EL DORADO COUNTY GRAND JURY 2010-2011

MENTAL HEALTH DETENTION POLICY AND PROCEDURES

Case Number GJ010-009

REASON FOR REPORT

As a result of a complaint, the El Dorado County Grand Jury investigated the policies and procedures applicable to mental health patients held on the Western Slope of the county under the Welfare and Institutions Code §5150.

BACKGROUND

In March 2010, a United States Department of Agriculture Forest Service Officer took a citizen into custody who appeared to be a danger to self and severely impaired. This was done under the authority of Welfare and Institutions Code §5150 (5150) that establishes requirements and procedures for law enforcement and hospital personnel for taking such a person into custody for 72 hours of evaluation and treatment. The officer transported this citizen to the Crisis Center of the El Dorado County Mental Health Psychiatric Health Facility for a mental health evaluation. After approximately four hours, the patient was transported to Marshall Medical Center for a required medical clearance. Four hours later, a Marshall Emergency Department physician medically cleared the patient. About 10 hours later, while arrangements were being made for continuing care in a Sacramento psychiatric facility, the patient walked out (eloped) from the hospital emergency department. An ambulance with keys on the floor was parked outside of the emergency department. The patient found the keys

and drove away. Immediately, the Placerville Police Department was called. Subsequent events resulted in the death of the patient.

Department of Mental Health statistics revealed an average of 27 individuals per month held under §5150 on the Western Slope of El Dorado County for a three month period from October 25, 2010 through January 21, 2011.

POLICY AND PROCEDURE REVISIONS

MENTAL HEALTH

Under previous policies, some Western Slope 5150 patients detained by law enforcement were transported to the Crisis Center of the El Dorado County Psychiatric Health Facility (PHF commonly pronounced "puff") prior to being medically cleared at Marshall Medical Center.

After review, the State Department of Mental Health ordered that the Crisis Center not be used for evaluation and treatment of 5150 patients. Now, all Western Slope 5150 patients are taken directly to Marshall Medical Center for evaluation and treatment. The clearance is the physician's determination that the patient has no medical conditions that would preclude placement.

Mental Health Psychiatric Emergency Services is notified when a patient is being transported to Marshall and makes every effort to have a mental health crisis worker at Marshall within 20 minutes. If this is not possible, Marshall is notified when the mental health crisis worker will arrive. The purpose of this mental health crisis worker is to provide mental health care support but not to provide security.

Several subdivisions of the Department of Health Services participate in the Multi-Disciplinary Team coordinated effort to develop protocols in crisis prevention and intervention.

MARSHALL MEDICAL CENTER

As of March 2010, 5150 patients were observed by mental health workers, nursing staff and hospital security personnel under the supervision of the charge nurse. Communication between these groups was inconsistent and sometimes ineffective.

After March 2010, Marshall Medical Center developed a Plan of Correction in response to a list of serious federal violations received from the Department of Health and Human Services Centers for Medicare and Medicaid. This plan includes a commitment by Marshall for constant observation of 5150 patients, rapid response and triaging by nurses and physicians, and additional training of the nursing and other staff.

Emergency Department policies have been revised to clearly state that the hospital is solely responsible for the custody of persons suspected of being mentally ill.

Designated hospital personnel will be given Crisis Intervention Team (CIT) training including Emergency Medical Technicians (EMT) and paramedics. Supervisors will receive a 40-hour course and other employees will receive an eight-hour course.

MARSHALL MEDICAL CENTER SECURITY

Security is provided by Healthcare Security Services (HSS), a private security company. There are a total of 10 officers, including one supervisor. Two officers each staff three shifts per day, providing 7-day weekly coverage.

Neither the HSS Supervisor nor any of the other officers is required to have law enforcement training or experience. The officers have California state certificates and receive about two hours of 5150 training at the Northern California District Office of HSS in Livermore. The HSS officers received a local training course related to observing dementia patients taught by the Coordinator of Crisis Services for Mental Health Services.

In March 2010, under the previous policies, security officers were called on as needed to watch 5150 patients. Otherwise, the nursing staff or a mental health worker would observe the patients. Under the new policies, security will keep all 5150 patients under continuous observation. If a patient attempts to leave the area, security or emergency department staff will guide the patient back to bed. However, the security guard will not physically prevent an elopement; in that event, law enforcement would be called.

There is a video surveillance system in the Marshall Emergency Department consisting of two cameras and one monitoring station. The recordings are retained for one week and are available for investigations. Monitoring the video is not a priority duty.

AMBULANCE

Under the previous policy, ambulance keys were left on the floor of the ambulance. No keys were hidden. Under revised rules dated July 29, 2010, the keys may no longer be left in the ambulance, but instead the driver and both medics retain their own set of keys at all times.

LAW ENFORCEMENT AND FIRE DEPARTMENT

A Multi-Disciplinary Team (MDT) has been formed on the Western Slope of El Dorado County. The MDT provides a resource for mental health crisis prevention and intervention. Team member assistance can potentially de-escalate encounters between law enforcement and mentally ill persons. The Sheriff's Office has been an active and involved participant in the MDT; the Placerville Police Department's involvement has been less evident.

A Crisis Intervention Team (CIT) has also been formed. Crisis Intervention Team Cards (formerly called Yellow Cards) are being used to record and report contacts with individuals who have mental health issues. These cards are used in all law enforcement vehicles, ambulances, and fire trucks. The cards are forwarded to the Sheriff's Department where the information is evaluated by a team with Crisis Intervention Training. This evaluation may help law enforcement improve decision making during encounters in the field. In the future, it may also help identify means of providing individuals with needed assistance. This system was put in place in conjunction with the MDT. It is envisioned that in the future there will be a feedback mechanism so that information can be provided to officers on duty in the field.

The functions of the CIT system and the MDT are also referenced in the accompanying 2011 El Dorado County Grand Jury Report GJ010-007 entitled Mental Health Crisis Intervention.

METHODOLOGY

The 5150 policies and procedures of the various organizations in effect in March 2010 were reviewed. The revisions that were made from that date through March 30, 2011, were evaluated with particular attention to their effectiveness in preventing another incident.

The following persons were interviewed:

- Deputy District Attorney, El Dorado County
- Coordinator, Crisis Services, El Dorado County Mental Health Department
- Manager, Marshall Medical Center Emergency Department
- House Supervisor, Marshall Medical Center
- Current Sheriff, El Dorado County
- Director, El Dorado County Public Health Services/Mental Health
- Officer, United States Department of Agriculture Forest Service
- Parent of the mental health patient

- Supervisor, Hospital Security Services, Marshall Medical Center
- Executive Director, El Dorado County Emergency Services Authority

Documents Reviewed and Date Referenced:

- Marshall Medical Center Emergency Department Manual of Protocols, dated 7/10 (11/10)
- Cooperative Law Enforcement Agreement Between the Sheriff of El Dorado County and the Pacific Southwest Region of the USDA Forest Service, dated 5-23-03 (1/11)
- Amador County Health Services Department Policies and Procedures Manual, 5150 Hospital Call Out Routine, dated 9-15-09 (2/11)
- County of Sacramento Division of Behavioral Health Services policy #05-03 entitled 5150 Welfare & Institutions Code Certification & Designation (2/11); Mental Health Treatment Center policy #04-02 entitled 5150 Designation policy (2/11); Mental Health Treatment Center policy #04-03 entitled 5150 Application (2/11); Mental Health Treatment Center policy #0-01 entitled Intake Team (2/11)
- Placer County Mental Health Policy and Procedures for Adult System of Care and 5150 Memorandum of Understanding among partner agencies, Effective Date 11-06-09 (2/11)
- San Joaquin County Mental Health Service Policy and Procedure Manual – Revised May 21, 2004 (3/11)
- El Dorado County Emergency Medical Services Authority, Draft of 5150 Patients Policy, dated 10-25-10 (3/11)
- District Attorney's Official Report of Investigation of the incident, dated 3-28-10 (8/10)
- Department of Health & Human Services Centers for Medicare and Medicaid Services letter to Marshall Medical Center, dated 6-30-10 (12/10)
- Department of Health & Human Services Centers for Medicare and Medicaid Services Statement of Deficiencies and Plan of Corrections to Marshall Medical Center, dated 7-12-10 (12/10)
- El Dorado County Department of Mental Health Psychiatric Emergency Service Policies and Procedures - West Slope, dated 1-20-08 (1/11)
- El Dorado County Western Slope Agencies, MOU, Policy and Procedures Regarding Detention of Persons Pursuant to WIC §5150 Agreement #833-M0810, dated 6-08 (1/11)
- California Department of Mental Health to El Dorado County Health Services Department, Mental Health Division, Re: Notice of Completed Review with Deficiencies, dated 11-11-10 (1/11)
- California Health Services Department, Mental Health Division Correspondence from Director to County of El Dorado Grand Jury, dated 3-31-2011 (3/11)

FINDINGS

MENTAL HEALTH

1. A major causal factor in the March 2010 incident was the fact that previous to March 2010, attention to detail and awareness of the agencies involved in the care and observations of 5150 patients had lapsed.

2. The March 2010 incident shed light on the oversight of the agencies that relate to 5150 patients.

MARSHALL MEDICAL CENTER SECURITY

3. Hospital security, as currently provided by HSS, is marginally adequate. There is only one officer with law enforcement training. The other security officers were not extensively trained when hired and their training has not been updated.

4. The HSS Supervisor at Marshall spends a significant portion of his day doing administrative work and attending meetings. This leaves the only other day shift officer alone to deal with both the ordinary security functions as well as 5150 surveillance. In addition, the supervisor is the only designated on call person in case of an emergency.

5. Currently, hospital staff and HSS officers provide continuous 5150 patient observation within the emergency department. However, Marshall Medical Center is not a designated mental health facility with a locked, secure area for 5150 patients.

6. Hospital security failed to document important events and information from their shifts.

7. The video camera system is inadequate. There are areas in the Marshall Emergency Department that are not covered by cameras. The video recordings are retained for one week.

AMBULANCE

8. As of October 25, 2010, revisions to the ambulance policy have been under discussion. Proposed changes would require that all 5150 patients riding in El Dorado County Emergency Service Authority vehicles be secured. Gravely disabled and incapacitated patients would be secured with gurney straps. Patients, who have a history of violence or are violent, agitated or angry,

coupled with the physical capability of inflicting harm and endangering themselves, would be placed in a four-point restraint.

MULTI-DISCIPLINARY TEAM

9. Marshall Medical Center, Healthcare Security Services officers, Director of the Emergency Services Authority, and the USDA Forest Service Law Enforcement has expressed an interest in participating in the MDT.

RECOMMENDATIONS

Based on the Grand Jury's evaluations and findings, recommendations were developed for further policy and procedure changes to decrease the likelihood of another incident involving 5150 patients.

MENTAL HEALTH

1. The Mental Health Division of the El Dorado County Health Services Department should be the lead agency in an annual reminder of the March 2010 incident and training for all agencies involved in the care and monitoring of 5150 patients.

MARSHALL MEDICAL CENTER SECURITY

2. Coordination and communication between hospital personnel and the security guards is essential. All Marshall HSS security personnel should be trained to deal with mentally impaired patients.

3. HSS security staff needs training in documenting important events that occur on their shifts related to the monitoring of 5150 patients. All daily security notes regarding 5150 patients should be provided to the Charge Nurse.

4. The purpose, current usage and configuration of the video monitoring system should be re-evaluated. The current system must be upgraded if it is going to be of any use in preventing another incident.

AMBULANCE

5. The Executive Director of the El Dorado County Emergency Medical Authority has proposed changes to the Ambulance 5150 policy that are intended to reduce the likelihood that a patient would harm themselves or others. The proposed changes should be reviewed by other agencies; especially Marshall Medical Center, which has policies and procedures for transporting persons with mental health issues.

MULTI-DISCIPLINARY TEAM

6. Marshall Medical Center, Healthcare Security Services officers, Director of the Emergency Services Authority, and USDA Forest Service Law Enforcement should be included in MDT training.

EL DORADO COUNTY

7. El Dorado County should have a designated health facility where 5150 patients and others with mental health impairments would be evaluated and treated in a safe, secured environment.

RESPONSES

Responses to findings and recommendations in this report are required in accordance with the California Penal Code §933 and §933.05. Address responses to: The Honorable Suzanne N. Kingsbury, Presiding Judge of the El Dorado County Superior Court, 1354 Johnson Blvd., South Lake Tahoe, CA 96150.

This report has been provided for a response to the following agencies:

- Director, Health Services Department, 670 Placerville Drive Suite 1B, Placerville, CA 95667
- Chief Executive Officer, Marshall Medical Center, 1100 Marshall Way, Placerville, CA 95667
- Healthcare Security Services Supervisor, Marshall Medical Center, 1100 Marshall Way, Placerville, CA 95667
- Executive Director, Emergency Services Authority, 480 Locust Road, Diamond Springs, CA, 956667
- El Dorado County Sheriff, 300 Fair Lane, Placerville, CA 95667
- Chief, Placerville Police Department, 730 Main Street, Placerville, CA 95667

- Chairperson, El Dorado County Board of Supervisors, 330 Fair Lane, Placerville, CA 95667
- Patrol Captain, El Dorado National Forest, 100 Forni Road, Placerville, CA, 95667

Elected officials under statute are given 60 days to respond, and non-elected officials are provided a 90-day response period from the release date of this report.