Memorandum

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DJ 168-017-11

Subject	Date
Napa State Hospital Proposed S.10 Investigation	25 JUN 1985

To

Wm. Bradford Reynolds
Assistant Attorney General
Civil Rights Division

From

Arthur E. Peabody, Jr.
Chief
Special Litigation Section

We recommend the initiation of an investigation into conditions of confinement and treatment at Napa State Hospital (NSH), pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997. NSH is a state facility located in Imola, California. It is operated by the Department of Developmental Services. NSH was established in 1875 and is presently certified by the Department of Health and Human Services (HHS) for 1943 beds. 1/

Sources of Information

A lawsuit on behalf of four patients at NSH concerning the conditions of confinement first brought our attention to this facility. 2/ Many of the factual allegations were derived

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1/ Telecon. Ronald Curry May 17, 1985. The reported number of beds varies from 1600 (See San Francisco Chronicle, April 5, 1984) to 1835, see JCAH Survey Report (JCAH Survey), October 19, 1984, p. 6.

2/ Dennis Bedger, David Hendrickson, by and through his conservator Barbara Teyrel, Gary Wolpert, by and through his conservator, Fred Wolpert, Kristine Hamala, by and through her conservator, Marge Hamala v. Napa State Hospital, Michael O'Connor, individually and in his capacity as Director of the Department of Mental Health for the State of California, Gary MaComber, individually and in his capacity as Director of the Department of Developmental Services for the State of California, Fred Valenzuela, individually and in his capacity as Executive Director of Napa State Hospital, et. al., Civil Action No. C85-0983, U.S. District Court, Northern District of California, filed January 23, 1985. This is not a class action suit, thus any remedy achieved would be limited to the four patients named in the suit.

from two surveys of NSH conducted by the Joint Commission on Accreditation of Hospitals (JCAH). The first was conducted in October of 1983 and the second in August 1984. Although presently on a second appeal, JCAH officials decided not to accredit the facility. 3/ Other sources of information include the following: newspaper articles; Families and Advocates for the Mentally Ill of Napa State Hospital; letters and conversations with patients and their parents; and a memo of County Liaisons concerning the conditions of confinement.

Personal Safety

Based on our information, a pattern of violence prevails at NSH. Frequent deaths have occurred at NSH over the past year and a half, four of them since the beginning of 1985. These include patient suicides and murders as well as the death of a staff member. In light of NSH policy to hold all incident reports confidential from the general public in addition to liaisons and conservators of patients involved, 4/ the disturbing number of incidents that we have documented takes even greater significance.

On April 27, 1985, Marilyn Marie Conners failed to return to her ward after she and another patient were permitted out on the grounds of NSH under a "buddy pass" system. While on the grounds, the two separated and Marilyn was observed going off with a man. Her nude body was found on April 29, 1985, about 200 yards from the fenced hospital grounds. An autopsy revealed she was strangled to death sometime on the 27th. The police suspect another patient, with a history of aggressive, assaultive behavior, of Ms. Conners' murder. 5/

At approximately 4:30 p.m. on March 3, 1985, Sandra Wilson went to her room at NSH because she did not feel well. For an hour and a half Ms. Wilson was not seen and no staff member checked on her condition. At 6:00 p.m., after a head count by staff, Ms. Wilson was discovered dead in her room. It has been determined that she was strangled by a male patient. 6/

3/ Napa Register, March 27, 1985.

4/ Memo of County Liaisons at Napa State Hospital to Greater Bay Area Conference of Local Mental Health Directors (Memo of County Liaisons), undated but reportedly completed in the latter part of 1984, p. 2; Telecon. Barbara Teyerl, March 5, 1985.

5/ Napa Register, May 1, 1985.

6/ Letter of Helen Gerling, President of Families and Advocates for the Mentally Ill of Napa State Hospital, March 12, 1985; Napa Register, March 4, 1985.

Another incident involved Tina Gonzalez, who was placed in solitary confinement for aggressive behavior. When staff checked on her condition they found Ms. Gonzalez strangled to death by a bedsheet. Hospital officials have labeled this a suicide. 7/ However, this death brings into question the adequacy of supervision and use of seclusion procedures by NSH staff.

In March of 1985, another patient committed suicide by setting herself on fire. 8/ Similarly, on January 6, 1984, a female patient was given a "grounds pass" by NSH staff. She wandered off the hospital grounds to a nearby gasoline station where she committed suicide by setting herself on fire in the gas station's bathroom. 9/ Finally, a patient with documented suicidal tendencies was placed in unsupervised seclusion where he again attempted suicide, sustaining third degree burns on his arms. 10/

In addition to the murders and suicides at NSH, assaults are common occurrences. It is reported that there are more than 5000 violent attacks each year on patients and hospital workers. 11/ One patient characterized the environment at NSH as "hostile." 12/ A patient was so severely beaten at the facility that he sustained permanent brain damage. 13/ On September 20, 1984, Al Gonzalez, a staff member, intervened in a fight between two patients and was killed. One patient is now awaiting trial for Mr. Gonzalez's murder. It was reported that these patients were fighting previously, but were not separated by staff members. 14/

In December of 1984 a patient was attacked by another patient who thought he was poisoning the food. This fight was halted by other patients; no staff member intervened. In January 1985, this same patient intervened on behalf of a

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7/ Letter of Helen Gerling, March 12, 1985; Napa Register, December 29, 1984.

8/ Telecon. Barbara Teyerl, April 29, 1985.

9/ Napa Register, January 12, 1985; Telecon. Helen Gerling June 7, 1985.

10/ Letter of Lois Eneshenko to Helen Gerling, November 16, 1984.

11/ San Francisco Chronicle, April 5, 1984.

12/ Telecon. Dennis Bedger, March 15, 1985.

13/ Letter of Lois Eneshenko to Helen Gerling, November 16, 1984.

14/ Napa Register, October 22, 1984; October 30, 1984; November 5, 1984.

staff member involved in a fight with a fellow patient. As a result, the patient was badly beaten. 15/ Finally, the parent of one patient found bruise marks on her son's neck due to assaults by a staff member. That staff member is still employed at NSH while undergoing psychiatric treatment. 16/

Furthermore, our information shows that drugs are available on the grounds of NSH, even in the wards themselves. 17/ This exacerbates the already dangerous environment to which a vulnerable population is exposed. There are eyewitness accounts of patients and high school students selling prohibited items, including drugs, on the grounds of NSH. 18/ Some patients have been caught by staff members smoking marijuana. 19/

We believe that the existing pattern of violence over this short period of time is due to a combination of insufficient staffing, inadequate supervision of staff and the lack of a classification system. The loss of 191 staff members over a ten month period was "significant" to JCAH surveyors, who noted staff deficiencies for nurses, social workers and psychiatric technicians (i.e., direct care staff). Surveyors also determined that supervision of staff was provided by individuals lacking credentials or experience necessary to supervise, i.e., psychiatric technicians. In addition, psychiatric technicians and other non-physician staff were found to have overall responsibility for the quality of clinical care provided to patients and to have evaluated physicians' professional competence. 20/ Staff development was determined to be limited and failed to increase professional competence. 21/

15/ Telecon. Dennis Bedger, March 15, 1984.

16/ Telecon. Barbara Teyrel, May 5, 1985.

17/ Memo of County Liaisons, pp. 4-5.

18/ Id.; Letter of Lois Eneshenko to Helen Gerling, November 16, 1984.

19/ Statement of Anthony Hoffman, June 16, 1984.

20/ JCAH Survey, pp. 3 and 6.

21/ JCAH Survey, p. 10.

Approximately 30% of NSH's population are aggressive, assaultive and manipulative patients who are housed indiscriminately with the general population. 22/ JCAH discovered patients placed in large dorms regardless of their age or clinical needs. 23/ It was reported by the County Liaisons that 21 out of 25 adult wards have an inappropriate mix of patients. 24/ There are 250 penal code (i.e., forensic) patients in the facility, 25/ a number of whom JCAH surveyors found on every ward. 26/ This lack of segregation endangers vulnerable patients by making them easy prey for those more aggressive, assaultive and manipulative patients housed in the same wards, and therefore more susceptible to unreasonable risks to their personal safety.

Fire Safety

There is also a serious threat to the life and health of residents at NSH from inadequate fire prevention and safety measures. JCAH surveyors found numerous deficiencies at the facility which pose a present danger of residents being trapped and consumed by fire. Deficiencies were found in all buildings of NSH and include the following:

1. All but one building lacked a fire alarm system;
2. Several exits were obstructed by closed courtyards;
3. Lack of 1-hour fire-resistive construction or approved automatic fire extinguisher system in "hazardous" areas;
4. Failure to provide two approved remote exits on each floor or fire section of the building;
5. Large open wards in which patients' doors do not open directly onto exit corridors;
6. Failure to provide illuminated exit signs; and
7. Louvers and transoms in corridor doors were not closed and made smoke tight by permanent noncombustible construction. 27/

22/ Memo of County Liaisons, pp. 1, 6-8; Napa Register, November 2, 1984.

23/ JCAH Survey, p. 17.

24/ Memo of County Liaisons, p. 1.

25/ Napa Register, May 1, 1985. This is the maximum amount allowed under state legislation.

26/ Summation conference between the Survey Team of the JCAH and the Employees of Napa State Hospital (JCAH Summation Conference), November 18, 1983, p. 3.

27/ JCAH Survey, pp. 12-15.

Additionally, there is a grave question of whether present staff levels would be sufficient to safely escort the patients out of the facility in time of an emergency. 28/

Medical Care

Harm has also come to the patients at NSH through inadequate medical care. JCAH reported that the medical staff is given little authority and minimal opportunity to effectively influence decisions about medical care. 29/ On the night shift JCAH found insufficient and unqualified medical staff. This was determined to be a "serious hazard to patient health and safety." 30/ Only one physician was available on the night shift for the entire 1835 bed facility. On numerous occasions JCAH ascertained that the one physician on the night shift was a psychiatrist who was not experienced or trained in general medicine or surgery. 31/

The medical care provided to patients itself has serious deficiencies. Patients' medical problems are ignored, misdiagnosed and improperly treated. In the Summer of 1984, Mr. Dennis Bedger, a patient at NSH, pleaded for medical attention when he began to suffer from a bladder and urinary tract infection. When Mr. Bedger was eventually transported to the hospital he had to have his right testicle surgically removed due to the severe infection. He spent three months in the hospital recovering. When he returned to NSH he developed another urinary tract infection that was again ignored by NSH staff. When Mr. Bedger was finally treated by a urologist, a visicostomy had to be performed. As a result, he is forced to wear a plastic bag to collect his urine. After Mr. Bedger returned to NSH a third urinary tract infection developed which was again ignored by NSH staff until the infection was so severe that he had to be treated by intravenous antibiotics. 32/

Barbara Robinson was transferred to a medical-surgery ward of NSH on March 18, 1985. She was told she had pneumonia and a fever. Two days after the transfer, Ms. Robinson's mother was

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28/ This concern is hightened by overcrowding and poor lighting conditions found by JCAH surveyors. See JCAH Survey, p. 16.

29/ JCAH Survey, p. 3.

30/ Id. at 19.

31/ Id. at 6, 18-19.

32/ Bedger v. Napa State Hospital, Civil Action No. C85-09853.

told that her daughter might have tuberculosis and therefore could not visit her. Some ten days later Ms. Robinson was transferred to a local hospital with a 104-105 degree fever. She died four days later. 33/

Gary Wolpert developed tardive dyskinesia allegedly due to the overuse of medication. 34/ Another patient attempted suicide allegedly as a result of the inappropriate mixture of thorazine and other neuroleptics. 35/ Kristine Hamala, a patient at NSH, had diseases of the teeth and gum that were allegedly ignored by staff personnel. 36/

Medical records were also criticized by JCAH surveyors. They concluded that treatment plans failed to identify the clinical needs of the patients and lacked documented goals, objectives (in measurable terms) and criteria for the termination of treatment. 37/ These recordkeeping deficiencies indicate that patients' medical records are inadequate to serve as a basis for medically appropriate and reasonably safe treatment decisions.

Freedom From Unncessary Physical Restraint

Our information shows that the use of restraint and seclusion at NSH violates patients' constitutional rights. The lack of clinical assessment, specific treatment plans, and proper documentation and supervision has led to widespread abuse of seclusion and restraint.

After a violent reaction to psychotropic medications, David Hendrickson was put in 4 and 5 point restraints for more than one year. While in seclusion he was given no clothes, sheets or blankets and NSH staff continued to administer psychotropic medication despite David's documented paradoxical response. 38/ In another case, a patient

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33/ Letter of Helen Gerling, May 2, 1985; Telecon. Mrs. Robinson, May 17, 1985.

34/ Bedger v. Napa State Hospital, Civil Action No. C85-09853.

35/ Letter of Louis Eneshenko to Helen Gerling, November 16, 1984.

36/ Bedger v. Napa State Hospital, Civil Action No. C85-09853.

37/ JCAH Survey, pp. 10-11.

38/ Bedger v. Napa State Hospital, Civil Action No. C85-09853; Letter of Barbara Teyrel to JCAH, August 28, 1984.

was put into seclusion for agitated behavior and until, according to staff, "he tells us why he acted that way." 39/ Another patient had a scuffle with a psychiatric technician after the patient refused to clean the ward floors at night. For this he was placed in five point restraints for three hours without any clothes. 40/ These are clearly inappropriate uses of seclusion and restraint.

JCAH surveyors found occasions when "special treatment procedures" (restraint and seclusion) were employed for staff convenience or for punishment. The rationale for use of these "special treatments" was not documented and their use represents a substantial departure from the exercise of professional judgment. In addition, JCAH discovered PRN (pro re nata, "as needed") orders used "extensively" in treatment plans. Clinical assessments were found to be cursory, infrequently done prior to writing an order for seclusion or restraint and were conducted over the telephone after the fact. Although review of seclusion and restraint orders is to be done by the head of the professional staff, it was frequently conducted by a secretary, who then reported the numbers to the clinical director. 41/

Conclusion

Based on available information, we believe an investigation of NSH is warranted in order to determine whether NSH is depriving residents' of their constitutional rights. These rights may be violated due to the existing pattern of violence against patients; inadequate fire safety and prevention measures; overuse and misuse of seclusion and restraint; inadequate medical care; and inadequate treatment and programming as is necessary to further the residents' interest in safety and freedom from undue bodily restraint. The need for our investigation is especially great in light of the recent deaths at NSH over a short period of time.

Notice letters as required by CRIPA are attached for your review and signature.

Approved: LXBR 7-14-85

Disapproved: _____

Comments:

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39/ Letter of Stephen and Nona Kaufman to Helen Gerling, January 15, 1985, quoting NSH staff member.

40/ Letter of Helen Gerling, April 29, 1985.

41/ JCAH Survey, pp. 11-12.