

Report of

**Napa State Hospital's Failure
to Project Residents from
Abusive Seclusion and Restraint Practices
and to Properly Investigate Related
Potential Criminal Acts by Staff**

Note: When this report was originally published, we were known as Protection & Advocacy, Inc. (PAI). In October 2008, we changed our name from PAI to Disability Rights California.

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I. INTRODUCTION

This report presents Protection & Advocacy, Inc.'s (PAI's) investigation into the circumstances surrounding a pattern of abusive seclusion and restraint practices at Napa State Hospital (NSH). PAI releases this report as part of its ongoing effort to protect people with psychiatric and developmental disabilities from abuse and neglect. In releasing this report, PAI seeks:

- To prevent similar abusive seclusion and restraint practices from recurring;
- To encourage the further development and permanent implementation of NSH's recently adopted proactive systems approach for responding to and preventing patient abuse;
- To call attention to the problem of inadequate and inherently compromised investigations of potentially criminal staff-to-resident abuse at state hospitals; and
- To hold accountable the California Department of Mental Health (DMH) -- the state agency responsible for ensuring the safety and well-being of disabled residents at state-run psychiatric hospitals -- for its failure to exercise needed leadership in implementing an effective, state-wide special incident reporting system for addressing the kind of abusive practices detailed in this report, and to ensure adequate internal investigations of such practices.

PAI is an independent, private, nonprofit agency which protects and advocates for the rights of persons with disabilities. Under federal and state law, PAI has the authority to investigate incidents of abuse and neglect of persons with mental and developmental disabilities. 42 United States Code (U.S.C.) §§ 6000 and 10801, et seq.; California Welfare & Institutions Code (Welf. & Inst. Code) § 4900, et seq.

PAI's investigation, which was initiated in March of 1996, included:

Interviewing over 30 people, including current and former NSH direct care, professional, and administrative staff; NSH residents; California Department of Health Services, Licensing and Certification (Licensing) evaluators; conservators; and mental health professionals.

- Reviewing 1994 and 1995 special incident reports, special incident briefs, daily logs, daily time records, and monthly attendance records from Unit A-8.
- Touring and photographing Unit A-8.
- Reviewing NSH's internal investigations into the illegal seclusion and/or restraint incidents that occurred on Units A-8, M-5, and A-2.
- Reviewing the clinical records of four NSH Unit A-8 residents and one NSH Unit A- 2 resident.
- Reviewing Licensing documents.
- Reviewing relevant program descriptions, administrative and patient care policies, procedures, and directives from NSH and the California Department of Mental Health.
- Reviewing NSH employee job performance rating materials and duty statements.
- Reviewing current medical literature pertaining to seclusion, restraint, and patient abuse.

A copy of this report has been forwarded to the United States Department of Justice, Civil Rights Division; the California Board of Consumer Affairs; the California Department of Mental Health; the California Office of the Attorney General, Bureau of Medi-Cal Fraud and Patient Abuse; the Joint Commission on Accreditation of Healthcare Organizations; and the Napa County District Attorney's Office.

PAI has elected to use pseudonyms throughout this report.

II. EXECUTIVE SUMMARY

This report by Protection & Advocacy, Inc. (PAI) describes a pattern of improper seclusion and restraint practices during 1994, 1995, and 1996 at Napa State Hospital (NSH). The primary focus of PAI's investigation was the repeated use of unauthorized seclusion during the night shift on Unit A-8. This abusive practice -- which reportedly occurred as often as two to three times per week for more than a year and a half during 1994 and 1995 -- was carried out at the direction of the night shift supervisor, and then concealed from the other shifts.

Due to the nature of the victims' disabilities -- which include significant cognitive and communication impairments -- they were unable to protect themselves from or report this abuse. When the abuse was finally reported by a staff member, the shift lead successfully encouraged other night shift staff to engage in a cover-up and to lie to management and the Senior Special Investigator during NSH's first internal investigation. Their collusion to hide the misconduct continued for an entire month, until one nurse broke the code of silence.

PAI's investigation uncovered a pattern of unauthorized seclusion and restraint practices beyond those which occurred on Unit A-8. From September 1995 through August 1996, NSH received similar reports of residents being subjected to the intentional misuse of seclusion and/or restraint by direct care staff on two other units; M-5 and A-2. Although involved staff on all three units were aware of proper seclusion and restraint procedures, they nevertheless engaged in the misconduct. PAI's investigation also revealed that during 1995 and 1996, the California Department of Health Services, Licensing and Certification repeatedly cited NSH for seclusion and restraint violations and patient abuse that occurred on other residential units throughout the facility.

PAI investigators determined that NSH failed to take timely and effective measures to protect patients from further abuse. Until late 1996, instead of taking a comprehensive proactive approach to determine the underlying causes of the abusive pattern of restraint and seclusion at NSH, the facility's leadership continued to respond to the incidents on a reactive case-by-case basis.

PAI investigators further determined that the facility's Senior Special Investigator (the primary law enforcement officer responsible for conducting investigations of alleged abuse of residents by staff) failed to conduct a minimally adequate investigation into the abusive seclusion practices on Unit A-8. For example, the Senior Special Investigator failed to gather and analyze readily available documentary evidence which corroborated witness statements concerning the abuse; attempted to interview only one of the four victims; and improperly prejudged the unauthorized use of seclusion as not being potentially criminal conduct on the part of involved staff.

Based on these facts and the Findings and Conclusions, which are further detailed in this report at pp. 60-61, PAI recommends that NSH and the California Department of Mental Health promptly take all steps necessary to ensure that:

- NSH, and all hospitals under the jurisdiction of the California Department of Mental Health, fully implement effective proactive systems for identifying and responding to abuse-related incidents, including but not limited to the comprehensive collection and analysis of relevant abuse and "special-incident" related data to assist leadership in identifying, understanding, and addressing the root causes of abuse.
- All allegations of staff-to-resident abuse are thoroughly and competently investigated, and that appropriate follow-up action is taken, including meaningful disciplinary measures and referrals for criminal prosecution, as warranted.

III. BACKGROUND

A. NAPA STATE HOSPITAL

Napa State Hospital (NSH) is located in Northern California and has been in operation since 1875. NSH is one of four state hospitals operated by the California Department of Mental Health and is capable of housing over 1,300 long-term care residents with mental and developmental disabilities, ranging from age 5 upwards.

NSH is licensed by the California Department of Health Services, Licensing and Certification (Licensing). Licensing enforces care and treatment standards under applicable state and federal regulations. In addition, NSH, like all state hospitals serving people with psychiatric disabilities in California, is voluntarily accredited by the Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission).¹

According to NSH's "Service Philosophy," as stated in its Directory of Services & General Information:

Napa State Hospital's mission is to maximize clients' ability for independence and for safe and effective community placement. We assist clients to achieve optimum mental and physical health, social functioning and personal well-being. Clients are encouraged to enter into a working alliance with their treatment teams and to have optimal participation in the team decision making process. We offer a wide range of treatment including biomedical, psychiatric, psychological, psychosocial, vocational, rehabilitation therapies, and education.

In that same Directory (in an open letter to clients, parents, families, and friends of NSH residents/clients), the Executive Director, in relevant part, states:

Our [NSH's] major focus is to establish and promote collaborative partnerships between clients, staff, families and client advocates in order to

¹ The Joint Commission is a private health care monitoring agency that promotes quality of care standards and evaluates facility compliance with their standards and related performance outcomes.

maintain an environment where services, treatment and rehabilitation are provided with dignity and respect for all. . . .

B. SECLUSION AND RESTRAINT

Seclusion and restraint is used in facilities such as NSH to prevent physical injury to an individual with a disability or to others in the immediate area. Seclusion is the involuntary isolation of an individual from others, usually in a locked, stark room -- much like solitary confinement in a jail. See, Attachment A, photograph of exterior A-8 seclusion room door; and Attachment B, photograph of interior A-8 seclusion room. When a resident is placed in a room by staff and not allowed to leave, the resident is secluded, regardless of whether the door is locked or unlocked.

Restraint is defined by the Joint Commission as "any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body." (The Joint Commission, "Care of Patients," The Comprehensive Accreditation Manual for Hospitals: The Official Handbook (1996), p. TX-47.)

Studies show that persons with psychiatric disabilities are most frequently subjected to seclusion and restraint when they are involuntarily hospitalized, as is the reality for the overwhelming majority of NSH residents.

Seclusion and restraint can cause serious physical and emotional harm, especially when used for long periods of time, for inappropriate reasons, or without giving sufficient consideration to the condition of the individual. Risks associated with seclusion and restraint include physical injury; worsening of the person's mental condition as a result of being isolated and alone; and, in some cases, even death. Common psychological responses include discomfort, anger, resistance, fear, humiliation, denial, resignation, and agitation. Consequently, to mitigate against painful memories, some "debriefing" may be necessary following the person's removal from seclusion and/or restraint. See, Fisher, "Restraint and Seclusion: A Review of the Literature," *American Journal of Psychiatry*, Vol. 151:11 (1994), pp. 1584-1591; Norris and Kennedy, "The View From Within: How Patients Perceive the Seclusion Process," *Journal of Psychosocial Nursing*, Vol. 30,

No. 3 (1992), pp. 7-13; Tooke and Brown, "On the Seclusion of Psychiatric Patients," *Social Science and Medicine*, Vol. 35, No. 5 (1992), pp. 711-721.

Because of the inherent risks of harm and the potential for abuse and neglect, it is critical that appropriate safety and monitoring practices be followed during the use of seclusion and restraint. California law does provide some basic guidelines. Mentally and developmentally disabled persons who are receiving care and treatment in facilities such as NSH have the right to be free from harm, including unnecessary physical restraint or seclusion. See, Welf. & Inst. Code §§ 4502(h) and 5325.1(c).

Under existing regulations, these interventions may only be used when alternative, less restrictive methods are insufficient to ensure the physical safety of the individual or others in the immediate area. See, e.g., Cal. Code Regs., Title 22, § 71545; Title 9, § 865.5. Properly documented authorization from a physician must be obtained before placing individuals in seclusion or restraint. See, e.g., Cal. Code Regs., Title 22, § 73409. In a clear case of emergency, a patient may be secluded or restrained at the discretion of a registered nurse, and the physician's order obtained thereafter. See, e.g., Cal. Code Regs., Title 22, § 71545.

Furthermore, seclusion and restraint cannot be used as punishment, or as a substitute for a more effective medical and nursing care program, or a less restrictive alternative form of treatment. See, Cal. Code Regs., Title 22, § 73403; Cal. Code Regs., Title 9, §§ 865.4(a) and 865.5.

As detailed in this report, seclusion and restraint used for punishment or for any purpose not authorized by a physician constitute physical abuse and must be reported to local law enforcement (i.e., NSH's Senior Special Investigator) and/or protective services agencies. Welf. & Inst. Code §§ 15610.63(f)(1) & (3) and 15630(b)(2).

The potential for treatment staff to become involved in abusive seclusion practices has long been recognized by the psychiatric profession. In 1984, the American Psychiatric Association, in relevant part, reported:

Seclusion of a patient as a purely punitive response is contraindicated. Similarly, absent a patient's specific clinical needs, a patient should never be secluded:

- 1. for the pure comfort or convenience of the staff . . .*
- 2. for mere mild obnoxiousness, rudeness or other unpleasantness by the patient to others;*
- 3. for staff anxiety alone . . . or*
- 4. solely because of factors in ward dynamics.*

The Task Force does not condone excessive or poorly implemented seclusion or restraint resulting from inadequate staffing or other resources.

(Report of the American Psychiatric Association Task Force on the Psychiatric Uses of Seclusion and Restraint, "Seclusion and Restraint: The Psychiatric Uses" (1984), p. 22.)

Noteworthy to this investigation is the fact that the Joint Commission's 1996 Standards for Restraint and Seclusion emphasize the pivotal leadership role of hospital administration in protecting patients from abusive seclusion and restraint practices:

Creating a physical, social, and cultural environment limiting restraint and seclusion use to clinically appropriate and adequately justified situations or that actually reduces their use through preventive or alternative strategies helps organization staff focus on the patient's well-being. The leaders' role is to help create such an environment. This requires planning and, frequently, new or reallocated resources, thoughtful education, and performance improvement. The result is an organization approach to restraint and seclusion that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.

(The Joint Commission, "Care of Patients," The Comprehensive Accreditation Manual for Hospitals: The Official Handbook (1996), p. TX-47.)

C. STATE HOSPITAL POLICIES AND PROCEDURES REGARDING PATIENT SECLUSION AND RESTRAINT ABUSE

As indicated above, the improper use of seclusion or restraint constitutes patient abuse. The California Department of Mental Health (DMH) and NSH have explicit policies and procedures regarding the reporting and investigation of such patient abuse.

- CALIFORNIA DEPARTMENT OF MENTAL HEALTH

DMH Special Order #701, entitled "REPORTING OF ELDER AND DEPENDENT ADULT ABUSE," applies to all state-run psychiatric hospitals and states, in part:

Special Order: All hospital staff are required to make any reports concerning suspected elder and dependent adult (aged 18 or older) abuse cases occurring in state hospitals to the designated investigator in the state hospital.

Method: . . . 2. All staff must report any observed or suspected case of abuse of an adult patient that occurs within the hospital. . . . This report is to occur immediately or as soon as possible by telephone and within two working days . . . to the special investigator at the state hospital. . . . This requirement applies to staff at all employment classifications and it refers to abuse of patients aged 18-64 as well as those over 65.

- NAPA STATE HOSPITAL

NSH's Administrative Directive #437, entitled "Patient Abuse," states, in pertinent part:

It is the policy of Napa State Hospital that all patients shall be treated with dignity and respect at all times and be protected from risks of bodily harm. All incidents of suspected or alleged physical, sexual or psychological abuse of patients will be reported immediately, promptly investigated and acted upon by licensed clinical staff and Hospital Administration. No staff member may be subject to adverse action for reporting known or suspected abuse. . . .

General Definitions:

I. Physical Abuse: The use of excessive or unnecessary physical contact with patients which may be considered harmful or offensive.

II. Psychological Abuse: The use of any cruel or harsh treatment, neglect, harassment, ridicule, or other act that is a detriment to the well-being, dignity, or treatment of patients. . . .

Procedures:

I. Reporting of All Suspected Abuse:

All incidents of alleged or suspected abuse are to be reported to the attending physician, the Program Director and the Senior Special Investigator by any employee having knowledge of the allegation or suspicion. . . .

The Program Director will review the result of all investigations of alleged patient abuse and take whatever steps might be necessary to protect the patient in question, or any other patient, from any type of abuse. If hospital employees are determined to have committed abusive acts against patients, appropriate corrective or disciplinary action will be taken to assure the safety and freedom from abuse of all patients. . . .

III. Reporting of Elder and Dependent Adult Abuse

A. Adult abuse refers to, but is not limited to: assault/battery; physical constraint; isolation or deprivation; sexual abuse; neglect; abandonment; chemical or physical restraint without authority or for a purpose or duration other than for which it was authorized; fiduciary abuse and mental suffering. . . .

B. The Senior Special Investigator shall fully investigate these incidents and file a written report, including recommendations, with the Executive Director. Representatives from the Welfare Agency who wish to investigate the incident should be referred to the Senior Special Investigator.

C. In the absence of the Senior Special Investigator or if the incident is between patients, the Hospital Police Department shall handle these cases. . . . (Emphases added.)

As summarized above, NSH policies, procedures, and directives make clear that the unauthorized use of seclusion or restraint by direct care staff is impermissible and constitutes patient abuse. NSH also requires that, on an annual basis, all direct care staff, including psychiatric technicians and registered nurses, complete six hours of training regarding the proper use of seclusion and restraint and the management of assaultive behavior. Nevertheless, as chronicled in this report, a number of NSH direct care staff chose to disregard these policies, procedures, and directives.

D. ETHICS FOR PSYCHIATRIC TECHNICIANS AND REGISTERED NURSES

Patient care at NSH is generally provided by licensed psychiatric technicians and registered nurses. Psychiatric technicians are licensed by the California Board of Vocational Nurses and Psychiatric Technician Examiners, while registered nurses are licensed by the California Board of Registered Nursing. Both of these Boards operate under the State of California, Department of Consumer Affairs, which is responsible for licensing and regulating a number of different health providers (including licensed psychiatric technicians and registered nurses) and for responding

to complaints from consumers and others involving violations of applicable California Business and Professions Code provisions.

NSH is required to report to these Boards all Business and Professions Code violations committed by psychiatric technicians and registered nurses, including patient abuse. According to the California Association of Psychiatric Technicians (CAPT):

The Board maintains an enforcement function to safeguard the consumer's right to skilled, competent mental health treatment. To supplement the state licensing process, the California Association of Psychiatric Technicians maintains the Psychiatric Technician Standards of Practice and Code of Ethics.

- CODES OF ETHICS

CAPT and the California Nurses Association are voluntary, professional associations that maintain ethical standards and principles for the delivery of quality patient care.

CAPT's Code of Ethics states that all psychiatric technicians have "a personal obligation to uphold and adhere" to the code "and to ensure that colleagues do the same." CAPT's Interpretive Statements for the Psychiatric Technician Code of Ethics states, in pertinent part:

3. The Psychiatric Technician acts to protect clients/patients and the public from the incompetent, unethical or illegal practice of any person.

The Psychiatric Technician commits to the welfare, habilitation, daily care and safety of the client/patient. The Psychiatric Technician must act as an advocate regarding instances of incompetent, unethical, prejudicial or illegal practice by any member of the healthcare system. Psychiatric Technicians should be aware of state laws, licensing regulations and the policies and procedures where they work.

When Psychiatric Technicians are aware of inappropriate or questionable conduct, they have a legal responsibility to report the practice to the proper authority within their work environment. . . . (Emphases added.)

According to the California Nurses Association Code for Nurses:

4. *The Nurse acts to safeguard the patient . . . when health care and safety are affected by the incompetent, unethical, illegal, or inappropriate practice of any person.*
5. *The Nurse assumes responsibility and accountability for individual Nursing judgments and actions. (Emphasis added.)*

PAI investigators note that most psychiatric technicians and registered nurses embrace and uphold the values embodied in their professional association's ethical codes, and strive to provide humane and dignified care, often under difficult institutional circumstances. However, as revealed during this investigation of abusive seclusion and restraint practices, despite the legal and ethical obligations to report and protect patients from abuse, a strong code of silence among direct care staff still exists -- which must be overcome.

- CODE OF SILENCE

The "code of silence," or the failure to speak out when wrongdoing is committed by co-workers, is only one of many institutional barriers that prevent staff from reporting the abuse of residents at facilities such as NSH.

Studies indicate that institutional barriers make it unrealistic to rely primarily on direct care staff to break the code of silence and report abuse by fellow employees.

Despite official expectations and no matter how conscientious the direct-care staff, it is unrealistic to expect that staff abuse can be adequately monitored and disciplined by relying on fellow workers as the primary reporters. Aside from strong personal considerations, including loss of

effective working relationships and documented threats of retaliation, there are institutional barriers to this sort of freelance monitoring.

(Staff Report on the Institutionalized Mentally Disabled: Joint Hearings Before the Subcommittee on the Handicapped of the Committee on Labor and Human Resources and the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Committee on Appropriations, United States Senate (April 1-3, 1985).)

Additional obstacles to the reporting of abuse by staff include the staff's own view of themselves as victims of their working conditions and circumstances:

Because direct care staff see themselves as victims of a larger system that would be quick to punish them for minor abuses but that is slow to recognize and improve the adverse working conditions that contribute to abusive behavior, at most they will merely caution an abuser not to repeat a behavior. . . .

[T]here are powerful factors at work in the state hospital system to hinder prompt reporting of severe patient abuse by employees as well as by patients. These factors include the facility director's attitude toward employees charged with allegations of patient abuse; perceptions of staff about the even handedness of the disciplinary system as applied to professional and direct care staff; and the effectiveness of the disciplinary machinery in punishing alleged abusers.

See, e.g., Sundram, C., "Obstacles to Reducing Patient Abuse in Public Institutions," *Hospital and Community Psychiatry*, Vol. 35:3 (1984), pp. 238-243 at 240.

Rindfleisch and Bean (1988), in their study on the willingness to report abuse in residential facilities, found that residents had the highest level of willingness to report, while direct care workers and administrators had lower levels of willingness to report. In fact, "being a resident was positively related to willingness to report while being an administrator was negatively

related to this variable." (Rindfleisch, N. and Bean, G., "Willingness to Report Abuse and Neglect in Residential Facilities," *Child Abuse and Neglect*, Vol. 12 (1988), pp. 509-520 at 517.)

In April of 1993, CAPT surveyed senior psychiatric technicians regarding factors contributing to abuse and neglect at California Developmental Centers (state hospitals for persons with developmental disabilities). Among their findings, CAPT found that "68% feel there is an unspoken 'code of silence' that encourages employees not to report abusive incidents they observe. . . . In addition, 41% statewide said they had personal knowledge of employees being subjected to reprisal from other employees for reporting abusive incidents." (CAPT, *Factors Contributing to Client Abuse and Neglect in California Developmental Centers: A CAPT Survey of Senior Psychiatric Technicians* (April 1993), p. 5.)

Compounding the problem of the code of silence is the fact that state hospitals, like all large institutions and bureaucracies, are further challenged by resistance to change. The CAPT survey also states: "More than four out of five (83%) said they believe there are actions employees could properly take in dealing with clients a few years ago which are now considered abusive or otherwise inappropriate." (Ibid., p. 4.)

During interviews, PAI investigators were repeatedly told that it had historically been common practice at NSH to place residents in seclusion without proper authorization. As one person stated to PAI investigators: "[I]t's the kind of old Bughouser mentality. . . ." ²

² According to Webster's, "bughouse" means "an insane asylum" or "mentally deranged; crazy." "Bughouser mentality" thus refers to an inhumane, undignified, custodial attitude towards the care and treatment of institutionalized persons with mental disabilities (such as those residing at NSH) -- which is no longer acceptable.

IV. PATTERN OF ILLEGAL SECLUSION ON UNIT A-8 AT NAPA STATE HOSPITAL

On October 2, 1995, a staff member at Napa State Hospital (NSH) reported to the A-8 unit supervisor that residents had been subjected to illegal and abusive seclusion by night shift personnel, at the direction of Psychiatric Technician Sam Norris {PSEUDONYM}, the night shift lead (supervisor). Mr. Norris reportedly directed staff to place residents into seclusion without securing physician's orders, without documenting justification for the seclusion, and without noting those seclusion incidents in the patients' medical records, as required.

A. BACKGROUND

- UNIT A-8 PROGRAM DESCRIPTION

NSH Unit A-8, also known as the "Biological Psychiatry Treatment and Research Center," houses up to 36 male residents between the ages of 18 and 54. NSH Program 4 (the "General Acute, Continuing Medical, Intermediate Psychiatric Program") has administrative responsibility for Unit A-8.

NSH's pamphlet regarding the Biological Psychiatry Treatment and Research Center explains the program's purpose as follows:

The Program's purpose is to expand our understanding of the biological basis of major psychiatric disorders while extending to this treatment population current advances in the field.

Since most patients served at this facility have failed to adequately respond to traditional treatment strategies, the intent of this research is to improve diagnosis and treatment through the advancement of knowledge. . . .

Treatment decisions are based on individualized treatment plans. Staff efforts are directed toward providing patients with a solid reality base, self-awareness, understanding of their illness, improved self-esteem, and independence based on each patient's ability. (Emphasis added.)

Some A-8 residents participate in research that includes the administration of new medications and treatments. Research on A-8 has been conducted

in collaboration with Stanford University and the University of California at both San Francisco and Davis.

- UNIT A-8 NIGHT SHIFT STAFF

The night shift for Unit A-8 begins at 11:00 PM and ends at 7:00 AM the following day. Usually, at least three staff members are present during the night shift. Staff duties during the night shift include, but are not limited to: ensuring the well-being of residents by checking on them every 30 minutes; checking medications, supplies, and equipment; and auditing clinical records.

In March of 1994, Sam Norris, a psychiatric technician who had worked for more than 20 years for the State of California, was transferred from Unit M-5 (formerly part of the Youth Project at NSH) to Unit A-8. Mr. Norris subsequently became the A-8 night shift lead (supervisor) responsible for overseeing the care of all A-8 residents while on duty, as well as supervising the unit's night shift staff, which consisted of a registered nurse and other psychiatric technicians.

- UNIT A-8 RESIDENTS SUBJECTED TO ILLEGAL SECLUSION

The four A-8 residents victimized by the illegal seclusion practices on this unit are developmentally and/or psychiatrically disabled,³ and have limited

³ Three of the four NSH A-8 residents who were subjected to the unauthorized seclusion practices have developmental as well as psychiatric disabilities, which is common for residents of state-run psychiatric facilities such as NSH. A developmental disability is defined as:

a severe, chronic disability of an individual 5 years of age or older that --

- (1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (2) Is manifested before the individual attains age 22;
- (3) Is likely to continue indefinitely;
- (4) Results in substantial functional limitations in three or more of the following areas of major life activity --
 - (i) Self-care;
 - (ii) Receptive and expressive language;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Self-direction;
 - (vi) Capacity for independent living; and
 - (vii) Economic self-sufficiency.

42 U.S.C.A. 6001(8).

communication and cognitive skills. Because of the nature of their disabilities, they were particularly vulnerable to this type of abuse, as they were unable to protect themselves from staff's illegal and potentially dangerous practices. Although staff witnesses identified only four residents as being victims of the unauthorized seclusion practices, PAI investigators note that, according to information gathered from A-8 documents, there may have been more residents subjected to such abusive practices.

- ANDREW BATISTA {PSEUDONYM}

Mr. Batista is a 49-year-old man diagnosed with chronic schizophrenia, lung problems and insomnia, and has been disabled since 1963. He has lived at NSH since 1982. His mother is his private conservator, visits him frequently, and has "even donated to the Patient Benefit Funds" at NSH. According to NSH records, Mr. Batista "speaks in monosyllables" and at times may be difficult to understand. A 1985 psychological evaluation indicated that Mr. Batista's scores fell within the range of being mildly mentally retarded; however, it is unclear whether those scores were attributable, in part, to his "severe emotional disturbance." During an interview with PAI investigators, Mr. Batista was unable to communicate anything specific about Mr. Norris or the use of seclusion.

- PAUL WILSON {PSEUDONYM}

Mr. Wilson is a 44-year-old man diagnosed with chronic schizophrenia, and, according to clinical records, has been disabled since the age of 13. He is publicly conserved by the County of Santa Clara and has been at NSH since 1982. A 1995 neuropsychological evaluation conducted at NSH indicate that Mr. Wilson has "an impaired ability to remember both verbal and non-verbal material," both "recent and remote." Mr. Wilson stated during an interview with PAI investigators that he sometimes would get up and walk around at night. He also told PAI investigators that he remembers Sam Norris and remembers being placed once into the seclusion room.

- FRANCISCO MARCOS {PSEUDONYM}

Mr. Marcos is a 38-year-old man diagnosed with paranoid schizophrenia and moderate mental retardation. He has had a psychiatric disability since

1979. Mr. Marcos is publicly conserved by the County of Sacramento and has resided at NSH since 1993. His clinical records indicate that he has "severe cognitive deficits (comprehension, social judgment, memory) which are compromised by a thought disorder." When interviewed by PAI investigators, Mr. Marcos was unable to recall anything significant about his care or treatment on Unit A-8 during the night shift.

- **JAMES NELSON {PSEUDONYM}**

Mr. Nelson is a 56-year-old man diagnosed with "late-onset" chronic schizophrenia, dating back to 1965. According to hospital documents, he has an Associate's degree in engineering and served in the Navy as a radar technician from 1959 to 1962. Mr. Nelson is publicly conserved by the County of Santa Clara and has resided at NSH since 1982. His clinical records indicate that he has "severe difficulty with articulation," resulting in "less than 50% intelligible" speech. When Mr. Nelson was interviewed by PAI investigators, he did not articulate anything about his treatment on Unit A-8 during the night shift.

PAI's investigation suggests that the ongoing pattern of illegal seclusion practices continued partly because staff knew that these particular A-8 residents were unable to report such practices. Furthermore, as one NSH employee pointed out to PAI investigators: "[H]ow's the patient ever gonna know whether there's been a legitimate order or not? All the patient knows is that something's happened and that he's been put in seclusion."

B. UNAUTHORIZED SECLUSION OF A-8 RESIDENTS

A-8 night shift staff told NSH Senior Special Investigator (SSI) Coleman {PSEUDONYM} that Mr. Norris "directed" them to place residents into seclusion without proper authorization or adequate justification. Two staff members stated that although they knew what they were doing was wrong, they did so anyway because they were following directives from their supervisor. Also, according to A-8 night shift staff, they deliberately concealed from day shift personnel the evidence regarding this unauthorized practice. PAI's review of A-8 documents indicate this illegal practice began as early as one week after Mr. Norris' arrival on Unit A-8

(i.e., late March of 1994), and continued until it was finally reported to the A-8 unit supervisor on October 2, 1995.

With Mr. Norris' encouragement, mental health direct care staff on the A-8 night shift continued to collude to hide their misconduct for an entire month after the pattern of abusive seclusion practices was initially reported by a staff member who broke the code of silence.

The circumstances surrounding the misuse of seclusion on Unit A-8 illustrate the activities of far more than one "bad apple" -- these events indicate the existence of a strong code of silence by staff and a culture of tolerance towards the mistreatment of disabled residents. These events also evidence the dire need for more active and effective supervision during the night shift. As one manager told PAI investigators: "[I]t's a different hospital at night than it is during the day time."

V. INVESTIGATIONS BY NAPA STATE HOSPITAL INTO THE CIRCUMSTANCES SURROUNDING THE ILLEGAL USE OF SECLUSION ON UNIT A-8

At Napa State Hospital (NSH), as at all state hospitals, investigations of patient abuse are usually conducted by the facility's Senior Special Investigator (SSI), who is a sworn peace officer.⁴

A. AUTHORITY FOR INTERNAL CRIMINAL INVESTIGATIONS AT NAPA STATE HOSPITAL

- STATE OF CALIFORNIA STATUTES

Incidents of potential criminal staff-to-resident abuse at state-run facilities for the disabled are investigated by the facility's own law enforcement, usually the SSI. California statutes set forth the authority for internal police investigations at all state-run hospitals.

Welfare and Institutions Code Section 4313 states:

The hospital administrator of each state hospital may designate, in writing, as a police officer, one or more of the bona fide employees of the hospital. The hospital administrator and each such police officer have the powers and authority conferred by law upon peace officers listed in Section 830.38 of the Penal Code. Such police officers shall receive no compensation as such and the additional duties arising therefrom shall become a part of the duties of their regular positions. When and as directed by the hospital administrator, such police officers shall enforce the rules and regulations of the hospital, preserve peace and order on the premises thereof, and protect and preserve the property of the state.

Penal Code Section 830.38, in pertinent part, states:

⁴ PAI investigators note that under current California statutes and regulations, the California Department of Health Services, Licensing and Certification Division is the only external agency mandated to routinely receive all reports regarding allegations of abuse and neglect of adult residents which occur at state hospitals. Allegations of child abuse must be reported to both Licensing and Child Protective Services (an external protective services agency).

The officers of a state hospital under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services appointed pursuant to Section 4313 or 4493 of the Welfare and Institutions Code, are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 as to any public offense with respect to which there is immediate danger to person or property. . . .

- NAPA STATE HOSPITAL POLICIES AND PROCEDURES FOR INVESTIGATING POTENTIALLY CRIMINAL PATIENT ABUSE

NSH Administrative Directive #435 ("Investigation of Alleged Criminal Acts and Employee Misconduct"), which was in effect at the time the illegal seclusion practices occurred on Unit A-8, sets forth very minimal investigatory procedures to be followed by the SSI.

Policy:

It is the policy of Napa State Hospital to investigate all known or alleged criminal offenses that occur on the Hospital grounds. The investigation shall be conducted by the Hospital Police Department or Senior Special Investigator.

Procedure:

I. All allegations of employee misconduct including patient abuse and patient sexual abuse will be investigated by the Senior Special Investigator. Any other alleged criminal acts will be investigated by the Hospital Police.

II. The assigned investigator/officer shall investigate the incident and interview persons involved in the allegation e.g. victim, witness, suspect, etc.

III. Interviews of patients shall be conducted by the investigator/officer. These interviews may include those staff members deemed appropriate by the investigator/officer.

IV. The investigator/officer may request written, signed statements from those employees involved in the allegation. Staff members are expected to cooperate.

V. At the completion of the investigation, a copy of the investigative report shall be sent to the Executive Director and Hospital Administrator.

The above procedure fails to address basic investigatory techniques, such as preserving physical evidence and photographing the crime scene.

- CONFLICT OF INTEREST DILEMMA

Entities such as NSH who are responsible for conducting internal investigations face an inherent conflict of interest -- the dilemma of (1) being ultimately liable for the abuse and/or injury inflicted by its own staff; and (2) being responsible for investigating that same patient abuse and, in some instances, assisting with the prosecution of the involved employees.

Authority for the disposition of investigations by NSH, by both policy and law, rests with the administration of that facility. This, however, poses a dilemma, as referring an incident for prosecution may be viewed as an admission of failure on the part of the facility and, among other things, may open the door to negative publicity.

Several studies and journal articles have commented upon this conflict of interest dilemma facing all agencies (such as NSH) who are authorized to investigate themselves. "Choosing to handle the matter through internal channels may earn the appreciation of the institution if it is sincere in its concern for young people in its care or trying to protect its public image. . . . [T]he possibility remains that no internal action will be taken. This is particularly likely in an institution which is hoping to ignore or cover up the incident." See, e.g., Durkin, R., "No One Will Thank You: First Thoughts on Reporting Institutional Abuse," *Child and Youth Services* (1982), pp. 109-113, at 112.

The Office of Inspector General, Federal Department of Health and Human Services stated in their 1990 study on resident abuse in nursing homes: "In some cases, administrators may initiate investigations and take corrective

action but fail to report the incident." The Office of Inspector General recommended that "administrators should not be allowed to delay reporting of possible cases of abuse in order to conduct internal investigations." (Office of Inspector General, Office of Evaluation and Inspections, Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints (1990), pp. 1-28, at 15 and 23.)

B. INADEQUATE INTERNAL INVESTIGATIONS INTO THE ILLEGAL USE OF SECLUSION ON UNIT A-8

- NAPA STATE HOSPITAL'S FIRST INVESTIGATION

On Monday, October 2, 1995, A-8 Unit Supervisor Mary Hughes {PSEUDONYM} was speaking over the phone with night shift Psychiatric Technician Joann Sorenson

{PSEUDONYM}, who casually mentioned that it had been unfortunate that two residents had been in a fight during the day shift. Ms. Sorenson further stated that the night shift had resolved this problem by putting one of the residents in seclusion. As Ms. Hughes continued to question Ms. Sorenson, she realized that the illegal practice had been occurring at the direction of Sam Norris, the psychiatric technician in charge during the night shift.

The next day, Ms. Hughes filled out a Special Incident Report and informed Program 4 Managers Stephen Jones {PSEUDONYM} and Dmitri Robinson {PSEUDONYM} that she intended to confront the night shift staff about these improper seclusion practices. Ms. Hughes questioned two night shift psychiatric technicians, Angela Green {PSEUDONYM} and Mel Denton {PSEUDONYM}, who both denied knowledge of residents being placed into seclusion without authorization.

On October 4, 1995, Program Director Marvin Silverberg {PSEUDONYM} notified NSH's Executive Director of the allegations regarding unauthorized seclusions on Unit A-8. The matter was then referred to NSH's Senior Special Investigator (SSI) Coleman. According to SSI Coleman's records, this referral was received by him on Friday, October 6, 1995 via Special Incident Report.

The "Description of Incident" in the Special Incident Report states:

On 10-2-95 I received a phone call from Joann Sorenson P.T., who is currently working 4/5 X [four-fifths time] on A-8 night shift. During our conversation Joann informed me that patients are sometimes being put in room seclusion on night shift without obtaining a physicians [order] or documenting their behavior in their medical record.

The "Investigation and Findings" section of the Special Incident Report states:

I visited night shift this AM. Only 2 regular staff were on duty Mel Denton PT and Angela Green PT. - I told of this practice on night shift & asked if this was true. After a brief silence, during which both staff turned to look at each other, Ms. Green put her hand over her mouth & I could see her eyes smile, then she turned to Mr. Denton and said 'your [sic] in charge, you tell her.' It was obvious to me they were uncomfortable and I said "I already know" - at that point they both nodded their head once - As I explained the consequence they just listened in silence - I informed them that this would be investigated by hospital police.

According to SSI Coleman's NSH Report of Investigation #95-10-059, dated October 27, 1995, he started investigating this matter on October 24, 1995. His investigation consisted of interviewing five night shift staff on Unit A-8 -- all of whom (with the exception of the staff member who first reported the abuse) denied the allegations that patients were being secluded without proper authorization, in violation of state law and NSH policies and procedures.

Ms. Sorenson, both in a written statement and during her interview with SSI Coleman, related that she had seen Shift Lead Sam Norris put a patient into a locked seclusion room, without authorization, on at least one occasion. She further related that one specific patient, who would become unruly at night, was put into a locked seclusion room on several occasions without proper authorization.

According to SSI Coleman's investigatory report, during a tape-recorded interview with Sam Norris, Mr. Norris denied ever having placed a patient at NSH into seclusion without proper authorization.

SSI Coleman states in the "Conclusion" section of his report:

There is insufficient evidence or information to substantiate the allegation that Sam Norris had placed patients in seclusion without authorization and documentation.

In the "Recommendation" section, SSI Coleman states: "Case Closed; A copy of this report to the Executive Director and Personnel Officer, for their review and disposition."

Program 4 management told PAI investigators that they were "disappointed" with the outcome of NSH's investigation.

[I]t was also . . . you know, not the first time that the whole staff would hang together on something. Especially a night staff . . . they kind of get a little closer together. They have less contact with the others. . . . [I]t's kind of an 'us against the rest of the hospital.' So yeah, I didn't like that first report. I was hoping that we'd get . . . the goods.

According to one Program 4 manager:

We had conflicting information. Our feeling was, it was more to it than that. But probably that somebody was not entirely truthful or forthcoming in what they say. . . . And we shared our feelings, but that ended up moot. We basically had to go back and do more probing.

- NAPA STATE HOSPITAL'S SECOND INVESTIGATION

On Monday, November 6, 1995, SSI Coleman received a handwritten admission of wrongdoing from night shift staff member Mark Anderson, R.N. {PSEUDONYM}, concerning the illegal seclusion practices on the unit, which stated:

I have to reconsider what I've told you about Sam Norris. My conscious [sic] will no longer allow me to go along with this charade. I mislead [sic] myself out of fear and need to protect Sam Norris.

I have witnessed Sam place patients into seclusion rooms and lock the door. Patients include Batista, James Nelson, Wilson and others.

I was new to state service, 9 months to date.

As I witnessed this occurring more and more frequently I approached Sam. Sam told me it was 'illegal as hell.' And if it ever got out you could 'lose your job.' Referring [sic] to my status as an RN.

I am not alone. This conspiracy is fabricated with fear of losing licenses and jobs. I will no longer lie for Sam. I cannot live with it any longer. Please accept my apology. Sam was my mentor. But it was wrong and he should have set a better example. . . .

This admission of wrongdoing prompted SSI Coleman's second investigation, and once again he spoke with the same five staff members that he had previously interviewed. According to information received by SSI Coleman during this second investigation, A-8 night shift staff had lied and engaged in a cover-up during the initial investigation in an attempt to conceal their participation in illegally secluding A-8 residents. Furthermore, according to information received by SSI Coleman, Mr. Norris had been telephoning staff at home, pleading with them to "deny everything."

In a November 9, 1995 interview conducted by SSI Coleman, Joann Sorenson stated that she had seen Sam Norris place patients James Nelson and Francisco Marcos into seclusion without proper authorization. She further stated that staff members Angela Green and Mel Denton related that "they were going to make up a story and stick with it" and that "they would just deny everything."

During another interview that same day with SSI Coleman, Mel Denton stated that, "out of fear of being fired or losing his license," he had not told

the truth the first time he was interviewed. He stated that he had "seen Sam Norris place patients in seclusion at night without a doctor's order" and that Mr. Norris had "directed him to lock patients up at night, primarily James Nelson and Batista." Additionally, Mr. Denton stated to SSI Coleman that he and Angela Green had discussed what might happen if someone found out what was taking place, and that out of fear of losing their jobs, they both agreed to deny everything.

On November 9, 1995, SSI Coleman also spoke with Mark Anderson. Mr. Anderson reiterated that the decision by A-8 night shift to remain silent regarding the illegal seclusion practices was based primarily on fear, instilled in them by Sam Norris. Mr. Anderson explained that involved staff feared that they would be fired and their licenses revoked if anyone found out that they were placing patients in seclusion without proper authorization.

Mr. Anderson said that he had seen Mr. Norris place patients into seclusion without proper authorization -- primarily Andrew Batista and James Nelson -- for simply wandering the halls or appearing agitated. These illegal seclusion incidents happened a minimum of two or three times per week, each improper seclusion lasting for two to six hours each. Afterwards, "Sam would instruct them to be sure to take the patients out of seclusion, clean up the rooms, and make the beds, so there would be no indication that anyone was ever in seclusion."

In a statement to SSI Coleman, Mr. Anderson reportedly explained that Mr. Norris would sit in the staff office and say: "Mel or Angela, Batista has bought himself a side room for the night. Take him down and lock him up." Mr. Anderson further stated that even though he knew that what they were doing was wrong, he did not question Mr. Norris' authority because Norris was the shift lead.

Mr. Anderson also stated that he had spoken with Angela Green and Mel Denton about the issue of improper seclusion practices and that Ms. Green suggested they deny everything. Mr. Anderson also said that Mr. Norris called him at home on several occasions, pleading with him not to say anything. For instance, Mr. Anderson quoted Mr. Norris as saying:

"Don't tell them anything. If anything gets out, we are in trouble. It is getting too close to my time [retirement], so please deny everything."

According to the SSI report, Mr. Norris repeatedly told night shift staff who were involved in the unauthorized use of seclusion: "[A]s long as we continue to deny it, nobody can prove it." Mr. Norris reportedly had a saying regarding the facility's investigations: "If you drive out with a State piano in your truck and someone stops you and says, that is a State piano, deny any knowledge of it."

On November 15, 1995, in the presence of a union representative, SSI Coleman informed Mr. Norris that he was going to advise him of his constitutional rights, at which point Mr. Norris' union representative cancelled the interview.

On November 16, 1995, SSI Coleman interviewed Angela Green, who related that she too had assisted with placing patients into seclusion at the direction of her supervisor Sam Norris. She stated she was not aware whether proper authorization had been obtained from a physician, as it was Mr. Norris' responsibility to get the doctor's order. She denied having had discussions with other A-8 night shift staff in regards to what would happen if the information regarding the use of illegal seclusion got out to others.

In the "Conclusion" section of his second report, SSI Coleman states:

Mark Anderson, Mel Denton and Joann Sorenson all state that they have personal knowledge that Sam Norris placed patients in seclusion without a doctor's order, authorization or documentation. Mel and Mark both admit to being a party to it, but only because Sam was their supervisor and under the threats of fear that they could either lose their jobs or license [sic] if they didn't cooperate.

Angela Green continued to deny her involvement in this incident, while all other three staff members indicate that Angela Green was a party to placing patients into seclusion without a doctor's order. Angela has personal knowledge that

Sam Norris had placed patients in seclusion, unsure if there was a doctor's order.

In the "Recommendation" section of his second report, SSI Coleman states: "Case [to] be referred to the Executive Director and Personnel Officer for their review and disposition."

There is no mention in either of SSI Coleman's reports to indicate that he reviewed any of the readily available documents or records relating to these allegations, such as the daily logs or clinical records -- only that he interviewed five staff members. There is also no mention whether SSI Coleman talked to anyone from the Napa County District Attorney's Office regarding referral for prosecution.

NSH's Executive Director told PAI investigators that Sam Norris opted to resign prior to being terminated from state service.

C. DENIAL OF REASONABLE ACCESS TO EFFECTIVE LAW ENFORCEMENT

SI Coleman had two separate investigatory opportunities to obtain and act upon considerable documentary and corroborative evidence (including witness statements) which supported the allegations that residents had been illegally secluded and that staff engaged in a cover-up to conceal their acts of illegal conduct. His investigations into the unauthorized use of seclusion on Unit A-8 were inadequate and raise serious questions regarding the residents' reasonable access to competent law enforcement.

Fundamental investigatory shortcomings were:

- (1) SSI Coleman failed to collect and analyze basic documentary evidence.

He did not thoroughly review relevant and readily available records or documents which corroborated staff's witness statements, and thus failed to identify any dates or times when the episodes of unauthorized seclusion occurred.

(2) SSI Coleman attempted to interview only one of the four identified victims of the illegal seclusion practices.

(3) SSI Coleman failed to retain, for a reasonable amount of time, key evidence that he actually collected.

SSI Coleman told PAI investigators that he had conducted a taped interview of Mr. Norris, the instigator of the illegal seclusion incidents. However, when PAI investigators requested copies of the tape, PAI was informed that Mr. Coleman taped over the interview with Mr. Norris after he had closed his first investigation.

(4) SSI Coleman improperly prejudged the incidents as not being potentially criminal in nature.

SSI Coleman stated:

I did not feel that since they did not come forward as victims, and even if they did, based on the information I received from the staff, I did not see how it was going to add to the particular case, since there was not going to be a criminal investigation. (Emphasis added.)

When PAI investigators asked SSI Coleman for clarification regarding the source of "information" he received from staff about the victims, he replied: "Just that they were not real communicative, that they were roamers at night . . . it was actually [that they were] probably happy that [they were] being placed in a room."

(5) SSI Coleman failed to make a formal referral to the Napa County District Attorney's Office regarding possible criminal conduct on the part of staff involved in the illegal seclusion incidents.

In an interview with PAI investigators, SSI Coleman stated that he spoke on the phone twice with Mr. Ted Parson {PSEUDONYM}, an investigator with the Napa County District Attorney's Office. According to SSI Coleman:

The District Attorney's office stated that 'no victim, no crime'. . . . [B]ased on the information that the patients involved . . .

did not complain themselves, and so there's no complaint, and we also had no specific information as to what dates and times these incidents actually happened, that they [the D.A.'s office] would not file a complaint. (Emphasis added.)

Mr. Parson confirmed to PAI investigators that conversations had taken place between SSI Coleman and himself, but that he had not read nor seen SSI Coleman's report. Mr. Parson also stated that the preferred and usual process for referring a potential criminal case to the District Attorney is for NSH to forward a copy of the SSI's investigatory report to the Napa County District Attorney's Office for review. As indicated earlier, this was not done.

VI. INVESTIGATION CONDUCTED BY LICENSING IN RESPONSE TO THE ILLEGAL USE OF SECLUSION ON UNIT A-8

A. AUTHORITY

The California Department of Health Services, Licensing and Certification Division (Licensing) is responsible for licensure of state-run health facilities; for enforcement of state regulations governing health facilities such as Napa State Hospital (NSH); and, as the agent of the federal government, for enforcement of applicable federal regulations. Licensing exercises its regulatory authority by conducting compliance surveys; issuing citations for violations of law; and requiring health care facilities, subject to its regulatory oversight, to develop and implement plans of correction. Licensing is also vested with the responsibility to investigate written and oral complaints of alleged regulatory violations, including complaints of abuse.

Complaints to Licensing regarding a health facility are usually received by the local district office responsible for the area in which the facility is located. The Santa Rosa District Office receives complaints regarding NSH. Complaints are then prioritized and assigned for investigation. If a long-term care facility, such as NSH, is found to be in violation of an applicable statute or regulation, and it is determined that the violation has more than a minimal relationship to the health and safety of patients, a citation is issued to that facility.

B. LICENSING'S INVESTIGATION

According to Licensing records, on Friday, October 13, 1995, Licensing received notification from NSH that patients had been secluded on Unit A-8 without a physician's order.

On December 19, 1995, Licensing's health facility evaluator initiated her investigation, which included:

- Review of clinical records, personnel records, incident reports, and SSI Coleman's reports.

- Interviews with NSH A-8 residents, direct care staff, management, and SSI Coleman.

A tour of Unit A-8.

The health facility evaluator nurse concluded that:

The facility failed to treat each patient with dignity and respect and subjected patients to physical abuse by isolating and locking patients in a seclusion room on the night shift without a physician's order and for no apparent medical reason. This failure presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

Consequently, on January 11, 1996, Licensing issued Class A Citation #01-1086-00990-S to NSH for violating California Code of Regulations, Title 22, Section 73315(b) (regarding Nursing Service-Patient Care), which requires that: "Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind." According to Licensing documents, Mr. Norris' misconduct was reported by

Licensing to the Department of Consumer Affairs, and, on December 12, 1995, Mr. Norris received a Notice of Adverse Action for Dismissal from NSH.

NSH did not contest the "Class A" citation, which had a Penalty Assessment of \$8,000.00.⁵

On February 26, 1996, PAI investigators received a copy of the citation and determined that there was probable cause to conduct a systemic investigation into the illegal use of seclusion at NSH.

⁵ The assessment of fines for state hospitals is symbolic in nature, as state hospitals do not pay fines levied by Licensing.

VII. RESPONSE BY NAPA STATE HOSPITAL ADMINISTRATION

As described later in this report, in addition to the A-8 incidents, the intentional misuse of seclusion and/or restraint occurred on two other NSH units between the latter part of 1995 and as recently as August of 1996. See, Section IX, at pages 48-53. Nevertheless, NSH's Executive Director wrote to one county official in May of 1996, stating that "the incident of seclusion . . . without staff's calling a physician is a rare isolated event that was dealt with individually." This statement is consistent with the failure of NSH's leadership to appreciate that the pattern of abusive seclusion and restraint practices on various units within the hospital warranted a comprehensive analysis and systems response. A proactive, hospital-wide response geared towards prevention would have been far more effective than a reactive response to each individual incident. Until the Fall of 1996, NSH leadership continued to respond to the incidents of abuse summarized in this report on a case-by-case basis, failing to take a comprehensive and preventative systems approach to the problem. What follows are corrective actions taken by NSH leadership in response to the abusive seclusion and other practices which occurred during 1995 and 1996 that were brought to NSH's attention by Licensing and PAI.

- MEMORANDUM FROM ADMINISTRATION TO PROGRAM 4 STAFF

In the aftermath of the illegal use of seclusion on Unit A-8, Program 4 staff received from Napa State Hospital (NSH) administration the following December 15, 1995 memorandum:

Please take special care to review Administrative Directive No. 761 'Behavioral Seclusion and/or Restraint' effective January 10, 1995, and Nursing Procedure Manual SAFE: 1506. It is essential that all staff closely follow the dictates and instruction that these policies provide. Failure to do so could result in administrative action, licensing board reviews of your respective licensing agency, and even criminal or civil law violations.

Each program staff member has a responsibility to assure that this AD and Nursing Procedure is followed. Deviations or violations must be reported to the appropriate person immediately upon your discovery/awareness.

- NAPA STATE HOSPITAL'S RESPONSE TO CITATION FROM LICENSING

In response to the citation issued by Licensing, NSH developed the following Plan of Correction to be completed by January 15, 1996:

- 1. Disciplinary Action initiated, as appropriate, for involved night shift employees. Responsible person: Program Director*
- 2. Unit Supervisor will meet with NOC shift lead weekly to discuss night shift issues, problems and responses. The Unit Supervisor will increase visits to NOC shift to assess compliance with all AD's until NOC staff can demonstrate compliance. Responsible person: Unit Supervisor*
- 3. R.N. Case Managers will teach each identified client their specific rights and requirements of AD 761 Seclusion and/or Restraint. Documented in IDN's when completed. Responsible person: Unit Supervisor*
- 4. Unit treatment team will inform patients of their rights and staff obligations concerning use of seclusion and/or restraint at least monthly and ask if any violations have been observed. This will be documented in Ward Government Meeting minutes. Responsible person: Unit Supervisor*
- 5. All unit staff will be trained in requirements of AD 761 and NPM Safe 1506. Responsible person: Program Director*
- 6. CNS - HSS staff will inspect seclusion rooms during rounds, verify appropriate documentation and other requirements of AD 761. Responsible person: Coordinator of Nursing Services*
- 7. Program Officer of the Day will make rounds of the NOC shift at least 1 time during the week they are assigned and*

document in POD log. Responsible person: Program Director.

The Program Director is responsible to monitor compliance of this plan on an on-going basis.

- NAPA STATE HOSPITAL ADMINISTRATION CHALLENGED TO CORRECT PATTERNS OF PATIENT ABUSE ON A PROACTIVE SYSTEMS BASIS

In October of 1996, during the Joint Commission on Accreditation of Healthcare Organizations' (the Joint Commission's) three-year reaccreditation survey of NSH,⁶ PAI challenged NSH's leadership to address patient abuse problems throughout the hospital. On October 25, 1996, in the presence of NSH's Executive Director, PAI Investigations Unit staff presented to the Joint Commission surveyors information from public Licensing files,⁷ including the citation regarding the illegal use of seclusion on Unit A-8. According to preliminary reports, NSH was found to be out of compliance with Joint Commission standards regarding seclusion and restraint practices, as well as numerous other patient care standards.

On October 28, 1996, in a separate action by Licensing, NSH was asked to produce a systemic Plan of Correction for remedying the increased amount of citations the facility had received regarding patient abuse: "What measures will be put into place or what systemic changes [NSH] will make to ensure that the deficient practice does not recur. . . ."

On November 15, 1996, NSH's Executive Director responded to Licensing, saying:

Similar to the Department of Health Services, the Department of Mental Health and Napa State Hospital also have a zero tolerance policy for client abuse. We have and will continue

⁶ Though the Joint Commission is a private organization, accreditation through this agency is important. Accreditation indicates compliance with appropriate health care standards and performance outcomes regarding patient care, organizational structure, quality assurance, and leadership.

⁷ This process for presenting this information is referred to by the Joint Commission as a Public Information Interview. (A copy of this document is available from PAI upon request.)

to work very hard to ensure that all individuals served at the hospital are treated with dignity and respect and are not subjected to abuse of any kind. However, we realize that this is a very complex matter given the individual, organizational, and environmental contingency factors that may directly or indirectly impact the hospital's ability to eliminate client abuse from happening in the first place.

Because of this complexity, the hospital has expanded its comprehensive analysis of data and processes to better understand the factors that impact the hospital's ability to eliminate client abuse. It is our intention to utilize the comprehensive analysis to make necessary changes in policy, procedures and practices.

In response to Licensing's October 1996 request that the facility institute systemic measures to protect residents from abuse, NSH established the Multidisciplinary Management Action Team. According to NSH's November 15, 1996 letter to Licensing, the Multidisciplinary Management Action Team is responsible for providing oversight of a comprehensive, proactive, correction plan for addressing abuse and is specifically charged with the responsibility of "analyzing the root causes of abuse incidents, and developing recommendations to the Executive Team." Proactive steps identified to be taken to mitigate against patient abuse on a systemic level include:

- 1. Based on data collection, identify contingency factors that may impact the hospital providing an abuse free environment*
- 2. Based on the analysis of data, define the problematic factors affecting the hospital providing abuse free treatment*
- 3. Diagnose all the possible causes of the factor(s) that may contribute to abuse and abuse allegations*
- 4. Evaluate the process(es) surrounding the identified factors that may contribute to abuse and abuse allegations*

5. *Generate solutions and recommendations for each identified factor*
6. *Implement changes in policies, procedures and practices*
7. *Monitor results and make necessary modifications in plan of action*

NSH's November 1996 formation of a multidisciplinary, proactive management team to address abuse, while a significant initial step, should have occurred long ago. The formation of this multidisciplinary team reflects the beginning of a proactive systems approach which should continue to be developed and refined by NSH leadership on a permanent basis. NSH leadership's acknowledgement that a systemic approach is necessary is a critical first step towards remedying and preventing patient abuse.

VIII. PAI'S INVESTIGATION INTO THE ILLEGAL USE OF SECLUSION ON UNIT A-8

A. PATTERN OF ABUSIVE SECLUSION PRACTICES ON UNIT A-8

Seclusion⁸ or restraint may only be used when alternative, less restrictive measures are insufficient to ensure the physical safety of a person or others in the immediate area. In addition, seclusion, as it appears to have been used on Unit A-8, cannot be used for the convenience of staff nor as a substitute for less restrictive, alternative forms of treatment.

When staff places a resident in a seclusion room, and that resident is prevented from leaving, the resident is being secluded. As a Program 4 manager explained to PAI investigators: "If the patient's kept in there against his will, coerced by the staff, that is seclusion, whether or not the door is locked." The use of seclusion (whether the door is locked or unlocked) is a significant clinical and legal event which requires proper justification, authorization, monitoring, treatment planning, and documentation.

Nevertheless, A-8 daily logs indicate that, for over a year and a half, residents were subjected to periods of unauthorized seclusion during the night shift, in the absence of any properly documented or reported justification whatsoever. Although four victims were clearly identified by staff witnesses during NSH's investigation, PAI investigators note that A-8 daily logs indicate other residents may have also been victimized.⁹

- A-8 RECORDS CONFIRM UNAUTHORIZED USE OF SECLUSION

When PAI investigators reviewed relevant A-8 daily logs, an obvious pattern of improper use of seclusion emerged on the nights that Sam Norris was the shift lead. Using the daily logs and other readily available documentation such as the residents' clinical records, PAI investigators

⁸ As previously described, seclusion is the use of a separate area (usually a locked room) to isolate a patient -- much like solitary confinement in a jail setting.

⁹ NSH's Unit Daily Log Procedure requires, among other things, that the number of clients who are in seclusion or restraint be recorded at the beginning of the shift. Procedure further requires that the Unit Daily Log be forwarded to the Program Nursing Coordinator each morning. Given that the A-8 night shift daily logs documented the use of the "side room" (i.e., seclusion room) numerous times, responsible management needed only to check a couple of clinical records to determine whether the use of seclusion was authorized by a physician's order. This is an example of the failure of management at NSH to use available information in a proactive manner, and why the mere promulgation of more procedures is not the solution for addressing abusive practices at NSH.

constructed a list of 44 separate instances when the "side room" (or seclusion room) was used during the night shift in 1994 and 1995. PAI investigators identified numerous A-8 daily logs containing entries regarding the use of the "side room," which appear to be in Sam Norris' own handwriting. Nineteen of the 44 documented entries in the daily logs clearly pertained to the four identified victims. None of the entries had a corresponding physician's order in the clinical record, as required; however, one of the 19 incidents (documented in the daily log on September 23, 1995) was documented in the resident's interdisciplinary notes. (Please refer to Attachment C; 1994 and 1995 tables of documented seclusion episodes.)

September 23, 1995 is the final and most recent date that Sam Norris appears to have documented seclusion episodes in the A-8 daily logs, stating that the "side room" was "unlocked." (Refer to 1995 table in Attachment C for further specifics.) However, a more reliable written statement by Joann Sorenson regarding this incident was provided to SSI Coleman, which states that the side room was "locked," directly refuting the documentation in the clinical record and the daily logs that the seclusion room door was "unlocked."

- PAI INTERVIEWS CONDUCTED

In addition to reviewing A-8 documents, PAI investigators interviewed over 30 people, including A-8 residents and night shift staff who were either involved in the illegal use of seclusion or who had relevant information regarding the improper practice. PAI investigators also contacted Sam Norris, but he declined to be interviewed.

PAI investigators were told by involved staff that their motivation to engage in a cover-up and remain silent for one month after the unauthorized seclusion was reported included the threat of job loss, license revocation, and retaliation from Mr. Norris and others. As explained to PAI investigators by NSH's Executive Director: "[T]he Shift Lead is in control of the unit . . . during those hours. They make the assignments, they help add to the evaluation of an individual, they can make life miserable for people if they so desire."

Joann Sorenson told PAI investigators that one morning she noticed that a seclusion episode which occurred during the night shift had not been reported to day shift staff, although standard protocol is to report such an occurrence. When she mentioned this to other night shift staff, they said that "it had happened before."

Ms. Sorenson also related to PAI investigators that A-8 night shift staff had previously complained about Sam Norris:

[W]e just didn't feel comfortable doing everything for him. And we had reported him several times. And when this thing came up, I just figured it was one more thing that Mary should know about, you know, that he's not going through procedures the way that, you know, that we do.

Ms. Sorenson went on to say that after NSH's investigation was initiated: "[Sam Norris] got my [home] number from somebody. . . . And he called and told me that I was to say absolutely nothing; that if we all said nothing, there was nothing that they could do."

After NSH's investigation was completed, Ms. Sorenson was verbally counseled by her supervisor. While she did not regret reporting the illegal seclusion of A-8 residents, Ms. Sorenson stated to PAI investigators:

I'm very uncomfortable a lot of the time. And a lot of them think that they know what went on; some of them do, some of them don't. We have two Union people on the unit. And one of them has made quite sure that everybody knew on the day shift.

After being informed by Joann Sorenson that Sam Norris was engaging in a practice of illegally secluding patients, Unit Supervisor Hughes decided to confront night shift staff about it. Ms. Hughes told PAI investigators that when she confronted Mel Denton and Angela Green about residents being placed in seclusion without proper authorization, their actions and body language seemed to indicate guilt. Ms. Hughes reported that they both looked at each other and, after an uncomfortable moment of silence, Ms. Green pointed at Mr. Denton and stated, "You tell her! You're the boss! You're in charge! You tell her!" Ms. Hughes stated that Ms. Green covered

her mouth but her eyes were "smiling," while Mr. Denton's face "turned red. . . . And neither of them could look at me."

PAI investigators were told that Mel Denton received a formal letter of reprimand for his involvement in the illegal seclusion of A-8 residents. This type of letter remains in an employee's personnel file for three years. Mr. Denton also declined to be interviewed by PAI investigators.

Angela Green stated to PAI investigators that she had previously complained to Mary Hughes about Sam Norris, but:

[Mary] felt that he was doing his job. And that she wasn't going to do anything about him. And, basically, as a part-timer, I had to just deal with it. She came and she said that she apologize[d] for not listening to me that it should have raised a red flag when I came to talk to her. And she apologized in that she was aware that Sam had -- or, someone told her that Sam was locking patients up or something. And I told her I didn't know about it, and she had to talk to the guy who had been working with me on that unit.

. . .

Ms. Green denied ever having been present or participating in conversations with other night shift staff about how they should handle the investigation. Ms. Green told PAI investigators that she felt other staff were making her the scapegoat.

We had never talked about Sam. They knew I didn't like him, or didn't get along with him. . . . I would not cover for Sam. . . . I was singled out because I was going to Mary and complaining about my involvement with the unit, and different things on the unit, and Sam. And I was kind of singled out because I was a part-timer and just worked, you know -- and I didn't work consistent [sic]. So I didn't have a good relationship with anyone that I worked with on that night shift. . . . I didn't like the way he approached patients. I didn't like the way he approached me. And I went to Mary about it.

After NSH's investigation was complete, Ms. Green received a formal letter of reprimand, which will remain in her personnel file until the end of 1998.

Mark Anderson stated to PAI investigators that he first became aware of Sam Norris' practice of illegally placing people in seclusion when Sam Norris "asked [him] to go down and clean up a room, to go and let the patient out of the room."

Mr. Anderson also told PAI investigators that he had directly observed Sam Norris place residents into the seclusion room and lock the door, without having obtained proper authorization. "I saw him doing it more and more frequently. . . . And I started to question him about it . . . he just sort of blew me off. . . . I told the staff members that this needed to stop, this was a research unit, and that this would have ramifications on patient care. . . . I also talked to Sam. . . . He told me he was going to stop it. . . ."

Mr. Anderson stated to PAI investigators that when the complaint regarding the illegal seclusion practices finally surfaced, he was taken by surprise "because [he] thought it had all ended." As Mr. Anderson reported to PAI investigators, the night shift staff:

[T]alked amongst each other. And Angela Green scared the living Jesus out of us. . . . And she said that this process that was now going to occur with Sam was going to involve everybody and that . . . it was going to threaten our licenses directly, we'd all be pulled down with Sam, this is going to be an incredible mess. . . .

According to Mr. Anderson, following this discussion, night shift staff decided they "were going to just deny everything happened, just deny it, and that it would go away."

Mr. Anderson told PAI investigators that Sam Norris called him repeatedly during NSH's investigation and pressured him for information regarding the progress of the investigation. Mr. Anderson further stated to PAI investigators that he decided he "could no longer lie for Sam Norris," explaining:

I couldn't live with the fact that this guy would come back on the unit. And the possibility was real strong that this might start reoccurring with him again.

Now I had heard he's got a past history of doing this before on other units. And, by god, I wasn't going to let it happen. And so I talked to Joann about it . . . and she said that you might want to talk with the Investigator again. So I wrote a letter to the Investigator.

Mr. Anderson told PAI investigators that, because he broke the code of silence and reported the abuse, he experienced threats of retaliation from other staff.

A [psychiatric technician] shop steward took me to the side and told me that his Union was going to pursue further punishment against me because of the fact that I was an R.N. and -- and it appeared to him and his constituency within their Union that these people [the other night shift staff], because they were psych techs, somehow were given harsher punishment than myself. He told me that he had complete access and had read all information regarding this case, which shocked the hell out of me. Because I was told specifically by the Investigator that everything, I mean everything, that I had shared with him would be kept in the strictest confidentiality. This shop steward works on my ward.

As a result of his involvement in the illegal seclusion of A-8 residents, Mr. Anderson received a counseling letter, which remained in his personnel file for one year. Mr. Anderson told PAI investigators: "Angela was right -- right to some degree. This thing has gone on and on and on and on and on and on."

B. RAMIFICATIONS OF ILLEGAL USE OF SECLUSION ON UNIT A-8

The illegal seclusion practices on Unit A-8 during the night shift violated the residents' right to be free from abuse and neglect and likely constituted dependent adult abuse. The abusive practices had other ramifications, including interference with the residents' rights to individualized treatment

and client-directed services, and, in one resident's situation, possibly compromised medication research protocol.

- **INTERFERENCE WITH TREATMENT AND THE "TEAM" PROCESS**

According to NSH's Directory of Services, treatment of every NSH resident requires that:

[M]embers of each client's Interdisciplinary Team meet with the client to develop a treatment/program plan designed to meet the specific, individual needs. Once developed, the plan is reviewed regularly by the Interdisciplinary Team in order to assess the client's progress, and to revise the plan as appropriate.

The use of unauthorized seclusion interfered with this "team" process and with the development and implementation of the residents' individualized treatment plans. Having no knowledge that residents were being repeatedly subjected to seclusion -- which is a highly significant event -- other clinical staff on the "team" could not accurately assess the treatment needs of those residents. Furthermore, in carrying out the abusive seclusion practices, the most important member of the "team" -- the resident -- was left out. (As indicated earlier, none of the victims discussed in this report were able to protect themselves from the abusive use of seclusion.) These illegal seclusion practices also specifically interfered with the residents' opportunity to have "a working alliance with their treatment teams and to have optimal participation in the team decision making process," as required by NSH's Directory of Services.¹⁰

¹⁰ In Mr. Batista's case, even a simple care plan to address his recurrent insomnia did not exist until two months after Mr. Norris' illegal seclusion practices were finally reported.

- POTENTIAL INTERFERENCE WITH MEDICATION RESEARCH PROTOCOL

As previously stated, some A-8 residents are involved in research protocols, including the pre-market testing of medications. Mr. Batista was participating in a comparison study of the effectiveness of Haldol, a well-known antipsychotic medication, with Olanzapine, a newer psychiatric medication.

One of the challenges of medication studies, such as the Olanzapine study, is the existence of many variables which contribute to the patient's response to the medication. The more variables, the harder it is to determine which variable caused, contributed, or correlated with a particular finding. The use of a powerful behavioral intervention such as seclusion, especially in the unauthorized and unmonitored way that it was used on Unit A-8, introduced a different variable to the Olanzapine study.

Pharmaco International, Incorporated (Pharmaco) sponsored the Olanzapine study for Eli Lilly and Company, a major drug company. Pharmaco is a contract research organization specializing in full drug development programs; all phases of clinical research; biostatistics and data management; and bioanalytical laboratory research.

Pharmaco field monitors overseeing the Olanzapine study did not respond to multiple phone calls or the facsimile transmittal from PAI investigators regarding (1) whether the unauthorized seclusions were reported to them; or (2) what implications, if any, such unauthorized seclusions may have had on the research.

PAI investigators question whether and how the Olanzapine study researchers could reliably evaluate the effectiveness of the medication protocol when Mr. Batista was being subjected to illegal seclusion.

IX. OTHER SECLUSION AND RESTRAINT VIOLATIONS AT NAPA STATE HOSPITAL DURING 1995 AND 1996

Following is a brief summary describing a series of improper seclusion and restraint practices which occurred at Napa State Hospital (NSH) during 1995 and 1996 on units other than A-8.

A. ILLEGAL SECLUSION ON UNIT A-2

On December 29, 1995, Mr. Robert Jackson {PSEUDONYM} was secluded during the night shift without a physician's order. Ironically, this unauthorized seclusion incident bore striking similarities to the A-8 incidents, and in fact occurred while NSH Program 4 management was developing and implementing the Plan of Correction in response to the A-8 illegal seclusion incidents. Much like the victim residents on A-8, Mr. Jackson also has severe difficulty communicating. This unauthorized seclusion incident also occurred during the night shift. Furthermore, just two weeks prior to this incident, the psychiatric technician who carried out this illegal seclusion had signed a roster indicating that she was aware of NSH policies and procedures regarding the use of seclusion and restraint. She had also recently participated in a training regarding seclusion and restraint, which was conducted as part of a corrective measure in response to the pattern of abusive seclusion incidents on Unit A-8.

According to SSI Coleman's Report, Loretta Reyes {PSEUDONYM} told SSI Coleman that she was doing one-to-one supervision with another resident when Mr. Jackson swung at her with a clenched fist and then ran to his room. She followed him and discovered that he had messed up his room and was disturbing his roommates. He followed her command to go into the seclusion room and she then locked the door.

SSI Coleman's report stated:

When asked if she was aware of the Policy and Procedure for putting patients in seclusion, why she didn't follow it. She replied, 'I was doing a one to one and couldn't leave.' She stated she didn't think about calling for help or reporting to Yvette about putting Robert in seclusion. . . . [She] stated that the patient was locked in the room for approximately 30 minutes until [Yvette Hall] came down the hall. . . . She said she knew she needed a Doctor's Order to put a patient in

seclusiona [sic] and her reason for not getting a doctor's order was because she was doing a one to one and would be unable to leave that area and report to [Yvette] that the patient was put in seclusion. She stated several times that she left the decision up to [Yvette] because [Yvette] was Acting Shift Lead. . . .

Yvette Hall, P.T. {PSEUDONYM}, discovered Mr. Jackson in seclusion after she relieved Loretta Reyes from providing one-to-one supervision to another resident. According to Ms. Hall, she twice "heard a noise behind her like shuffling of feet," but no one was around:

[A]t this point she got up and looked into the seclusion room and turned on the light in the room. She stated that Mr. Jackson was just standing in his nightgown and the bedding was on the floor. Ms. Hall said she immediately unlocked the door and led Mr. Jackson back in his bed in the dorm. Ms. Hall stated when employee Loretta Reyes came back, she asked Loretta why Robert Jackson was locked in seclusion and Loretta said 'because he was bothering me.'

In conclusion, SSI Coleman wrote in his Investigator's Report:

Employee Loretta Reyes has admitted to putting patient Robert Jackson in seclusion without a doctor's order and without following the Policy and Procedure outline for putting patients in seclusion. She has admitted to being aware of the policy and could not give an explanation, other than the fact that she was doing a one to one, as to why she did not follow the Policy and Procedure.

Licensing's annual survey, conducted at NSH in January of 1996 regarding this incident, found that:

Record review of patient #9 reveals diagnoses of Schizophrenia, Chronic; Congestive Pulmonary Disease, and Kyphosis. Review also reveals that patient #9 has a

communication deficit, as he refuses to speak at this time. Further review of patient #9's record revealed that in the early AM hours of December 29, 1995 staff A locked patient #9 in a seclusion room, on the unit, without a Doctor's Order. This was observed and noted by staff B who let resident #9 out of the seclusion room. No orders for patient #9 to be locked in a seclusion room were noted in the record. Staff A stated the reason Patient #9 was locked in the room was that 'he bothers me.' Staff B reported this to Staff C.

B. UNSAFE AND INAPPROPRIATE USE OF RESTRAINT ON UNIT A-1

On April 1, 1995, a deaf male resident with multiple physical disabilities died after being improperly restrained to a chair with a Velcro waist belt. Although the nursing notes indicate that he was "quiet" after receiving medication, he was nonetheless restrained throughout the night for at least six hours thereafter. A physician's standing order written two weeks prior to the resident's death stated the intended use of waist restraints was "to prevent falls."

The only documented contacts that night shift personnel had with the male resident were at 11:15 PM, 12:15 AM, 1:30 AM, and 5:30 AM. Licensing records indicate that staff failed to carry out required circulation checks or to periodically release the resident from restraint. Later that morning, at 7:00 AM, a day shift employee noticed that the resident was reclining sideways in his chair and that "his hands were on the floor and it looked as if he was trying to push the chair."

According to Licensing, documentation received from the facility stated: "Color of the face and hands was ashen and the lower extremities was [sic] flushed pink in color, eyes dilated."

A staff witness indicated that the Velcro waist restraint around the resident's waist was restrictive and twisted unusually tight. Shortly after being removed from restraints, the resident "ceased breathing" and died. The autopsy findings included "abdominal skin compression and hemorrhage of the abdominal muscles"; the cause of death was listed as "cerebral and cerebellar hypoxia, undetermined cause."

As stated in a citation issued by Licensing, the facility's failure to provide adequate supervision presented "an imminent danger to the patient and was a direct proximate cause of death of the patient."

On February 1, 1996, less than one year after the restraint-related death described above, Licensing surveyors again cited the facility for improperly restraining and inadequately supervising restrained residents on Unit A-1. According to Licensing:

[NSH] failed to provide sufficient numbers of nursing personnel on a 24-hour basis to ensure nursing care to all residents in accordance with the residents' plans of care and to ensure that residents are free from physical restraints used for discipline or staff convenience in the absence of staff.

During 1996, over half of the citations Licensing issued to NSH were for subjecting residents to abuse. All but one of those incidents occurred on the Intermediate Care Units (such as Unit A-8). PAI investigators note that NSH was also repeatedly cited for physical assault incidents during 1995 and 1996.

An October 28, 1996 letter from Licensing to NSH, regarding the Intermediate Care Units, noted an increase in the number of citations issued for violations of California Code of Regulations, Title 22, Section 73315(b), which requires that "each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind."

C. ILLEGAL SECLUSION, RESTRAINT, AND PATIENT ABUSE ON UNIT M-5

On the evening of September 6, 1995, Gerald Grant {PSEUDONYM} restrained and/or secluded three hearing-impaired children without a physician's order -- two of those children were restrained to their beds while the other child was placed in a "soiled linen closet." According to NSH, Mr. Grant had recently received training on the proper procedure for restraining residents. Mr. Grant admitted that he knew it was "illegal" to restrain the children without a physician's order, but that he had "had it with these kids."

Following discovery of these abusive acts, Mr. Grant was allowed to leave the facility and was not arrested. A Licensing investigation revealed that when NSH staff had complained to management about Mr. Grant prior to this incident, no additional training was conducted to improve his job performance.

One month after the Senior Special Investigator completed his report regarding these criminal incidents, NSH made a referral to the Napa County District Attorney's Office. On November 2, 1995, the District Attorney's Office filed four misdemeanor charges against Mr. Grant, charging him with two counts of cruelty to a child by inflicting injury, and two counts of cruel punishment in state hospitals.

After learning that Mr. Grant had an extensive criminal history, had served two years in state prison, and had a warrant pending for his arrest, PAI investigators became extremely concerned for the safety of other individuals with disabilities who might come into contact with Mr. Grant. Consequently, on March 26, 1996, PAI investigators referred documents to and registered a complaint with the California Department of Consumer Affairs, Board of Vocational Nurses and Psychiatric Technicians. Within seven working days following PAI's referral, Mr. Grant was arrested by a Consumer Affairs investigator.

According to Napa County Municipal Court File No. CR25520, the District Attorney reduced the four misdemeanor counts to a single count of battery, to which Mr. Grant pled "no contest." He was sentenced on February 3, 1997 and ordered to pay a restitution fine of \$100.00, serve two days in jail (with credit for time served), and provide two days' community work through the "Work Program" in the county where he resided.

Another M-5 psychiatric technician subjected residents to abuse and seclusion without a physician's order -- apparently, once in 1995 and again in August 1996. According to yet another investigation by Licensing, the 1996 incident was observed and reported not by NSH staff, but by visitors who observed the male psychiatric technician lock a 17-year-old male resident "in the seclusion room without a physician's order and did not allow him to eat breakfast or other food until at least 11:15 a.m." Additionally, the visitors observed that the same psychiatric technician

picked up a 13-year-old female resident and forcefully "slammed her down on the couch as hard as he could."

The investigation by Licensing, which included the review of relevant personnel records, revealed that this psychiatric technician had a history of abusing children at NSH, as well as other documented performance problems.

While his 1995 annual clinical performance evaluation was not available, both his 1994 and 1996 evaluations indicated on-going problems with excessive lateness, excessive use of sick leave and documentation deficiencies. On September 11, 1995, he received a Memorandum of Instruction from the facility for lifting an eight year old patient by the arm, secluding him without a physician's order and not documenting the incident. (Emphasis added.)

D. DELIBERATE INSTIGATION OF SECLUSION ON UNIT T-4

On December 22, 1995, according to Licensing documents, a staff member reported that she had observed a co-worker "deliberately agitate" a resident "to the point of requiring seclusion." This same staff member also stated that it "was not the first time" she had seen the co-worker deliberately goad residents into becoming agitated, in order to justify the use of seclusion. She failed, however, to report the previous incidents.

X. POSSIBLE CRIMINAL CONDUCT RESULTING FROM THE SECLUSION AND RESTRAINT INCIDENTS

The Senior Special Investigator -- most often the resident's only available law enforcement -- is responsible for fully investigating incidents of alleged abuse and possible criminal misconduct on the part of Napa State Hospital (NSH) staff, and for making formal referrals to the District Attorney's Office, when appropriate. The events chronicled in this report indicate that both felonies and misdemeanors may have been committed by NSH employees. A felony is a "crime which is punishable with death or by imprisonment in the state prison." Every other crime or public offense is a misdemeanor except those offenses that are classified as infractions. Cal. Penal Code § 17(a).

- ASSAULT

Assault is defined as an "unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another." Cal. Penal Code § 240. Each of the unjustified, and unauthorized incidents of seclusion on Unit A-8 potentially constituted separate and distinct acts of criminal assault by involved staff.

The restraint and/or seclusion of three hearing-impaired children on Unit M-5, carried out by a psychiatric technician without a physician's order, also may have constituted acts of criminal assault -- two of the children were restrained to beds while the third child was placed in a "soiled linen closet."

Assault is punishable by a fine of up to \$1,000.00 and/or imprisonment in county jail up to six months. Cal. Penal Code § 241.

- BATTERY

The California Penal Code defines battery as "any willful and unlawful use of force or violence upon the person of another." Cal. Penal Code § 242. The unauthorized seclusion of patients on Unit A-8 were intentional acts on the part of staff and thus may have constituted criminal batteries of the patients involved.

The inappropriate use and inadequate monitoring of restraints that likely led to the death of a resident on Unit A-1 may have also constituted criminal battery. Staff's conduct may have involved the unlawful use of force on the resident. According to Licensing, NSH documentation stated that staff had

restrained the resident in an unusually tight and restrictive manner, with no indication in the records that night shift staff periodically conducted circulation checks or periodically released the patient from restraint, as is required.

The unauthorized seclusion and restraint of the three hearing-impaired children on Unit M-5 may have also constituted criminal batteries. The M-5 technician restrained and secluded the children without an order or apparent justification, which is illegal.

A battery is punishable by imprisonment in county jail for up to six months and/or a fine of up to \$2,000.00. Cal. Penal Code § 243(a). If the battery results in serious bodily injury, the crime may be punishable by imprisonment for not more than one year in county jail, or for two to four years of confinement in state prison. Cal. Penal Code § 243(d).

- FALSE IMPRISONMENT

False imprisonment is any "unlawful violation of the personal liberty of another." Cal. Penal Code § 236. The series of unauthorized seclusion incidents on Unit A-8 may have been acts of false imprisonment, as the residents were unlawfully deprived of their freedom of movement.

The restraining and secluding of the children on Unit M-5 may have also constituted criminal acts of false imprisonment. The children's liberty was unlawfully violated as a result of the abusive actions of the psychiatric technician. Two of the hearing-impaired children were restrained to beds without authorization or justification and a third child was secluded in a "soiled linen closet."

The seclusion of a Unit A-2 resident by night shift staff may have also constituted criminal false imprisonment. The psychiatric technician locked the patient in a seclusion room without authorization from a physician and, apparently, without legal justification.

False imprisonment is punishable by a fine not to exceed \$1,000.00 and/or imprisonment in the county jail for up to one year. If the false imprisonment

was effected by violence, menace, fraud, or deceit, the punishment allows for imprisonment in the state prison. Cal. Penal Code § 237.

- CRIMINAL CONSPIRACY

The California Penal Code states that criminal conspiracy exists where "two or more persons conspire to commit any crime." Cal. Penal Code § 182(a)(1).

The misconduct of staff members on Unit A-8 suggests criminal conspiracy. A-8 night shift staff intentionally worked together to illegally seclude residents and took deliberate measures to conceal those illegal acts. During the first investigation conducted by NSH's Senior Special Investigator, they also engaged in a cover-up to hide the truth regarding their misconduct. The evidence suggests A-8 night shift staff may have conspired to abuse, assault, batter, and falsely imprison the patients by subjecting them to unauthorized seclusion and by intentionally failing to report those incidents of seclusion, as required by abuse reporting laws.

Under existing criminal law, if the conspiracy is to commit a felony, it is punishable in the same manner and to the same extent as the felony; and if the conspiracy is to commit a misdemeanor, the punishment is imprisonment in the county jail for up to one year and/or a fine not to exceed \$10,000.00. Cal. Penal Code § 182.

- CHILD ENDANGERMENT

Under circumstances which are not likely to produce great bodily harm or death to a child, it is a misdemeanor for any person to "willfully cause[] or permit[] any child to suffer, or inflict[] thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully cause[] or permit[] the person or health of that child to be injured, or willfully cause[] or permit[] that child to be placed in a situation where his or her person or health may be endangered." Cal. Penal Code § 273a(b). The restraint and seclusion of the three hearing-impaired children on Unit M-5 by involved staff likely was child endangerment. Seclusion in a "soiled linen closet" and restraint to a bed without authorization or justification likely inflicted

unnecessary pain and mental suffering on those children and put their health in danger.

- CORPORAL PUNISHMENT OF A CHILD

It is a felony for anyone to "willfully inflict[] upon a child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition." Cal. Penal Code § 273d(a). The incident involving the abuse of the hearing-impaired children on Unit M-5 may have also implicated this statute. Punishment may be imprisonment in the state prison for two, four or six years, or in the county jail for up to a year and/or a fine not to exceed \$6,000.00. Cal. Penal Code § 273d(a).

- ABUSE OF DEPENDENT ADULTS AND ELDERS

A dependent adult is "any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights," and includes any person "who is admitted as an inpatient to a 24-hour health facility." Cal. Penal Code § 368(e). An elder is defined as any person who is 65 years of age or older. Cal. Penal Code § 368(d).

It is a misdemeanor for any person to "willfully cause[] or permit[] any elder or dependent adult, with the knowledge that he or she is an elder or dependent adult, to suffer or inflict[] thereon unjustifiable physical pain or mental suffering" on an elder or dependent adult, or for any person having the care or custody of any elder or dependent adult to "willfully cause[] or permit[] the person or health of the elder or dependent adult to be injured or . . . to be placed in a situation such that his or her person or health may be endangered." Cal. Penal Code § 368(b).

The repeated use of unauthorized seclusion on Unit A-8 may have been criminal dependent adult abuse. The repeated unauthorized use of seclusion by involved staff endangered the health of those patients subjected to it, and may have also involved the infliction of unjustifiable mental suffering.

The death of the resident on Unit A-1, which involved the unsafe and inappropriate use of restraints, may have also been criminal abuse of a dependent adult. Licensing documentation indicates that staff, by not conducting appropriate checks, permitted the patient to be placed in danger and to ultimately sustain restraint-related injuries which likely caused his death.

Furthermore, the alleged deliberate instigation of seclusion on Unit T-4 may have also constituted dependent adult abuse, as the goading of patients by staff could be shown to have been an infliction of unjustifiable mental suffering and/or endangerment to the patients' health.

Finally, the unauthorized seclusion of a patient by shift staff on Unit A-2 night may have also constituted abuse of a dependent adult, as the seclusion could be found to have inflicted unjustifiable mental suffering.

- REPORTING REQUIREMENTS FOR HEALTH PRACTITIONERS

Any care custodian of a dependent adult (which includes psychiatric technicians and registered nurses) is obligated under state law to report suspected or alleged physical abuse of the elder or dependent adult. As noted earlier, the unauthorized seclusion of a patient constitutes physical abuse and must be reported to the Senior Special Investigator (i.e., local law enforcement) and to Child Protective Services, if the victim is a minor. See, e.g., Welf. & Inst. Code § 15630(b)(2).

Health practitioners employed in health facilities such as NSH must make a report to local law enforcement (i.e., the Senior Special Investigator at NSH or, in his absence, the hospital police) of "any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct." Cal. Penal Code § 11160(a)(2). This Penal Code provision also requires that a telephone report be made immediately, or as soon as practically possible, and a written report prepared and sent to local law enforcement within two working days. Cal. Penal Code § 11160(b). Assaultive or abusive conduct includes, but is not limited to: manslaughter, battery, child abuse or endangerment, dependent adult abuse, or an attempt to commit any of these crimes. Cal. Penal Code § 11160(d). This provision specifically

forbids a supervisor or administrator, such as the A-8 night shift lead, from impeding or inhibiting the reporting of abuse, and prohibits any sanctions whatsoever against persons reporting under this section. Cal. Penal Code § 11160(g). The failure of Unit A-8 staff to report the unauthorized acts of unlawful seclusion also likely violated this provision.

Violating this provision is a misdemeanor, punishable by up to six months in county jail and/or a fine not to exceed \$1,000.00. Cal. Penal Code § 11162.

As summarized above in this report, from 1994 through August of 1996, a series of abusive and potentially criminal acts were committed against NSH residents by NSH employees. However, PAI's investigation into the pervasive use of unauthorized seclusion by night shift staff on Unit A-8 and NSH's failure to properly investigate that abuse indicates that all levels of NSH management staff, as well as the Senior Special Investigator, have yet to fully appreciate the criminal misconduct potentially involved in such staff-to-resident abuse.

XI. FINDINGS AND CONCLUSIONS

- **NAPA STATE HOSPITAL STAFF AT ALL LEVELS FAILED TO TAKE TIMELY AND APPROPRIATE ACTION TO PROTECT RESIDENTS FROM ABUSIVE SECLUSION AND RESTRAINT PRACTICES.**

The events chronicled in this report suggest a culture of tolerance towards the mistreatment of people with disabilities at Napa State Hospital (NSH) and the failure of leadership to take timely and needed action to address it. Staff involved in the abusive seclusion and restraint practices on Unit A-8 -- which was the primary focus of PAI's investigation -- were fully aware of the policies and procedures prohibiting their misconduct, but intentionally disregarded them. In addition, the night shift supervisor (a member of management) was the instigator of the unauthorized seclusion practices. Consequently, until leadership at NSH and the Department of Mental Health fully evaluate the nature and extent of this culture of abuse and indifference, and take necessary steps to confront and correct it, residents will remain at unnecessary risk of abuse by the very staff who are employed to protect and care for them.

PAI's investigation into abusive seclusion and restraint practices on Unit A-8 involved the unauthorized seclusion of four residents during the night shift. These abusive seclusion practices reportedly occurred as many as two or three times per week over a period of one and a half years during 1994 and 1995. In addition to night shift staff's carrying out these abusive practices at the direction of the Unit's night shift lead, night shift staff tried to hide such unauthorized seclusion by cleaning up the seclusion rooms, returning residents to their bedrooms prior to the arrival of the day shift, and failing to document the seclusion in the clinical records. Furthermore, during the SSI's first investigation, staff engaged in a cover-up, lied, and colluded in an effort to prevent the abusive practices from being exposed. In addition, from September of 1995 through August of 1996, NSH officials received reports of residents being subjected to the intentional misuse of seclusion and/or restraint by direct care staff on two other units. However, prior to November 1996, NSH leadership continued to respond to the abusive seclusion and restraint practices in a reactive manner, addressing each incident on a case-by-case basis.

Though long overdue, facility leadership has begun to identify and implement appropriate proactive measures to address patient abuse. PAI supports the initial efforts of the Multi-disciplinary Management Action

Team which has begun taking a systemic approach to help prevent, identify, monitor, and report incidents of abuse. These corrective measures include, but are not limited to the comprehensive collection and analysis of relevant abuse and "special-incident"-related data so that a root cause analysis of sentinel events can be conducted.

- THE INVESTIGATIONS CONDUCTED BY NAPA STATE HOSPITAL'S SENIOR SPECIAL INVESTIGATOR CONCERNING THE ABUSIVE SECLUSION PRACTICES ON UNIT A-8 WERE INADEQUATE.

The series of unauthorized seclusion incidents of vulnerable A-8 residents may have constituted dependent adult abuse and implicated a number of other penal statutes (see, Section X, at pp. 54-59), thus warranting a thorough criminal investigation. Instead, the Senior Special Investigator -- who is charged with the law enforcement responsibility of investigating the abuse of NSH residents by facility employees -- conducted a superficial investigation which failed to meet minimum standards of investigatory competence. For example, the Senior Special Investigator failed to collect and analyze basic and readily available documentary evidence; failed to appropriately evaluate the witness statements of involved staff; attempted to interview only one of four identified victims; failed to retain, for a reasonable period of time, key evidence that he actually did collect; and failed to make a formal referral to the local district attorney. This raises serious questions regarding the residents' reasonable access to competent law enforcement and prosecutorial services.¹¹

¹¹ Inadequate internal investigations of patient abuse in state facilities run by the California Department of Mental Health appear to be a systemic problem which warrants comprehensive analysis. DMH has been notified that PAI has begun such an analysis.

XII. RECOMMENDATIONS

- THE STATE DEPARTMENT OF MENTAL HEALTH SHOULD BE ACCOUNTABLE AND ENSURE THAT ALL OF ITS HOSPITALS FULLY IMPLEMENT A PROACTIVE SYSTEMS APPROACH TO ABUSE-RELATED SPECIAL INCIDENTS.**

The Department of Mental Health (DMH) should provide needed leadership, oversight, and support to: (1) ensure that Napa State Hospital (NSH) fully implements an ongoing, effective proactive system for identifying, preventing, responding, and reporting patient abuse; and (2) ensure that all facilities under its jurisdiction do the same. This will involve, among other corrective measures, an overhaul of DMH's special incident reporting system. DMH should implement an effective, uniform, state-wide data retrieval system for identifying, tracking, and responding to abuse.¹² NSH has undertaken a critical initial step in identifying appropriate proactive, corrective measures and assigning responsible staff to carry them out. However, full implementation of a new proactive system and ongoing effective quality assurance review of actual abuse prevention and response practices demand painstaking planning and leadership by management at NSH and accountability by DMH.

Moreover, DMH and NSH leadership at all levels should set appropriate expectations and ensure that needed corrective and disciplinary action is taken when abuse occurs, including the termination of employees and referral for prosecution, when warranted. Additionally, DMH and NSH should implement effective measures to protect, from retaliation, staff who break the code of silence and report abuse. DMH and NSH management should also ensure that patient care staff at all levels are provided with ongoing active and direct supervision and support so that leadership expectations, once effectively established (i.e., zero tolerance of abuse of residents and zero tolerance of retaliation against staff who report abuse), are internalized by staff and thus more likely to be carried out as a matter of routine practice.

¹² The Department of Developmental Services is in the process of implementing a state-wide uniform special incident data base system. DMH should assess the need for implementing this or another comparable, uniform special-incident data system, as identifying and tracking the trends and patterns of abuse is critical to the success of any proactive abuse prevention system.

- **NAPA STATE HOSPITAL AND THE CALIFORNIA DEPARTMENT OF MENTAL HEALTH SHOULD TAKE PROMPT ACTION TO ENSURE THAT ALLEGATIONS OF STAFF-TO- RESIDENT ABUSE ARE THOROUGHLY AND COMPETENTLY INVESTIGATED AND APPROPRIATE FOLLOW-UP ACTION TAKEN.**

NSH and DMH need to fully appreciate that inadequate internal investigations -- such as the two conducted by NSH's Senior Special Investigator (SSI) regarding unauthorized seclusion practices on Unit A-8 -- place residents at unnecessary risk of abuse. The substandard manner in which the two investigations of staff-to-resident abuse on Unit A-8 were conducted included the apparent failure of the SSI to understand that a series of crimes may have been committed against residents by the involved employees which warranted a thorough criminal investigation. As the SSI is the residents' primary law enforcement officer responsible for investigating patient abuse, DMH and NSH should take immediate steps to ensure that the SSI is able and willing to conduct thorough, uncompromised investigations of alleged criminal abuse of residents by employees, and to properly refer substantiated allegations of abuse to the district attorney, who, in his or her discretion, will determine whether prosecution is appropriate. This will require DMH and NSH to alleviate the conflict of interest dilemma posed by its internal investigations of such staff-to-resident abuse.

In addition, given the basic investigatory failings evidenced by the NSH A-8 investigation, DMH should (1) ensure that a comprehensive assessment and objective determination is made as to whether the facility's SSI has the training, experience, and demonstrated competence to carry out the critical function of investigating allegations of criminal abuse of residents by employees in a manner which meets community standards of law enforcement, and (2) take appropriate measures in accordance with such determination.