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Three suicides, two fires: How Temple's Episcopal hospital lost control during COVID

Pennsylvania's health department found an array of policy failures, staffing issues and shoddy facilities at Episcopal that contributed to a series of fires and suicides over 10 months.

by Aubrey Whelan and Marina Affo

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This story contains multiple references to suicide, mental illness, and self-harm. If you or someone you know is thinking of suicide, call the National Suicide Prevention Lifeline at 1-800-273-8255 or text TALK to the Crisis Text Line at 741741. The Disaster Distress Helpline, 1-800-985-5990, is also providing immediate counseling to anyone who is seeking help in coping with the mental or emotional effects of the coronavirus pandemic.

On March 30, 2020, Angelique Benrahou's parents picked up the phone and plunged into the unimaginable.

A psychiatrist from Episcopal hospital in Philadelphia's Kensington neighborhood was on the line. Benrahou, 28, a talented painter from Mount Airy, had been involuntarily checked in to the behavioral health hospital 18 days before. She had been struggling with what her parents say were suicidal thoughts and manic behavior stemming from bipolar and schizoaffective disorders.

The psychiatrist on the phone told the Benrahous their daughter had suffered a cardiac arrest. She was fighting for her life at the main campus of Temple University Hospital, part of the larger system that oversees Episcopal.

It would be another day before the Benrahous learned Angelique had attempted suicide, her parents contend in a lawsuit they would file against the hospital. It was later still that they learned an aide assigned to check on her every 15 minutes had left her alone in her room for nearly 45 minutes, the suit contends.

On April 8, the family made the agonizing decision to take her off life support. Angelique had died by suicide, something Episcopal and other psychiatric hospitals pledge to prevent.

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Though the state has posted detailed investigations into these subsequent incidents, there are no publicly available reports online about Benrahou's suicide, nearly 600 days after her death. Officials from neither Temple nor the state would confirm whether the state had probed her case — or say whether Temple had reported the death as required.

The extensive reports from state investigators on the fires and two later suicides outline an array of policy failures, staffing shortages, and shoddy facilities at Episcopal. They portray an overwhelmed hospital battling compounding crises — the pandemic, and its own unsafe conditions.

After the state investigations, Episcopal pledged policy changes and hired at least 17 new employees. Temple officials say they have "fully implemented" reforms, including redesigning wards and changing medical procedures.

"At the height of the COVID pandemic, while Philadelphia's opioid epidemic continued to spiral, Temple University Hospital faced a number of challenges involving our behavioral health unit," Temple said in a statement. Jeremy Walter, spokesperson for Temple Health, said hospital administrators would not answer any specific questions. Two top officials at Episcopal who oversaw operations there in 2020, executive director Kathleen Barron and chief medical officer William Dubin, are no longer in their positions. Barron left and Dubin retired six months ago. Both declined comment.

Debbie White, the president of Health Professionals and Allied Employees, the union representing Episcopal nurses and technicians, says the hospital has experienced the same kind of staffing issues facing hospitals around the country — issues that existed before the pandemic and grew exponentially worse.

“There is an increase in patients in mental health facilities as a result of the pandemic,” White said. “Our health care workers and nurses deal with that increased patient load. Without the right amount of staff at the bedside, we can’t deal with that effectively.”

The Joint Commission, a national organization that works with hospitals to improve patient safety, estimates that 45 to 65 suicides take place among hospital inpatients every year in the United States. That’s about three patients who die by suicide for every 100,000 psychiatric hospital admissions.

Arthur Caplan, a professor of bioethics at New York University’s medical school, said three suicides over nine months reflects a serious crisis at Episcopal that resonates well beyond its walls. But it also is a mark of the stress on all sorts of institutions during COVID — from psychiatric hospitals to homes for the developmentally disabled. In such places, Caplan said bluntly, “there aren’t enough eyeballs.”

The most vulnerable

Founded a decade before the Civil War by the Episcopal Church, the hospital in the 100 block of East Lehigh Avenue shed its religious connection 70 years ago. Temple Hospital bought the hospital in 1998 and about 20 years ago converted it to a psychiatric facility. It sits in Kensington at the epicenter of Philadelphia’s opioid overdose crisis and takes some of the city’s most vulnerable patients.

Episcopal cares for about 120 adult patients on any given night, in rooms on three floors. Some might be discharged within days. Others stay for months. The facility also has a regular medical emergency room on the first floor, and a crisis response center on the third to assess people who need acute mental health care.

Angelique Benrahou’s psychiatrist decided to seek judicial approval to involuntarily commit her to Episcopal on March 12, after her parents brought her to her office. She was agitated and manic. She hadn’t been taking her medications. The lawsuit says she “endorsed thoughts of suicide.”

A graduate of Friends Central and Chestnut Hill College, Benrahou had received a prestigious scholarship as a teen and, in her 20s, worked as a freelance artist, posting her vibrant paintings online and in exhibitions. In a 2019 interview with the Chestnut Hill Local about a café exhibition, she told a reporter that she loved the art of J.C. Leyendecker and Elly Smallwood “because of their expressive brushwork.”

And she loved painting portraits, she said, because “I like capturing the human soul.”

She was close with her parents, Denise and Lout Benrahou.

“She was brilliant. Funny. She just was joy,” Denise Benrahou said.

She struggled with mental illness: She had been diagnosed with bipolar and schizoaffective disorder and had previously spent time in Episcopal’s inpatient wards.

“My mother always taught me that, as a parent, my job is to help my child become everything she could possibly be. And if I could not help her, my job was to find someone who could,” Denise Benrahou said in an interview last week. “We spoke to the psychiatrist and she was saying you have to [involuntarily commit] her. So we went before a judge to ask, ‘Please help us help her.’”

When Angelique arrived at Episcopal’s crisis response center, she was restrained for “combative behavior,” her parents’ lawsuit says.

Over the next several days, she improved slightly but was agitated and delusional, the lawsuit says. She begged nurses and doctors to let her leave. In phone calls with her parents, she said she wanted to come home and asked them to buy her painting supplies.

On March 30, when another psychiatrist told her she couldn’t be discharged, she became “extremely agitated.” Her parents allege that psychiatrist, who had overseen her care during previous stays at Episcopal, should have known she had a high risk of suicide.

Three hours later, she was found unconscious on the floor of her bathroom.

In the lawsuit, the Benrahous, based on security video footage from the inpatient wards, allege the technician assigned to check on Angelique every 15 minutes, instead spent time talking with coworkers, checking on Angelique once over the course of about an hour — and falsifying three entries in a logbook to make it seem as if she had been checking in on the patient.

In a response to the Benrahous’ lawyers, the technician denied any negligence in Angelique’s care. The filing provided no details of her actions.

Temple, in a separate response to the suit, said the technician had been negligent and had contributed to Angelique’s death. The health system also admitted that by failing to adopt and enforce certain policies around supervising technicians and nurses, it was negligent. The same lawyer signed both the technician’s and Temple’s responses, despite their apparent contradiction.

Eventually, around 3:35 p.m., another technician knocked on Benrahou’s door but got no response. Three minutes later, he came back with a set of keys, and then yelled for help, the lawsuit contends. Benrahou never regained consciousness.

Because of the burgeoning COVID-19 pandemic, the Benrahous weren't able to visit their daughter in her last days.

By law, hospitals must report suicides and suicide attempts, which typically trigger state investigations. Hospitals that don't report can be fined $1,000 a day.

It is unclear whether Temple reported Benrahou's death to the state as required. There's no record on the state government's website of any probe conducted into Benrahou's case.

Pennsylvania health officials said they would not confirm or deny whether Temple had reported her suicide, saying such reports are "confidential." They added that investigations into suicides have no time limit and are posted on the state website only once completed. Temple would not answer direct questions about whether it had reported the death, citing ongoing litigation. Its lawyers did not respond to emails.

The two other later suicides at Episcopal in 2020 quickly triggered extensive investigations, all of which are documented on the state Department of Health's public website. Those records showed that the state began its probes within days of each death and completed them within six days.

The reports that are posted on the state website — all of which took place after Benrahou's death — don't mention her case.

A hospital in `jeopardy'

Two months later, Episcopal reported another serious event.

The patient, a 40-year-old man, had been admitted to Episcopal's ER on May 23, complaining of sharp chest pains and hallucinations. He fought with security staff on the way in, eventually handing them a lighter from his pocket.

But staff gave it back to him, the first in a series of security failures that would lead to a fire in the ER and the evacuation of the department, state investigators found.

State investigators found that the patient had been admitted to an ER room alone, violating an Episcopal policy that requires nursing staff to observe a patient with hallucinations at all times — and to remove all dangerous belongings from their rooms, including lighters, state investigators noted.

The patient's primary nurse later told investigators that she was trying to transfer another patient who had COVID and didn't have time to check on the man with the lighter.

Eventually, the patient barricaded himself in his room, and as panicked staffers watched through the hallway window, he turned the oxygen tank under his bed on and off. Then he pulled out his lighter, and lit the bed on fire.

ER staff immediately evacuated patients, fearing the tanks could explode. A facility engineer eventually broke the hallway window — and the patient jumped through it, hurled a chair into the nurses' station, and ran to the front of the ER before security staff subdued him.

The fire, along with another patient-set fire in Temple's main hospital on North Broad Street, triggered a state report released that fall that declared both Temple Hospital and Episcopal to be in "immediate jeopardy." That's a situation where failures to comply with state hospital regulations are likely to cause, or have already caused, serious harm to a patient.

Episcopal was required to implement stricter security screening, educate staff on managing aggressive patients, increase one-on-one patient observations, and remove dangerous items — like oxygen tanks — from underneath stretchers and beds. The ER rooms were also equipped with new doors to prevent barricade situations.

On Sept. 5, 2020, just days after the state's report on the fire was released, a new patient checked into Episcopal's behavioral health unit.

He would not leave alive.

No one watching

The man had been admitted Sept. 5, diagnosed with psychosis and substance-use disorder. On Sept. 7, he was one of 21 patients on the inpatient unit, watched over by two nurses and four mental health technicians.

As is alleged in Angelique Benrahou's case, a technician was supposed to visit patients face-to-face every 15 minutes.

But on the morning of Sept. 7, state investigators found, the patient went unobserved in his room for more than an hour, starting at 10:15 a.m.

Just after 11 a.m., a tech walked into the man's room, knocked on the closed bathroom door, and left when the patient said he was OK.

Fifteen minutes later, the technician went back to the room and opened the bathroom door.

The patient had hanged himself from the shower curtain rod.

(The Inquirer, unable to locate the man's family, is not identifying him.)

State investigators quickly determined Episcopal staffers weren't checking on patients often enough.

Even more troubling, investigators found, nurses were signing off on documents falsely claiming that technicians had appropriately monitored patients. Video camera captured numerous incidents in which the staff skipped checking on patients, but filled out paperwork claiming they had. Among the patients for whom false reports were filled out was the man who died by suicide on Sept. 7, state investigators said.

As it happened, the Benrahou family's lawsuit contends, video checks had shown the same behavior leading up to the death of Angelique Benrahou, several months before. The state report on the September death makes no mention of the earlier suicide.

In the report on the hanging, the investigators also found that the unit's furnishings presented a suicide risk. In behavioral health units, shower rods should easily break when any weight is placed on them to prevent hangings. But investigators found that the rod in the patient's room was homemade, a sturdy length of PVC pipe.

Searching through Episcopal building records, investigators found that staffers had mentioned a number of problems with shower rods as early as 2019, identifying several hanging risks.

The state placed Episcopal back in "immediate jeopardy" and led to a number of changes. Senior leadership began monitoring the 15-minute rounds on the inpatient unit, and nurse managers launched an audit of the hospital's medical records and rounds.

On Oct. 2, Episcopal's chief nursing officer "appropriately addressed rounding documentation issues" with one of the technicians.

In trouble, but discharged

The reforms launched after the May fire and the September suicide had been in place for months when, on Dec. 10, Robert Davis III, 33, checked into Episcopal's crisis response center.

Davis' mother, Barbara Magilton, had gotten a call from her son's girlfriend earlier in the day. The two had been at a gas station on Lehigh Avenue when Davis started saying he didn't feel right. An ambulance took him to Episcopal.

Magilton says she's never gotten a satisfactory explanation for what happened over the next few hours. All she knows is that, sometime after noon, Davis' girlfriend walked into the family home in Port Richmond and told them he was dead.

Davis' father screamed and fell to the floor. Magilton stared in shock.

According to state investigation records, he had displayed "aggressive behavior" as he arrived at the crisis response center. But the attending physician there wasn't alerted, a breach of hospital protocol.

An intern conducted an interview with Davis; the attending physician sat in for part of it, and the decision was made to discharge him.

COVID was again tearing through the region, and to keep the number of hospital patients down, anyone not likely to enter life-threatening addiction withdrawal was being discharged, according to the state investigation.

As Davis left, he again began acting aggressively, according to state records. Again, the attending physician wasn't notified.

Then, Davis sprinted away from staffers and threw himself out of a third-floor window.

Nearly a year after her son's death, Magilton says Episcopal has barely communicated with her. She received a letter signed by Dubin, then-Episcopal's chief medical officer, that expressed condolences — but also referred to her by the wrong last name and called her son "your husband." She, like the Benrahous, retained a lawyer from **Kline & Specter** in the matter.

Letter From Episcopal After a Suicide

William R. Dubin, then the chief medical officer at Episcopal Hospital, sent this letter to Barbara Magilton after her son, Robert Davis III, died by suicide at the hospital. The letter addresses Magilton by the wrong last name (the handwriting on the letter is hers), and also incorrectly refers to her son as her "husband." Magilton's address, the date of birth of her son, and Dubin's phone number are obscured for privacy.

Family members described Davis as a kind man who struggled with drug use and mental health issues; he had been in and out of prison for years on nonviolent drug and theft charges. He cared deeply for his family and friends, they said, and did his best to show it.

Magilton still keeps the intricate ornaments and picture frames he made for her in prison. Her son tried to do right by friends in even direr straits, she recalled: He would bring home friends who were experiencing homelessness and give them food and clothes, even lending his bike so they could get around.

"Bobby was a good guy born with the wrong poker cards," his obituary read. "He kept trying to get a winning hand, but he never got that Royal Flush."

The state's report on Davis' death was slim on details, but investigators said Episcopal staff had failed to adequately communicate about his aggressive behavior — so they did not assess his risk of suicide.

The Health Department placed Episcopal in "immediate jeopardy status" again, and administrators worked to come up with a reform plan.

Episcopal hired a behavioral health nurse to consult for up to a year while the plan was implemented. New protocols were established, including an additional assessment by RNs before patients left the hospital to ensure they were not agitated or exhibiting suicidal thoughts.

Extra security guards were posted to hallway doors from 7 a.m. to 5 p.m. during the workweek. And a special subcommittee of Temple's board of governors assembled to help oversee and implement the plan.

Less than a month later, there was another fire.

A wire, a spark

On Jan. 9, 2021, a patient was captured on security footage emerging from his room, wrapped in a blanket. No one acknowledged him. One technician was walking from room to room, checking on patients; another was monitoring the common area; and the nurses on the unit were changing shifts, handing off their reports at the nurses' station.

For more than five minutes, the patient sat unobserved next to an electrical outlet near the nurses' station, hiding under the blanket. With a wire pulled from his surgical mask, he coaxed a spark from the outlet, lit a piece of paper, and dropped it into a nearby trash can. Then he walked back to his room.

Another patient saw the rising flames and alerted staff, who rushed to put out the fire.

The incident triggered another state investigation. Investigators found that security staff couldn't closely observe common areas in the behavioral units because of how the cameras were set up; instead, video monitors flipped from place to place, leaving crucial blind spots.

The investigation also revealed troubling aspects of day-to-day life at the facility.

For example, despite policies encouraging patients to wear their own clothing on the unit — to preserve and recognize patients' dignity — state investigators noticed several patients wearing just hospital gowns and blankets when they visited the behavioral unit shortly after the fire.

Episcopal again worked to address the state's concerns. Over the course of a few weeks, according to the state reports, staff made repairs throughout the building — installing plastic glass over hallway windows so they couldn't be broken, removing bathroom doors on the behavioral units.

Security staffers began patrolling the behavioral health units, and nurses were instructed to make sure someone monitored patients during shift changes.

Episcopal also pledged to hire at least 17 new staffers — and, until they arrived, to decrease the number of patients on its three acute units. By Jan. 23, the number of patients there had dropped by a third.

No protection

Denise Benrahou said she was devastated to learn that two other families had lost loved ones to suicide at Episcopal. "We filed a lawsuit because I don't want any family to ever know what we know," she said. "We don't want this to happen to anyone else."

Episcopal said in its statement to The Inquirer that its plans to address the crisis at its behavioral health unit were approved by the state months ago and have since been fully put in place.

White, the head of the union that represents Episcopal employees, said she's heard from union members that the situation has improved since last year. "There is more staffing on the floor — they've increased the nurse and the tech population," she said.

"But it's sad that before something is improved, something catastrophic has to happen."

Inquirer news researcher Ryan W. Briggs contributed to this article.

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