'put in their time.' "
- "No official response was ever made by the administration at VMC" to repeated reports of medical care problems at the Juvenile Center, including complaints by physicians and nurses, VMC's patient advocate, and the 1977 panel chaired by Dr. Iris Litt.

The grand jury report goes on to suggest, among other things:

- That responsibility for supervising health care at county juvenile facilities be transferred from VMC's director of satellite clinics, Dr. Virgil Erickson, to VMC's department of pediatrics;
- That administration of the Juvenile Center nursing staff be turned over to the director of nursing at VMC;
- That written policies and procedures and standing orders for nursing staff be developed immediately; and
- That regular medical care audits and peer review and "a more intense and formalized . . . training program" be instituted.

According to VMC Director Sillen, responsibility for supervising nurses has already been changed in line with the grand jury's suggestion, overall medical supervision eventually will be transferred to the hospital's director of pediatrics, and standing orders for the nursing staff are being drafted. Other aspects of the grand jury report are being studied, Sillen says, and will be evaluated in conjunction with the findings of the reconvened Iris Litt panel, which is due to make its report in early July.

We're happy to hear assurances that VMC is at long last moving to correct the serious administrative problems at the Juvenile Center. We will be even happier when we see that the problems have in fact been corrected.

The problems at the Juvenile Center have been talked about before, cures have been suggested before. We know — we have known for years — what needs to be done. Must somebody else die before we do it?