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Report of an Inquiry into the Death of Marc Kiefer at East Bay Hospital

Failure to Conduct Proper Medical Examination and Monitor Disabled Man's Condition during Seclusion and Restraint Ends in Death

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 and Advocacy, Incorporated's (PAI's) inquiry into the circumstances surrounding the death of Marc Kiefer at East Bay Hospital (EBH) in Richmond, California, on February 3, 1993. Kiefer was found dead following nearly eighteen (18) hours of physical restraint and locked isolation.

Kiefer had not been able to shake the deepening depression which ensued following the sudden death of his brother in the Fall of 1992. Nevertheless, he remained motivated to resolve his grief and address related substance abuse problems. Kiefer continued to receive out-patient psychotherapy and take prescribed medications. In mid-January of 1993, Kiefer successfully "self referred" himself to Gladman Day Treatment Center (Gladman Center), a comprehensive mental health day program, participating five days per week, as recommended.

On February 1, 1993, after becoming uncharacteristically confused, Kiefer, accompanied by his father, went voluntarily to John George Psychiatric Pavilion (JGP) in San Leandro, California, for crisis evaluation. He was assessed at JGP, put on a "5150," and then transferred to East Bay Hospital for further evaluation and in-patient hospitalization. Kiefer died less than two (2) days later.

PAI is an independent, private, nonprofit agency which protects and advocates for the rights of persons with mental or developmental disabilities. Under federal and state law, PAI has the authority to investigate incidents of abuse and neglect of persons with mental or developmental disabilities. 42 U.S.C.§§ 6000 and 10801, et seq.; California Welfare & Institutions Code (WIC) § 4920, et seq.

PAI's five-month inquiry included:

- Reviewing Kiefer's clinical records from Gladman Center and interviewing Laura Post, M.D., Gladman Center psychiatrist.

- Reviewing Kiefer's clinical records from JGP and EBH.

- Reviewing available relevant administrative and patient care, policies, procedures, and directives from JGP and EBH, including, but not limited to, those concerning admission and evaluation, transfer and

discharge, seclusion and restraint, and medication prescribing practices.

- Reviewing Department of Health Services (Licensing) reports and statements of deficiencies pertaining to EBH for the years 1984 through 1993.

- Interviewing Regional Licensing personnel as well as Leon Starkman, M.D., consultant to Licensing.

- Reviewing Department of Health Services (Licensing) reports and statements of deficiencies pertaining to JGP for the years 1986 through 1993.

- Reviewing County of Contra Costa Sheriff-Coroner's findings, autopsy, and investigation reports, certificate of death and amendment of medical and health section data concerning Kiefer's death, and related toxicological reports.

- Interviewing Kiefer's parents and reviewing documents concerning Marc Kiefer provided by his parents.

- Interviewing Ernest Dernburg, M.D., Marc Kiefer's out-patient psychiatrist of over eighteen (18) years.

- Consulting with Richard C. Unger, M.D., Ph.D., a board-certified psychiatrist and molecular biologist with over fifteen (15) years of experience in evaluating and treating persons with mental disabilities.

- Consulting with James E. Meeker, Ph.D., Chief Toxicologist, Institute of Forensic Sciences Laboratory, who is also a pharmacologist with over ten (10) years of experience in analyzing the significance of toxic and biological effects of drugs upon human beings.

PAI thanks Gladman Center staff, Regional Licensing personnel, the Institute of Forensic Sciences Laboratory, and the Contra Costa County Coroner's Office for their cooperation and technical assistance in conducting this inquiry.

II. EXECUTIVE SUMMARY

On February 3, 1993, at 7:47 AM, Marc Kiefer, a 38-year-old man, was found dead at East Bay Hospital (EBH) in Richmond, California, on the second floor of the facility's psychiatric intensive care unit.

Kiefer died alone in an isolation room following nearly eighteen (18) hours of being restrained to a bed with leather straps, belts, and cuffs. According to the psychiatrist PAI consulted, Kiefer likely died from "the undiagnosed and untreated medical condition of anticholinergic toxicity from psychiatric medications as well as a prolonged period of improperly monitored seclusion and restraint." Despite the fact that Kiefer had been coping with schizophrenia for nearly twenty (20) years, this was the first time he had ever been on a locked psychiatric unit for in-patient care.

PAI reviewed the facts and circumstances surrounding Kiefer's death to determine what specific practices, if improved or changed, could prevent unnecessary deaths under similar circumstances.

A. FINDINGS AND CONCLUSIONS

EBH medical staff failed to conduct an adequate evaluation or physical examination.

Following Marc Kiefer's initial assessment at John George Pavilion (JGP) the afternoon of February 1, 1993, until the time of his death at East Bay Hospital (EBH) the morning of February 3, 1993, staff made a dangerous assumption, in spite of mounting objective clinical evidence, that the cause of Kiefer's decompensation was the result of his mental disability only, and that a medical condition was not a contributing factor.

Kiefer never received a proper medical evaluation, including a physical examination, while at EBH. After eight (8) hours of locked isolation, struggling "with and against" leather restraints and ever increasing agitation and disorientation, a physician came to conduct an "admissions" examination of Kiefer but deferred it entirely until Kiefer was "cooperative."

Nor did EBH medical staff ever obtain an adequate history, even though Kiefer's parents, his out-patient psychiatrist of over eighteen (18) years, and the Gladman Center psychiatrist who referred Kiefer for further evaluation due to "uncharacteristic mental status changes" attempted repeatedly to convey such information. Although some EBH staff indicated

that "confidentiality" prevented communication with the family, there is no evidence to support that contention. In any event, confidentiality laws in no way prevented EBH staff from receiving and acting upon information provided by loved ones or other clinicians.

The psychiatrist PAI consulted summarized EBH's failure this way:

> *A fundamental failing was that a good history was not obtained in a timely manner. That coupled with an inadequate medical and neurological assessment made an appropriate course of treatment unlikely.*

EBH Medical staff failed to identify and respond to a life-threatening medical condition.

By the early afternoon of February 2nd, Kiefer's condition was deteriorating rapidly, but medical staff still failed to evaluate him properly and order appropriate laboratory studies.

The psychiatrist that PAI consulted explained that although one symptom alone did not raise "a red flag" about probable drug toxicity or poisoning, the cumulative picture by the afternoon of February 2nd did, which included:

> *The patient's loss of insight and decreased alertness and sudden downhill course; reports of visual hallucinations; falling against the walls on the unit and later falling out of bed while in seclusion and restraint; increasing confusion and disorientation (for example, while in the restraints, thinking 'he was driving a car' and in a 'rowboat'); and, persistent dangerous levels of agitation to the point of breaking his skin from struggling with the restraints.*

Despite this "cumulative clinical picture," a basic neurological assessment was not even conducted. Nor were appropriate, comprehensive, qualitative toxicological studies obtained which, according to the forensic toxicologist PAI consulted, could have identified the anticholinergic poisoning within two (2) hours of testing. As pointed out by the psychiatric consultant, "EBH assumed or acted as if the initial assessment and screen for illicit drugs at

John George constituted a comprehensive medical and toxicological evaluation, which it did not."

Disturbingly, even when Kiefer's parents informed his treating physician that their son may have "overdosed" on Artane prior to his hospitalization, no appropriate response to avert a potentially life-threatening situation occurred. And, according to the psychiatrist PAI consulted:

> *[U]nfortunately, East Bay, given the patient's condition of anticholinergic toxicity, chose exactly the wrong course of treatment. Haldol, Thorazine, Benadryl and Cogentin all possess anticholinergic properties and were not safe to prescribe. In addition, Haldol was specifically contraindicated given the fact that it is known to increase the blood level of Anafranil.*

The forensic toxicologist PAI conferred with corroborated this concern, stating, in part:

> *For this situation basic laboratory screening was not done. While relying on a screen for three different illicit street drugs may be adequate in certain arrest situations it is not adequate when you have a psychotic patient who may have been taking illicit as well as prescribed medications that may be causing a medical problem....*

EBH nursing staff failed to monitor Kiefer's condition adequately while he was secluded and restrained.

EBH nursing staff failed repeatedly to follow the facility's own monitoring and documentation procedures while Kiefer was in seclusion and restraint. The pattern of inattention to Kiefer's monitoring needs was particularly egregious during the night shift.

EBH policy requires that persons in seclusion and restraint have their vital signs taken at least every four (4) hours. Despite this policy, Kiefer's complete vital signs were only documented as taken twice during his entire hospitalization at EBH, even though he was secluded and restrained for

eighteen (18) consecutive hours. Kiefer's last body temperature was taken nearly twenty-four (24) hours before he was found dead.

During the afternoon shift of February 2nd, Kiefer was becoming increasingly confused, disoriented, and agitated. He was described as struggling against the restraints "almost constantly," to the point of "breaking his skin." He even fell out of bed. Nonetheless, nursing staff did not even take his vital signs or call a physician to examine him. Instead of considering the possibility of adverse medication reactions or other medical problems, nursing staff continued to administer a number of psychiatric medications which were, given Kiefer's condition of anticholinergic poisoning, dangerously inappropriate.

Although during the night shift it is documented that Kiefer's circulation was assessed every fifteen (15) minutes as required by EBH policy that could not have occurred. Kiefer was found dead at 7:47 AM. Rigor mortis had already begun. No resuscitative efforts were therefore initiated. It takes hours, not minutes, for rigor mortis to set in. Thus, it appears that neither the night shift mental health worker nor the R.N. responsible for ensuring Kiefer's "well-being ... during a critical period of care" actually assessed him in person for at least a few hours. During part of Kiefer's last night at EBH when it was documented that he was "observed" as "sleeping," Kiefer was in fact dead.

B. RECOMMENDATIONS

EBH should ensure that all persons admitted to its psychiatric intensive care service receive timely and appropriate medical evaluations.

Procedures and practices should be improved to ensure accountability for the overall delivery of medical and psychiatric care from the time the person is admitted until discharge. EBH should improve its policies, procedures, directives, "rules and regulations," and quality assurance mechanisms pertaining to physician assessment requirements so that medical examinations, including adequate histories and complete physicals as well as appropriate laboratory and other diagnostic studies, are conducted in a timely manner.

The practice of "deferring" physical examinations should cease. Failing to conduct a physical examination is especially dangerous when a person's condition is deteriorating while in restraint and seclusion, as was the situation with Kiefer. Physicians responsible for conducting such examinations should receive specialized training on how to examine agitated persons undergoing seclusion or restraint. As explained by the psychiatrist PAI consulted:

> *It is not unusual that a patient is too agitated for a full physical examination. But the physician should do as much as can be done under the circumstances, such as taking vital signs; listening to the heart and lungs and abdomen; assessing the neurological status, by, for example, seeing if the patient's pupils are reactive to light, moving the neck to see if it's supple or stiff and checking gross motor reflexes; as well as feeling and observing the skin to see if it's flushed, wet or dry, cool or warm.*

In addition, EBH should develop appropriate policies and procedures to ensure that confidentiality requirements are not misused by staff, as they were in this situation, to avoid the responsibility for obtaining an adequate history. All medical and nursing staff should also receive prompt, comprehensive training concerning how to protect patient confidentiality while obtaining needed medical histories.

EBH should improve its capacity to identify and respond to potential life-threatening emergencies involving psychosis and agitation.

All medical and psychiatric staff should receive periodic ongoing education and evaluation of their clinical competency concerning the emergency treatment of acute psychosis and agitation. Such education should focus on reversing the dangerous assumption that a medical (as opposed to "psychiatric") condition is not playing a factor in the decompensation of a mentally disabled person. This education should also emphasize the important diagnostic role of timely, comprehensive, qualitative toxicological services when, as with Kiefer, poisoning or drug toxicity may be causing the person's decompensation.

EBH should also develop toxicological training, education, and guidelines for EBH physicians which address specifically the necessary criteria for initiating a comprehensive, qualitative toxicological evaluation, including evaluation of the possible misuse of prescribed medications; the importance of obtaining urine samples when a maximum amount of information is needed in a short time frame; and how to interpret such laboratory results so as to maximize their use in diagnosing and treating the person's distress.

EBH should ensure that all secluded or restrained persons are monitored properly by qualified medical and nursing staff.

EBH should modify its policies, procedures, and directives to require explicitly that regular observations by nursing staff be conducted face-to-face with the restrained person -- not through the window of a locked seclusion room.

In addition, the "assessment" and "approval" role of the R.N. should be redirected to bring the clinical expertise of senior nursing staff to the bedside more frequently where it is needed. R.N.'s should also more actively supervise other staff, such as mental health workers, involved in the ongoing care of secluded or restrained persons. "Episodically" verbalizing with other staff members responsible for performing more frequent assessments and reviewing the restraint and seclusion record, as required by current policy, have proven inadequate.

All nursing staff should receive periodic training and education concerning the inherent dangers of seclusion and restraint. Such training should increase nursing staff's competence to identify and respond to at-risk individuals such as Marc Kiefer. It should also focus on improving nursing staff's response to the heightened dangers posed by the combined risks of inappropriate or prolonged seclusion or restraint, polypharmacy, adverse medication reactions or toxicity, and other potentially life-threatening conditions such as unremitting agitation.

Under EBH policy, it is possible for a person to be secluded or restrained without being evaluated medically at all for twenty-four (24) hours. Although not required by current law, EBH policies, procedures, and directives

should be modified immediately to require that persons be "medically cleared" by a qualified physician immediately prior to or upon the initiation of seclusion and restraint whenever possible. When, due to exigent circumstances, seclusion or restraint must be initiated at the discretion of an R.N., within one (1) hour of its imposition, a qualified physician should evaluate the person to determine whether any medical contraindications outweigh the indication for its use. This medical evaluation and balancing of risks versus benefits should occur no less than every eight (8) hours thereafter. Had Kiefer been evaluated by a qualified physician during that prolonged period of seclusion and restraint, an appropriate life-saving course of treatment may have been initiated.

C. PUBLIC POLICY IMPLICATIONS

This is the fifth (5th) seclusion and restraint neglect-related death that PAI has reported upon publicly since it began investigating such incidents in 1991. A sixth (6th) death of a mentally disabled young man, also in a private acute psychiatric facility, is now pending. See, Investigation of the Circumstances of the Deaths of C.C. and K.C. at Patton State Hospital and J.V. at Camarillo State Hospital (Sept. 1991); Report of a Review of the Neglect, Restraint and Death of Zouhair Jadeed at Napa State Hospital (March 1993); See also, PAI memorandum entitled, "Restraint Problems in Facilities Serving Persons with Mental Disabilities" (Dec. 1993).

PAI's reviews and investigations reveal a pattern of factors which caused or contributed to the deaths of these mentally disabled individuals:

- The failure to evaluate the physical condition of the person adequately prior to or shortly after initiating seclusion or restraint.
- The failure to consider whether a medical condition, such as toxicity or an adverse medication reaction, might have caused the person's agitation or decompensation.
- The failure to conduct appropriate diagnostic and toxicological testing given the person's condition.

- The failure to provide adequate observation, care, and monitoring to assure the well-being of secluded or restrained persons, including interacting face- to-face with the person on a routine basis, taking vital signs, and assessing basic biophysical needs such as hydration.

None of these basic health and safety requirements exist under current laws. Mentally disabled persons, such as Marc Kiefer, continue to die as a result of the failure to provide this needed care and monitoring.

The evidence gathered thus far, in both volume and credibility, indicates that current laws, regulations, and practices do not assure adequate care and safety for the thousands of vulnerable mentally disabled Californians subject to seclusion and restraint in psychiatric health facilities every year. The evidence also suggests that while more enforcement of appropriate existing standards and staff education may be desirable, those strategies alone are not enough. (Licensing has, to its credit, expended considerable regulatory resources to assure quality care at EBH. But Licensing cannot effectively enforce standards, such as interacting face-to-face with a restrained person on a regular basis, which do not exist under current law.) The death of Marc Kiefer is yet another tragic example of why clearer, more comprehensive legal care and monitoring standards are required.

III. BACKGROUND

A. MARC KIEFER

Marc Kiefer was a physically healthy 38-year-old man when he entered East Bay Hospital (EBH) the evening of February 1, 1993. Kiefer died less than two (2) days later, following nearly eighteen (18) hours of restraint and isolation.

Kiefer became mentally disabled following high school. He was diagnosed as having paranoid schizophrenia and had been struggling to "get well," as he put it, ever since. According to his out-patient psychiatrist of more than eighteen (18) years, Kiefer occasionally experienced auditory hallucinations but never visual hallucinations. Kiefer's out-patient psychiatrist also indicated that Kiefer had used illicit drugs on a very limited, "situational" basis in an effort to cope with the death of his brother. Kiefer's out-patient psychiatrist also stated that in all of the years he treated Kiefer, Marc had never been confused, disoriented or suicidal. Despite Kiefer's disability, he lived quite independently, enjoying the support of his loving family and a circle of close friends.

Kiefer achieved many of his goals, both personally and professionally. Kiefer graduated from the University of California at Berkeley in 1980 with a degree in Native American Studies. He earned his teaching credentials in history and social studies from California State University at Hayward in 1992 and also studied mass communications at Chabot College. Kiefer was extremely athletic and loved baseball. He played varsity baseball and soccer during high school. After high school, Kiefer played semi-pro baseball in the California Baseball Association. Prior to his death, Kiefer was sharing a condominium with friends and working as a sports correspondent for the Alameda Newspaper Group.

B. GLADMAN DAY TREATMENT CENTER

Gladman Day Treatment Center is located at 2620 Twenty-Sixth Street in Oakland, California. Owned and operated by Telecare Corporation, Gladman Center, pursuant to a contract with Alameda County Mental Health Department, provides a range of voluntary out-patient services to eligible persons who live in Alameda County. According to an informational brochure:

> *The Gladman Day Treatment Center provides a multi-disciplinary treatment program for persons who are in need of active psychiatric treatment and rehabilitation for acute mental, emotional, or behavioral disorders and who, in the absence of such interventions, are at significant risk of acute psychiatric hospitalization. The Center also provides specialized dual diagnosed services for persons who, in addition to a major mental health disorder, also suffer from the effects of substance abuse.*
>
> *Located in an urban residential neighborhood, Gladman provides a supportive environment where individuals suffering from the effects of mental impairments can gain the living, working, learning, and social skills necessary to live independently, semi-independently, or in a supervised residential setting. The Center provides intensive day treatment including, but not limited to, assessment, medication, collateral services, individual, family, and group therapy. Clients attend the Center from two to five full days each week.*

Kiefer had been a client of Gladman Center from February 4, 1992 to October 5, 1992, and from January 19, 1993 until February 1st, the day he was referred to John George Pavilion for crisis evaluation due to significant mental status changes, including uncharacteristic confusion and disorientation.

C. JOHN GEORGE PSYCHIATRIC PAVILION

Operated by the County of Alameda, JGP is a Division of Highland General Hospital located at 2060 Fairmont Drive in San Leandro, California. According to JGP admission policy:

> *The John George Psychiatric Emergency Service provides rapid evaluation, treatment and disposition for psychiatric emergencies presented at the service site around the clock. A psychiatric emergency is defined as any situation that possibly meets the Lanterman-Petris-Short Act criteria for involuntary detention.*

All emergencies are evaluated by a qualified Psychiatrist....

D. EAST BAY HOSPITAL

East Bay Hospital (EBH) is a privately-owned and operated hospital located at 820 Twenty-Third Street in Richmond, California. The hospital is licensed by the Department of Health Services (Licensing) to provide general acute and acute psychiatric services. At maximum capacity, the facility is licensed to serve seventy-one (71) persons in need of acute psychiatric services. Kiefer was hospitalized in EBH's locked intensive psychiatric care unit which is a part of the facility's acute psychiatric service.

According to an EBH brochure:

> *East Bay Hospital provides high quality psychiatric care to adults suffering from all types of behavioral disturbances including stress symptoms, depression, eating disorders, schizophrenia, anxiety problems, alcohol and chemical dependency problems, psychosomatic problems and pain of long standing. Adult psychiatric treatment is aimed at alleviating discomfort, a return to normal functioning, and the development of new coping skills.*
>
> *All patients receive a complete physical examination and appropriate laboratory studies shortly after admission. It is important to discover whether physical abnormalities may be the cause of a patient's psychological distress.*
>
> *As a rule, family and friends and others want to help. At East Bay Hospital they are given the chance to do so. Concerned family members are invited to volunteer information. They are instructed about the patient's condition, and they are taught to participate constructively in his or her treatment plan.*

E. PSYCHIATRIC MEDICATIONS

Marc Kiefer, as many persons with the mental disability of schizophrenia, took antipsychotic and other types of psychiatric medications as part of his out-patient treatment. The evidence indicates that his usual out-patient

psychiatric medications included Stelazine and Artane, and that approximately three (3) months before his death, Kiefer began taking Anafranil, an antidepressant.

It appears that just prior to his hospitalization on February 1, 1993, Kiefer had been "self medicating" with his out-patient drugs (i.e., taking more than what was prescribed in an attempt to alleviate psychological discomfort). This is relatively common for persons with schizophrenia who, as was the situation with Kiefer, are also coping with depression. (Following Kiefer's death, it was discovered that twenty-two (22) oral doses of Anafranil, 50 mg. each, were unaccounted for and assumed ingested by Kiefer as well as forty-six (46) oral doses of Artane, 2 mg. each.)

Kiefer also received psychiatric medications at both JGP and EBH. At JGP, Kiefer received Stelazine and Cogentin. At EBH, Kiefer received Haldol, Thorazine, and Ativan, as well as Benadryl and Cogentin.

Antipsychotic medications benefit many individuals by minimizing or eliminating psychotic symptoms such as hallucinations (seeing and hearing things which do not exist) and delusions (grossly inaccurate beliefs which are obviously contrary to fact). They are also intended to reduce excitability, anger, confusion and withdrawal.

Because of their effects on the nervous system, the class of antipsychotic drugs called neuroleptics (e.g., Haldol, Thorazine, Stelazine, Mellaril) can produce neurological dysfunction, often called extrapyramidal symptoms (EPS). Symptoms of EPS include, but are not limited to, tremors, uncontrollable restlessness (akathesia), spasms of the face and neck muscles, involuntary protrusion of the tongue, difficulty swallowing (dysphagia), fidgeting, drooling, and shuffling movement of the feet. (According to Kiefer's out-patient psychiatrist of over eighteen (18) years, although Kiefer did not have a significant history of EPS, he did sometimes "self-medicate" with the Stelazine, thus making the prescribing of the side-effect medication Artane appropriate.)

The tricyclic antidepressants (e.g., Anafranil, Norpramin) are similar to the neuroleptics, producing some of the same side effects. However, severe EPS, including muscular reactions, occur less frequently with tricyclic

antidepressants. According to the toxicological and psychiatric consultants PAI conferred with, tricyclics are one of the most potentially toxic depressant drugs. Care must therefore be exercised to avoid toxicity or overdosing. In addition, as pointed out by these consultants, when tricyclics are combined with anti-parkinsonian and neuroleptic drugs, as was the situation with Marc Kiefer, disastrous consequences, including death, may ensue.

Anti-parkinsonian or anti-cholinergic medications (e.g., Benadryl, Artane, Cogentin) are generally prescribed to reduce extrapyramidal symptoms. These drugs can also produce their own adverse "anticholinergic" effects. Anticholinergic reactions may include sedation, sleepiness, dizziness, and disturbed coordination.

Anti-anxiety drugs (e.g., Ativan, Xanax), also known as minor tranquilizers or minor depressants, are prescribed in an attempt to control anxiety, nervousness, tension, agitation, and sleep disorders. More frequent effects include sedation, lethargy, dizziness, and problems with balance and walking.

F. SECLUSION AND RESTRAINT

Seclusion and restraint are interventions used in psychiatric facilities to prevent physical injury to the mentally disabled individual or others. Seclusion is the involuntary isolation of the individual from others, usually in a locked room. Physical restraint means restricting the individual's movement through mechanical devices or techniques such as ties or belts. (Leather belts, straps, and locked cuffs are generally used to restrain individuals in acute psychiatric care facilities such as EBH.)

California law sets forth only general guidelines about the use of seclusion and restraint. Mentally disabled persons who are receiving care and treatment in facilities such as EBH have the right to be free from harm, including unnecessary or excessive physical restraint or seclusion. See, WIC § 5325.1. Under existing regulation, these interventions are permitted to be used when alternative, less restrictive methods are not sufficient to ensure the physical safety of the mentally disabled individual or others. In addition, seclusion and restraint are not supposed to be used as

punishment, for the convenience of staff, or as a substitute for a less restrictive alternative form of treatment. See Title 22, CCR § 71545(a); Title 9, CCR §§ 865.4(a) and 865.5.

Seclusion and restraint are most often used when, as with Marc Kiefer, persons with mental disabilities are hospitalized involuntarily. In 1986 (the last year for which data were published by the Department of Mental Health), 24,232 incidents of seclusion and 28,671 incidents of restraint were reported by hospitals, such as EBH, to the Department. In the same year, there were 92,150 involuntary 72-hour evaluation-treatment episodes(commonly referred to as "5150's"). Thus, between 31 and 57 percent of those persons treated involuntarily on "5150's" were also involuntarily restrained or secluded, or both.

A recent study was conducted at the request of Senator Dan McCorquodale following increased complaints about the use of seclusion and restraint in California's mental health facilities during 1992. The study, which is the first of its kind, profiles seclusion and restraint practices in eight (8) California counties. Using a standardized data collection instrument, statutorily mandated advocates collected information by reviewing the chart documentation of 267 separate incidents of seclusion and restraint. This information was then analyzed for its statistical significance by notable mental health researcher Daniel Chandler.

Analysis of the data determined that the wide variability in the incidence and duration of use of these interventions "suggest unacceptably broad practice differences" that could not be explained by differences in "patient characteristics." The study also found that "overall compliance with appropriate [legal] care standards is highest when such standards are clear and specific." The data demonstrated that compliance with required observation checks was, for example, "much higher than the performance of assessments for release from seclusion and/or restraint or the provision of other medical or nursing care ... [where] [s]tandards ... are ill defined and uncodified." See, Nelson, et al., Seclusion and Restraint Practices in Eight California Counties (1993). See also, Joan Meisel and Daniel Chandler, Evaluation of Proposed Changes to California's Lanterman-Petris-Short Civil Commitment Statute Pursuant to SB 1708, Conference of Local Mental Health Directors (June 1988).

Seclusion and restraint can cause serious physical and emotional harm, especially when used for long periods of time, for inappropriate reasons or without adequate monitoring and care, as was the situation with Kiefer. Risks include dehydration, exhaustion, cardiac arrest or respiratory collapse, fractures, muscle and kidney damage, self-mutilation, strangulation, and a worsening mental condition as a result of being alone and isolated. The emotional impact of seclusion can be severe. Consequently, some "debriefing" may be necessary following the person's removal from seclusion to mitigate against painful memories. Physical restraints can also cause circulatory obstruction as well as aspiration if an individual is restrained on his or her back. See Tardiff, et al., "Seclusion and Restraint: The Psychiatric Uses," Report of the American Psychiatric Association Task Force on the Psychiatric Uses of Seclusion and Restraint (1984).

EBH policy emphasizes the importance of safeguarding persons undergoing seclusion or restraint, stating:

> *Restraints are the most restrictive measures which can be used to control a self-destructive or assaultive patient. Physical restraint must be limited to that which is absolutely necessary to handle the situation. The restrained or secluded patient must be protected from harm by any and all sources.*

In recognition of the dangers posed by seclusion and restraint, EBH policy also requires that:

> *Patients in restraints or seclusion will be assessed as often as is warranted, but no less frequently than at 15 minute intervals by the staff person assigned to the patient and no less frequently than every four (4) hours by a Registered Nurse.*

These 15-minute observation checks must, pursuant to EBH policy (although not required by current law), be conducted in a manner that ensures assessment of the restrained person's level of consciousness; circulation; changes in skin color (e.g., redness, paleness, blueness around the mouth); and identifies abnormalities such as swelling or skin abrasions and neurological problems. In addition, although also not required by

current law, EBH policy requires that persons undergoing seclusion or restraint have their vital signs (i.e., temperature, pulse, respirations, and blood pressure) taken every four (4) hours.

G. DEPARTMENT OF HEALTH SERVICES

The Department of Health Services, Licensing and Certification Division (Licensing) is responsible for inspecting, licensing, and regulating the quality of care and services provided at acute psychiatric facilities such as EBH. See CCR, Title 22, §§ 70101-70136.

Licensing has a range of authority to enforce patient care regulations. It possesses the authority to conduct inspections as frequently as is necessary to assure that facilities are providing quality care. The agency must, however, conduct such inspections no less than once every two years. Licensing may take a number of measures to correct identified deficiencies, including offering advice and consultation, requiring plans of corrections, and, when necessary, initiating legal action to revoke or suspend a facility's license. (Apparently, Licensing did consider seeking revocation of EBH's license during 1991 but later decided such action was not appropriate.)

Effective January 1, 1994, Licensing may also assess civil penalties not to exceed fifty dollars ($50) per patient affected by the deficiency for each day that the deficiency continues beyond the date specified for correction. Such penalties can only be assessed for deficiencies that pose "an immediate and substantial hazard to the health or safety of patients." Health & Safety Code § 1280.1.

IV. REVIEW OF THE CIRCUMSTANCES SURROUNDING THE DEATH OF MARC KIEFER

A. ASSESSMENT AT GLADMAN DAY TREATMENT CENTER

Around 8:30 AM on February 1, 1993, the manager of Marc Kiefer's condominium who is a family friend, called Kiefer's parents to tell them that Marc seemed disoriented. Mr. and Mrs. Kiefer then took their son to Gladman Day Treatment Center (Gladman Center). At Gladman Center, staff also observed that Kiefer was disoriented. He was, for example, unable to perform otherwise routine tasks such as tying his shoes properly. Kiefer was then seen by a staff psychiatrist (Dr. Gladman) who evaluated him around 1:00 PM and documented: "... ct. [client] clean, neat, very confused c [with] significant MS (mental status changes: unable to tie shoes), thought he'd seen me today (& [and] hadn't yet), unable to track the conversation...."

Dr. Gladman also noted that Kiefer indicated that he had been taking medications as prescribed, that he had been free of any other drugs, including alcohol, since December 1992 (which was verified by Gladman Center drug screens) and that he had no physical complaints or visible motor deficits. Although Kiefer's vital signs at that time were normal, Dr. Gladman was sufficiently concerned about Kiefer's condition to refer him for crisis evaluation. Dr. Gladman further noted:

> *May have aphasic process [impairment of communication skills due to brain dysfunction], early Wernicke's [brain dysfunction usually associated with chronic alcoholism or stomach cancer] s [without] nystagmus [constant involuntary eye movement] ... called fa [father] to take client to ER [emergency room, referring to JGP].*

A Gladman psychiatric technician likewise observed Kiefer's uncharacteristic disorientation, noting:

> *Attended DTC [Day Treatment Care]. By noon was disoriented. Couldn't remember where the bathroom was. When asked 'how are you feeling' replied 'I could give you the name of a celebrity.' BP: 112/86 80 976 I called ct's. Fa [father] who came to take him to John George Pavilion for an evaluation.*

According to Dr. Gladman and Kiefer's out-patient psychiatrist of over eighteen (18) years, as well as the psychiatrist PAI consulted, the mental status changes of confusion and disorientation are not characteristic manifestations of schizophrenia. Rather, they raise concerns about potential medical or neurological conditions warranting appropriate evaluation.

B. CRISIS EVALUATION AT JOHN GEORGE PAVILION

Frank Kiefer accompanied Marc to JGP. They arrived at JGP around 3:00 PM. Both Marc and his father were interviewed by a licensed clinical social worker (Social Worker #1). Social Worker #1 determined that Marc Kiefer appeared disoriented and confused and that he should receive further evaluation and in-patient psychiatric services.

An untimed JGP Psychiatric Emergency Services Note by Social Worker #1 states:

> *Pt. referred from Gladman Day Treatment where he is having difficulty doing basic skills tasks that he usually performs adequately. Pt. is disoriented at this time and though he is not threatening to himself or anyone else he needs to be stabilized on meds.*

That note further described Kiefer's mood as "somewhat depressed" and "somewhat anxious." Social Worker #1 also stated:

> *Pt. is willing to sign into our facility voluntarily. He is followed by [Dr. Outpatient] [referring to Kiefer's out-patient psychiatrist of over eighteen (18) years] [phone number omitted], and Gladman Day Treatment. He has a place to live and can return when stable.*

Additionally, Social Worker #1 noted: "I called [Dr. Outpatient] and left a message so that we can find out what meds he is taking," as neither Marc Kiefer nor his father could provide a "full account." Social Worker #1 further stated in her Note: "Plan (1) Admit voluntarily error on 5150 -- Gravely Disabled. Stabilize. Please do tox screen. (2) Discharge home."

According to the Intake Evaluation Record, JGP was aware of Kiefer's long history of out-patient treatment:

> *Pt. is followed by [Dr. Outpatient], psychiatrist who has been treating him since he was 18 years old. Pt. says he takes Haldol and Stelazine, but I do not know if this is reliable. I called Dr. Outpatient ... and am awaiting a return call. Pt. has headaches and takes Inderal. (Emphasis added.)*

Under "Other Relevant Information," the Intake Evaluation Record, in pertinent part, states:

> *Pt. has a place to live and can return when stable.... Pt. has a long history of paranoid schizophrenia and he has trouble accepting his disability. He has worked for a few newspapers, earned a teaching credential, but breaks down under stress and cannot [sic] sustain employment for long. In addition, he is still suffering from unresolved grief over the suicide of his brother, John, in September of 92.... Family support is solid: both father and mother are concerned and involved and can be reached at.... (Phone numbers omitted.) (Emphasis added.)*

The Mental Status section of the Intake Evaluation Record noted that Kiefer was "casually groomed with good hygiene." His behavior was described as "cooperative and trying to figure out how to tie his shoes; decompensated." It was also noted that Kiefer was "not alert to time, day or month, but aware of the president and place." In the section of the record entitled "thought content," it stated: "Denies voices at this time, but is internally preoccupied. Has visual hallucinations (thought the wall was fog)." No "gross neurological problems" were identified.

Around 4:30 PM, Mr. Kiefer watched his son sign a "Request for Voluntary Admission and Authorization for Treatment." Marc Kiefer was then taken through a door further into the facility for evaluation. That was the last time Marc Kiefer's father ever saw him alive.

A 4:35 PM Psychiatric Emergency Initial Nursing Data Base documents Kiefer's legal status as voluntary and the reason stated by Kiefer for such

voluntary hospitalization as: "I'm off the wall." No conditions requiring emergency medical treatment are noted. Kiefer's level of control was documented as "Cooperative." It was further noted that a search of Kiefer's person was conducted and that Kiefer had been brought in by his "father" from "home," and that he was "ambulatory."

Under "Psychological Assessment," the Psychiatric Emergency Initial Nursing Data Base indicates that Kiefer was oriented to time, place, and person. Kiefer's perception of the problem is quoted as: "Well, I think I want to get well." The document also indicates that Kiefer said he did not feel like hurting himself or others. His speech was noted to be "Slowed" and his affect "Blunted." Under "Disturbances of Perception," it is documented that Kiefer was having "Auditory Hallucinations." His behavior was described as ambivalent and withdrawn.

Kiefer's current (i.e., out-patient) medications were listed as Stelazine, Anafranil, and Artane. The section concerning dose/time/interval and reason was blank, as a more accurate medications history had not yet been obtained. It is further noted that Kiefer was "sober" from "ETOH [alcohol] -- 15 days."

At 4:45 PM, a Progress Note by a registered nurse (R.N. #1) indicates that Kiefer was put "into EBH's Psychiatric Emergency Services waiting area" (pending admission, discharge and/or transfer).

A 4:45 PM Nursing Admission: Assessment and Care Plan indicates that Kiefer would be oriented to the unit and its rules "ASAP," that staff would meet and talk with Kiefer at least twice per shift, that he would receive PRN medications as ordered, and that his level of control would be assessed every four hours. Kiefer's vital signs were documented at this time as Blood Pressure: 106/62, Temperature: 98.7, Pulse: 80, Respirations 18.

At 5:00 PM, a urine sample was obtained and sent to the lab.

At 6:13 PM, a JGP psychiatrist (M.D. #1), wrote these admission orders: "(1) Admit to PES [Psychiatric Emergency Services] (2) Stelazine 10 mg. po [by mouth] now.... Cogentin 2 mg. po now. Aspirin X gr. po now."

At 6:20 PM, according to the PRN Medication Record signed by R.N. #1, Kiefer received the following medications: Stelazine, 10 mg. po, for "voices"; Cogentin, 2 mg. po, to "prevent EPS" (extra-pyramidal symptoms); and Aspirin gr. X (10 grains) for "c/o (complaints of) headache." According to JGP records, Kiefer signed an untimed "Consent for Medication on Advisement" for the Stelazine. M.D. #1 signed off as the prescribing physician for this consent.

The Laboratory Examinations form indicates that JGP staff were informed that the "tox screen" was negative x 3 at 6:48 PM (referring to the results of the urine test for the illicit street drugs of Phencylidine (PCP), Amphetamine, and Cocaine Metabolites).

At 7:00 PM, M.D. #1 ordered that Kiefer's legal status be changed to a "5150" and that he be transferred to EBH. The Application for Emergency Psychiatric Detention, initiated by Social Worker #1 pursuant to WIC § 5150 at approximately 7:15 PM, alleged that Kiefer was gravely disabled and stated, in part:

> *Pt. is disorganized and decompensated. Pt. is loose, tangential and unable to formulate thoughts to articulate a basic, rational care plan for himself. Can't provide food and shelter for himself in his present condition.*

According to the 8:00 PM JGP Nursing Discharge Summary, Kiefer was "calming down after meds."

At approximately 8:00 PM, Kiefer was discharged and transferred by van service to EBH. Social Worker #1, who had evaluated Kiefer, then called Kiefer's parents to inform them of Marc's transfer, as required by JGP policy.

C. CARE AND TREATMENT AT EAST BAY HOSPITAL

At approximately 8:30 PM on February 1, 1993, for the first time in his life, Kiefer was admitted as an involuntary patient to a locked acute care psychiatric unit. Kiefer then signed routine EBH admission documents, including "Conditions of Admission to East Bay Hospital." The

interdisciplinary notes do not indicate when he was advised of his basic rights, but an untimed form dated February 1, 1993, and signed by Kiefer states that he received a copy of his basic statutory rights, as required, and understood them (e.g., the right to wear his own clothes and to see visitors each day unless denied for a "good cause").

As indicated earlier, Kiefer's father accompanied Marc to JGP. In addition, JGP records characterized family support as "solid," describing Kiefer's parents as "concerned and involved," and listing phone numbers to reach them. The EBH Summary sheet, however, lists no relative (or anyone else) to reach in case of an emergency. The same EBH Summary sheet lists Kiefer's physician as Psychiatrist #1 and Kiefer's "Financial Class" as "Medi-Cal."

The Patient History and Data Collection sheet indicates that Kiefer stated the reason for coming into the hospital as "need treatment," that "recent life changes" included attendance at a "day treatment program," that he lived with "friends in a condominium," and that he was "close" with his mom.

In responding to the inquiry about "one thing you like about yourself," it is documented that Kiefer answered, "baseball." In answer to the inquiry about "one thing you dislike about yourself," it is documented that Kiefer responded: "Cheating on a test in high school." The section for "Previous Therapist" is blank. Kiefer also indicated that he had used cocaine for a "couple of days" in the past. The Patient History and Data Collection sheet further indicates that Kiefer denied wanting to hurt himself or others. In response to the question, "What do the voices say to you?" it is documented that Kiefer replied, "I can hear the guy out there but I know he's not talking about me."

The R.N. Admission Assessment, signed by Registered Nurse # 2 (R.N. #2), indicates that Kiefer's vital signs at 9:00 PM were: Temperature: 97.8, Pulse: 78, Respirations: 18, and Blood Pressure: 80/60. Kiefer's height was recorded as 5'11-1/2" and his weight as 179 pounds.

Kiefer's appetite was noted as being poor, with a recent weight loss of 20 pounds. Hydration was noted as good. Despite the fact that JGP records list Kiefer's current medications as Stelazine, Anafranil, and Artane, the

only current medication documented on the R.N. Admission Assessment is Stelazine. (Nowhere in EBH's records is Anafranil ever mentioned.) The R.N. Admission Assessment also indicates that Kiefer had no "current physical complaints."

A 10:30 PM Nursing Admission Note states:

> *A 38 years [sic] old male admitted to EBH on 5150 hold as gravely disabled. Pt. [patient] was disorganized, confused, unable to sustain a logical thought process for basic function at admission. Pt. denies all issues but states that he lost 20 lbs. since his brother died in Sep. 1992. Pt. speech very loose and paranoid ideation. [Psychiatrist #2] answer service was notified about admission.*

A February 1 untimed "Psychotherapy" Admission Note by a third M.D. (Psychiatrist #3) states:

> *The patient is a 38 year old single white male admitted here for the time on 5150 initiated at the John George Pavilion. He was severely psychotically confused, pressured, and unable to pursue goal-directed conversation. Papers say that his Brother died in Sept. 1992 and he has gone downhill since with 20 lbs. weight loss.*
>
> *Diagnosis Axis I - acute exacerbation of chronic paranoid schizophrenia.... Plan: Patient refused to sign informed consent for stelazine and ativan.*

At approximately 11:30 pm, these routine Physician Admission Orders were completed by Psychiatrist #3: Admit to closed unit on involuntary basis; regular diet; history and physical to be done by on-call M.D.; lab work, including CBC (i.e., complete blood count), a urinalysis, a blood chemistry panel, and vital signs to be taken daily.

The following prn ("as needed") "routine admissions" medications were also prescribed: Cepacol lozenge q (every) 1 [hour] prn for sore throat, Mylanta 30 cc q 2 po (by mouth) for gastrointestinal distress, and Benadryl 100 mg. po q 3 prn for "agitation" or "insomnia." Psychiatrist #3 further

directed that staff contacts with Kiefer be "short" and "frequent," noting that staff should "avoid [a] confrontational stance" when interacting with Kiefer. Staff were also directed to intervene with Kiefer to "strengthen reality testing" and "encourage logical speech sequences." No restrictions on his right to see visitors were noted.

A Multidisciplinary Problem List dated February 1, 1993, identified the following "patient problems" for treatment planning: "anxiety level which impairs effective functioning," "mood disturbance" (depression), "poor self-care abilities functioning," and "thought disorder," specifying "paranoid." That document also directed staff to chart on Kiefer's depression and thought disorder. The Multidisciplinary Problem List also indicated that all of these identified problems had already been the subject of an initial treatment planning review by occupational, social services, nursing, and medical staff.

A document dated February 1, 1993, called East Bay Hospital Multidisciplinary Treatment Plan (which addresses "problems related to thought process disorders"), said that Kiefer was experiencing visual and auditory hallucinations. It also indicated, in contrast to JGP records, that Kiefer had "poor" personal hygiene. It further specified that Kiefer had "impaired reality orientation" evidenced by "depression." The document also identified Kiefer's anxiety level as a problem, but specified no symptoms of this problem. In addition, even though Kiefer had lived in his own condominium prior to hospitalization and, according to the facility's own records, stated so to EBH staff upon admission, the Assessment section for discharge planning specified a "behavioral objective" that Kiefer should identify resources outside the hospital, noting that he would be discharged to "residential treatment" (such as a board and care home or skilled nursing facility).

A 6:00 AM, February 2nd, 1993, Nursing Note by a psychiatric technician described Kiefer's first night in EBH: "Awake majority of noc (night). Confused, agitated. Resistive to redirection. Refused meds. 'Lost' his room, couldn't find the bathroom, stuffing clothes in the trash can. Checked hourly."

A laboratory printout indicates that specimen collection occurred at 6:50 AM. The printout says that the "Referring Physician" was "Psychiatrist #2," and the order "complete." However, no urinalysis results, if obtained as ordered, were present in EBH's records. The blood chemistry results were essentially unremarkable, and appear to be the only laboratory work completed during Kiefer's hospitalization at EBH.

At 7:00 AM, Kiefer's vital signs were documented as Temperature: 97.4, Pulse: 72, Respiration: 18, Blood Pressure: 110/74. (This was the last time Kiefer's body temperature was documented as taken prior to his death the following morning.)

Although the above 6:00 AM Nursing Note states that Kiefer refused medications during the night, at 10:45 AM, Kiefer took 100 mg. of Benadryl "prn" (as needed) for "agitation" by mouth. The PRN Medication Record (PRN record) states Kiefer's response to the Benadryl as "not effective."

An 11:30 AM Nursing Note by a mental health worker indicated that Marc Kiefer appeared depressed and withdrawn, "states he got this way after his baby brother committed suicide, pt. has been seclusive to self and bed."

At 12:15 PM on February 2nd, Psychiatrist #1 gave a telephone order for the following medications: "Thorazine 100 mg. po [1 time] only for emergency. Ativan 1 mg. po [1 time] only for emergency. If po refusal [if refuses to take by mouth] give: Thorazine, 50 mg. IM (intra-muscular) c [with] 1 mg. Ativan IM [1 time] only for emergency -- give together." Medication records indicate that Kiefer took the Thorazine and Ativan by mouth at 12:30 PM. (Kiefer's response to this medication is not indicated, as required by EBH policy, on the PRN record. Nor is the nature of the "emergency" necessitating such administration of those medications specified, as required.)

At 1:50 PM, Psychiatrist #1 gave a telephone order to "seclude and restrain for up to 24 hours, in up to 4 pts. as danger to himself and others." Psychiatrist #2 signed off on the order at 2:00 PM.

EBH Medication Informed Consent documents indicate that Kiefer agreed to take Ativan "up to 8 mg./day" for "agitation" and Haldol "up to 100

mg./day" for "psychosis" at 2:00 PM. The frequency of administration for both of these medications is indicated (by check marks) as "up to 4 times a day, plus PRN [as needed] doses up to every hour." The only alternative treatment to the administration of these medications is indicated on the form (also by check mark) as "other medication." (Other alternative treatment choices include "discharge," "psychotherapy," "milieu therapy," and "other.") The physician's signature on these Informed Consent documents appears to be Psychiatrist #2's.

According to EBH records, on February 2nd, 1993, Psychiatrist #1 dictated and had transcribed an untimed Psychiatric Evaluation concerning Kiefer. That Psychiatric Evaluation indicates, among other things, that Psychiatrist #1 was aware of the need to obtain a more complete medical history from Marc Kiefer's out-patient psychiatrist of over eighteen (18) years, as well as from Kiefer's family. That dictated Psychiatric Evaluation states:

> *Patient is unable to give any history himself. History is obtained from the records from John George Pavilion. He reportedly has a long history of a paranoid schizophrenic disorder and has had extensive prior treatment, apparently including treatment with Haldol and Stelazine in the past. He is treatment [sic] on an outpatient basis.... It is not known what his current medications are. He reported to John George that he was taking Haldol and Stelazine and also some Inderal for headaches.*
>
> *History of prior hospitalizations is not known. (Emphasis added.)*

Under the "Plan" section of the evaluation, Psychiatrist #1 stated: "We will need to contact the patient's family and his outpatient psychiatrist to obtain further history." Psychiatrist #1 does not mention in his dictated evaluation that Marc Kiefer was, as noted in the JGP records, also taking Anafranil, an antidepressant, on an out-patient basis.

The Psychiatric Evaluation by Psychiatrist #1 summarizes the reasons for and course of Kiefer's hospitalization thus far as:

> *The patient comes in now after being brought to John George Pavilion by his father. He had been recently followed at Gladman Day Treatment Center but had been unable to function there.... Examination at John George Pavilion showed him to be casually groomed with good hygiene. He was cooperative but was confused, having difficulties, for example, knowing how to tie his shoes. He appeared depressed and anxious with flat affects. He was not oriented to time, date and month. He was noted to be aware of the place and the president. He was internally preoccupied but was denying hearing voices. He had visual hallucinations, thinking the wall was fog. He showed thought blocking, flight of ideas and loose and tangential thinking. He was unable to state a logical plan to care for himself. There is no evidence of any known medical problems. There was a recent history in that he admitted to crack cocaine use several weeks ago. The patient was felt to be suffering from an acute exacerbation of chronic paranoid schizophrenia.*
>
> *A toxicology screen was obtained which apparently was negative [referring to the screen at JGP for three (3) illicit street drugs]. He did receive Stelazine 10 mg orally, Cogentin 2 mg orally and aspirin 10 gr orally in the Emergency Room [referring to JGP]. Apparently this produced some calming. However, he was still felt to be in need of acute hospitalization given his severe deterioration and inability to care for himself, and was therefore referred to East Bay Hospital for admission.*

Psychiatrist #1 further noted at this point in the Psychiatric Evaluation: "The patient is too agitated and psychotic to provide any further past history."

The "Mental Status Evaluation" section of Psychiatrist #1's report, in part, reads:

> *I evaluated the patient the following day [referring to February 2nd, the day EBH records indicate this evaluation was dictated and transcribed]. He was, at this point, highly agitated and pressured. He was hyperactive and hyperverbal.*

> *He had been placed in restraints due to agitation and continued to thrash about. He did calm somewhat when I spoke to him. He appeared very frightened. Affects were inappropriate and quite labile. He denied any suicidal ideation. His thought processes were markedly disorganized, at times being incoherent. At other times, he could respond well to direct questions. He appeared to be highly delusional with marked paranoid delusions, although it was difficult for him to articulate these clearly. He appeared to be hallucinating but again could not describe these to me. He was fully alert. He realized he was in a hospital and recognized me as a doctor. He could not give me the date or place. He did know his name. He could not cooperate with further cognitive testing. He did recognize he was acutely psychotic and was eager for some assistance in calming his fears.*

Psychiatrist #1's diagnostic impression was that Kiefer was suffering from an "acute exacerbation of chronic paranoid schizophrenia."

The "Plan" section of the evaluation also, in pertinent part, states:

> *As noted, he had become highly agitated and required the use of seclusion and restraints.... He will be seen by an on-call physician for medical evaluation and physical examination and screening laboratory studies will be obtained.... He will be allowed all visitors.... He will be seen for daily visits for hospital management as well as daily individual and group psychotherapy sessions. He will have a multidisciplinary evaluation and treatment plan. As noted, patient initially refused to sign informed consents with Psychiatrist #3. He had been started on Benadryl on a PRN basis for agitation and insomnia. At the time of my interview, he had received Thorazine 100 mg PO and Ativan 1 mg PO on an emergency basis. He was, then, during our interview to agree to consent to antipsychotic medications, particularly Haldol and Ativan. Despite his psychosis, he was able to*

discuss these with me and recognized that he had been on them previously.

In this evaluation, Psychiatrist #1 indicated that the estimated length of Marc Kiefer's hospitalization would be three (3) weeks. In spite of the fact that JGP and EBH Admission Data Collection Records indicate that Marc Kiefer was living independently in a condominium with friends prior to his hospitalization (as mentioned earlier) Psychiatrist #1's final comment in his dictated evaluation reads: "It is not clear at this time where the patient has been staying so it is not known if we will need to make further arrangements regarding this."

At 2:15 PM, Psychiatrist #2 wrote these medication orders: "Ativan 1 mg. po [by mouth] now; Haldol Conc. [concentrate] 10 mg. po TID [3 x a day] give 1st dose now; Cogentin 1 mg. po TID; and Haldol Conc. 10 mg. po + Ativan 1 mg. po q (every) 3 prn agitation." The medication record indicates that at 2:00 PM, Kiefer received the Ativan, Haldol, and Cogentin, as ordered. Kiefer's response to these medications is not documented.

A Seclusion and Restraint Record indicates that Kiefer was put in restraints and seclusion at 2:15 PM on February 2nd because "Pt. was threatening staff and kicking the door to the yard while in w/w [wrist to waist] restraints." Less restrictive measures documented as "tried and failed" were "1:1 redirection" and "reality testing." Nothing in the chart indicates, as required, why Kiefer ended up in wrist to waist restraints. Nor does the record state how long Kiefer was in wrist to waist restraints. (A subsequent Nursing Note does, however, state that Kiefer "[w]andered down the hall bumping into the walls while in wrist restraints....")

The Seclusion and Restraint Record at 2:15 PM indicates that Kiefer was in "2 pts." (meaning that two (2) extremities were restrained physically). Whether this notation refers to the wrist to waist restraints is not ascertainable from the record. At 2:30 PM, the record indicates Kiefer was in "4 pts." and at 2:45 PM, "4 pts." and "seclusion." From 2:15 PM to 3:00 PM, the Seclusion and Restraint Record indicates (by means of check marks) that Kiefer's circulation was checked, range of motion done, toileting and fluids offered, as well as a meal offered every fifteen (15) minutes. None of the boxes available to describe Kiefer's behavior during

this 45-minute period are checked, as required. The "Comments" section of the Seclusion and Restraint Record at 3:00 PM states: "Pt. redirected. Pt.'s restraints adjusted & tightened." At 3:15 and 3:30 PM, however, the following boxes were checked to describe Kiefer: "Agitated," "Threatening," "Yelling," and "Confused/Incoher-ent." In the "Comments" section, at approximately 3:30 PM, Kiefer is further described as "confused, yelling, struggling, delusional."

A Nursing Note at 3:10 PM describes Kiefer's deteriorating condition that afternoon:

> *... pressured and agitated, kicking the exterior door -- confused, delusional, paranoid, disoriented, hallucinating, danger to self ... pt. was gravely confused and disoriented. Wandered down the hall bumping into the walls while in wrist restraints; felt the police were after him. Thought they were around him. Said, 'look can't you see them,' let me out of here. Appeared very frightened. Thought he was driving a car. Said I've got to stop it. Made motions as though he was putting on breaks [sic]. Was coded and 4-pointed in his bed [referring to the procedure for confining a person to their bed by placing all 4 extremities in leather restraints]. Pt. struggled and pulled getting on his knees. Pt. was then transferred to seclusion room where he was again placed in 4 points on his back. He tried to cooperate and at times followed code green [restraining] directives. His speech was delusional, pressured and slurred mixed with delusional content.... Pt. appears to have visual and auditory hallucinations. Gravely paranoid and delusional. Speech disorganized, most incoherent. Pt. was a danger to self. (Emphasis added.)*

A February 2nd M.D. untimed Admit Note signed by Psychiatrist #2 stated that Kiefer was admitted "after presenting grossly psychotic at his day program. Imp. [impression] -- Acute exacerbation of paranoid schizophrenia." "Plan -- Locked unit, S&R (seclusion and restraint) for agitated & threatening behavior. Agrees to Haldol & Ativan [referring to the Informed Consent reportedly obtained from Kiefer at 2:00 PM], which are started."

At 3:45 PM, an EKG was ordered and Marc Kiefer was transferred to the care of Psychiatrist #1. There is no indication that an EKG was done.

Throughout the afternoon shift (3:00 PM to 11:30 PM), the Seclusion and Restraint Record indicates that Kiefer's circulation was checked every fifteen (15) minutes, range of motion done twice, instead of every two (2) hours as required, and fluids and food offered. The Seclusion and Restraint Record also indicates that Kiefer was "confused/incoherent" during every 15-minute observation that afternoon, and that he was never observed to be either "calm" or "threatening." In addition, the Seclusion and Restraint Record indicates that Kiefer was "agitated" throughout the afternoon shift, except from 8:45 PM to 10:30 PM. The same Seclusion and Restraint Record further indicates that Kiefer was "yelling" intermittently throughout the shift, approximately every one-half (1/2) to one (1) hour, except from 8:30 PM to 10:30 PM. (During this time, as discussed below, some of the restraints were removed temporarily and Kiefer had increased contact with staff.)

Even though the physician's order allowed restraint only "up to 4 pts.," the Seclusion and Restraint Record at 8:30 PM indicates that: "Pt. was reduced from 5 point restraints to 4 point restraints." This Seclusion and Restraint Record also indicates: "Pt. has been resistive to the restraints to the point of breaking his skin in places on both ankles." Kiefer's vital signs were documented at this time as: Blood Pressure: 122/92, Pulse: 128, Respirations: 24. Kiefer's temperature was not taken due to "pts. refusal."

The following fluids were documented as taken during the afternoon shift: 100 cc at 5:00 PM, 180 cc at 8:30 PM, 240 cc at 9:15 PM, and 240 cc at 10:30 PM. Meals were documented as offered and refused at 5:30 PM and 6:45 PM. The record does not indicate, however, that toileting was offered or what Kiefer's output was, if any.

As no output was ever documented in the Seclusion and Restraint Record during the afternoon shift on February 2nd or elsewhere in the chart, it is unknown what the status of Kiefer's bladder and kidney function was at that time or any time throughout his hospitalization. According to the toxicologist and the psychiatrist PAI consulted, such basic biophysical information (along with appropriate laboratory studies) could have been used to

determine the cause of Kiefer's increasing confusion, agitation and decompensation, and to treat him properly.

The medication record indicates that Kiefer received a second dose of Haldol Concentrate 10 mg. po and Cogentin 1 mg. po at 9:00 PM.

At 10:00 PM, more than twenty-five (25) hours after Kiefer's admission, a doctor came in to conduct a medical evaluation but instead deferred it entirely, documenting: "Pt. combative & un-cooperative presently in 4 points restraints unable to medically evaluate @ (at) this time will attempt medical evaluation @ later date, when pt. co- operative."

A 10:30 PM Seclusion and Restraint Record "comment" states that: "Pt. contracted with staff and was reduced to 2 point restraint (right arm/left leg)." A 10:45 PM Seclusion and Restraint Record "comment" states: "Pt. fell out of bed and was again struggling with the restraints. Pt. was increased to 3 point restraints (both hands)." According to the records, a registered nurse (R.N. #3) signed off as having "assessed" and "approved" the restraint and seclusion of Kiefer during the afternoon shift.

At 11:45 PM that night, a mental health worker documented the ongoing deterioration of Kiefer's condition evidenced by increased confusion, disorientation, and dangerous levels of persistent agitation. That Nursing Note, in pertinent part, stated:

> *... anxiety level which impairs effective functioning. Pt. was received in 5 point restraint in seclusion room. Staff contact was frequent and brief. Pt. refused all food, and although fluids were pushed, pt. only took in 760 cc of fluid.... Patient struggled against the restraints almost constantly, to the point of breaking skin in the area around cuffs. Pt. was unable to respond to staff directly when spoken to. Pt. stated, 'Let me out of this rowboat,' and was once observed attempting to catch something in the air with his mouth.... Pt. was reduced to 4 points and then 2 points, but then had to be increased to 3 points due to his continuing to struggle with restraints and thus falling out of bed x 2....*

According to the medication record, at 11:55 PM, Kiefer was given (for the third time since 2:00 PM that day) Ativan 1 mg. prn for "agitation" as well as Haldol concentrate 10 mg. prn for "agitation." The PRN record indicates that these oral prn's were "effective." Cumulatively, over a period of thirteen (13) hours, Kiefer had thus received: Benadryl 100 mg.; Cogentin 2 mg.; Thorazine 100 mg.; Haldol 30 mg.; and Ativan 3 mg.

Despite Kiefer's deteriorating condition (including the fact that he reportedly fell out of the bed twice while still in restraints), there is no indication that a physician was ever called to evaluate him medically. Nor is it documented that his vital signs were taken every four (4) hours while he was secluded and restrained, as required by EBH policy. In fact, Marc Kiefer's records indicate that complete vital signs were taken only two (2) times during his entire hospitalization. (His last body temperature was taken at 7:00 AM on February 2nd. And, as discussed below, no vital signs or other critical care was provided during the upcoming night shift.)

The justification for the ongoing seclusion and restraint of Kiefer during the night shift was stated as: "Pt. threatened staff verbally. Pt. kicked the door to yard while in w/w restraints" (referring back to what reportedly justified the seclusion and restraint more than ten (10) hours earlier).

The Seclusion and Restraint Record further indicates that Marc Kiefer was "agitated" when observed at 15-minute intervals from midnight until 12:45 AM, February 3, 1993. The "Comments" section of the record notes that Marc Kiefer received a "prn for agitation" at the beginning of the shift (referring to the 11:55 PM dose of Haldol and Ativan) and that at around 1:45 AM, Marc Kiefer was "awake and in 4 pts. for his safety pt. also self talking." The "Comments" section of the Seclusion and Restraint Record further documents that Kiefer was "sleeping" from 3:00 AM to 7:30 AM.

The Seclusion and Restraint Record also indicates that Kiefer's "circulation" was checked every fifteen (15) minutes throughout the night shift, from 12:00 AM through 7:30 AM. From 1:00 AM throughout the rest of the night shift, the Seclusion and Restraint Record does not indicate (by means of check marks, as required) any description of Kiefer's behavior (i.e., "agitated," "threatening," "confused/incoherent," "calm"). The Seclusion and Restraint Record for the entire night shift also does not indicate whether

range of motion was done, or fluids or toileting offered. No vital signs were documented as taken. The final comment on that night shift Seclusion and Restraint Record, at approximately 7:15 AM, states: "Pt. sleeping quietly in 4 points. Pt. need further evaluating by day shift."

However, a February 3, 1993, 6:30 AM Nursing Note by Registered Nurse #4 (R.N. #4) summarized Kiefer's night in seclusion and restraint as follows:

> *Received pt. in seclusion & 3 pt. restraints. Pt. constantly struggling c [with] and against restraints. Extensive bruising noted on ankles and lower extremities. Restraints padded and po prns administered. Placed in 4 pt. restraints for pt. protection. (Emphasis added.)*

Registered Nurse #5 (R.N. #5) signed off as having "assessed" and "approved" the seclusion and restraint of Kiefer during the night.

The early morning Seclusion and Restraint Record at 7:45 AM indicates that Kiefer remained in "4 pts.," that his circulation was checked, that he was given range of motion, and that toileting and fluids were offered. The justification for ongoing restraint is documented as: "Pt. threatened staff verbally. Pt."

In the "Comments" section of the Seclusion and Restraint Record at 7:47 AM, it states: "Pt. found with no pulse. Neck still warm, finger tips turning blue."

No resuscitative efforts were initiated.

According to a February 3, 1993, 8:15 AM Psychiatrist #1 note:

> *Called to see pt. by nursing staff, who reported he had been found s [without] pulse or respirations at 7:47 AM. On examination, he has no palpable or audible heart beat & no respirations. Pupils are fixed & moderately dilated. Rigor mortis is present. Skin is cool on extremities but warm in places on trunk. Pronounced dead at 8:15 AM.*

An 8:20 AM Nursing Note states:

> *[P]t. found by staff at 0747, I was called. I found pt. lying in restraints, he was ashen in color, had no pulse palpable, was not breathing. Rigor mortis has begun, his hands were stiff and cold as were his extremities. I notified the M.D. by phone.*

A Nursing Note by Registered Nurse #6 (R.N. #6), at 8:40 AM states: "Patient's family notified by [Psychiatrist #1]. Coroner ... of Contra Costa County called. May move body to third floor and permit family to visit."

D. COMMUNICATION WITH EAST BAY HOSPITAL

The evidence indicates that EBH treatment staff failed to obtain important information about Marc's history and medical condition, although offered repeatedly by Kiefer's parents, Kiefer's out-patient psychiatrist of more than eighteen (18) years, and the Gladman Center psychiatrist who assessed Kiefer on February 1st and determined that he should be evaluated further due to uncharacteristic mental status changes, including disorientation and confusion.

- **Mr. and Mrs. Kiefer**

The evidence indicates that Marc Kiefer's parents attempted to communicate with EBH staff responsible for their son's care and treatment at least nine (9) separate times throughout the day of February 2, 1993.

At approximately 11:00 AM, February 2, 1993, Frank Kiefer called EBH about his son Marc and was referred to a staff person (S.P. #1). S.P. #1 explained that she could not talk to Mr. Kiefer at that time, but that she would call him back at 12:15 PM. Mr. Kiefer never received that call, so at approximately 3:15 PM he called S.P. #1, who stated that "the case had been transferred to [Staff Person #2 (S.P. #2)]." S.P. #1 then apparently told Mr. Kiefer that she had no permission from Marc to speak to the family. (There is, however, no evidence indicating that EBH sought permission from Marc, as required by WIC § 5328.1, to speak with his parents. Nor is

there any evidence to suggest that Marc had any objections to EBH staff communicating with his parents about his condition.)

During this same telephone conversation, Mr. Kiefer was told that Marc's physician was Psychiatrist #2. S.P. #2 then got on the phone, saying she would call right back. According to the Kiefers, that return call was never forthcoming.

Later that afternoon, around 4:30 PM, Mr. Kiefer called S.P. #2 but she reportedly had gone home. The Kiefers then obtained the "patient" telephone number of Marc's unit. Frank Kiefer called the patient phone on the unit and asked to speak to his son, but could not reach Marc. (Marc was in seclusion and restraint at the time, but the Kiefers did not know this.)

Around 7:30 PM, Mrs. Kiefer called the patient phone and was told that "patients were in conference with counselors" and to call back in one and a half (1-1/2) hours. Mrs. Kiefer then called EBH again and got through to and talked to Staff Person # 3 (S.P. #3), a man who identified himself as a male nurse. S.P. #3 told Mrs. Kiefer that there was no Marc Kiefer admitted to the psychiatric unit.

Around 8:30 PM, Mrs. Kiefer called yet another time and was told that the hospital could not give out any information because of "confidentiality." At this point, Mrs. Kiefer became irate. The "floor nurse," R.N. #3, then came to the phone.

R.N. #3 indicated that responsibility for Marc's care had been transferred from Psychiatrist #2 to Psychiatrist #1. R.N. #3 indicated that Psychiatrist #1 had ordered Marc transferred to his service around 4:00 or 4:30 PM that afternoon. R.N. #3 then gave the Kiefers Psychiatrist #1's exchange number and, at the Kiefers' recommendation, agreed to leave a note on the chart with the Kiefers' phone number and the number of Dr. Outpatient, Marc's out-patient doctor of over eighteen (18) years. (The Kiefers' phone number is not listed anywhere in EBH's records. In a document called "Psychosocial Assessment," which lists "collateral contacts," it states "parents," with no accompanying phone number. Dr. Outpatient is also listed as a "collateral contact," along with a telephone number.)

The Kiefers asked R.N. #3 if they could speak with Psychiatrist #1 "tonight." R.N. #3 informed the Kiefers that Psychiatrist #1 was not in the hospital presently and that they should leave a message with his answering service or call the next day "during business hours." R.N. #3 then indicated that by 8:30 or 9:00 AM the next morning, staff would know when Psychiatrist #1 would be arriving at the unit.

Mr. Kiefer then inquired, "But Marc is there." R.N. #3 replied, "Yes, he is." R.N. #3 then said, "But I'm really not even supposed to tell you that much, I can't tell you anything more. I just need to talk to [Psychiatrist #1]." R.N. #3 further explained that "the reason the calls weren't getting back to you, the first doctor he was assigned to wasn't able to take him, and [Psychiatrist #1] did. I'm sorry you got the run around with the other names...."

R.N. #3 then indicated that EBH staff were looking after Marc, and recommended that the Kiefers call Psychiatrist #1 the next day, adding: "If he's doing better, maybe you can come during visiting hours."

During the telephone conversation with R.N. #3, Frank Kiefer grew increasingly frustrated and asked R.N. #3 to call Dr. Outpatient directly about Marc's medications, as the Kiefers were very concerned about Marc's condition.

R.N. #3 then asked what medications Marc had been taking. Mr. Kiefer indicated that Marc had been taking Stelazine and a "couple others."

Mrs. Kiefer asked if Marc was getting Stelazine at EBH. R.N. #3 responded: "See, I can't tell you any of those things, I'm not even supposed to tell you that he's here. It's a law...."

R.N. #3 went on to say: "When a patient comes in, we get their referring admission information from whatever agency sent him here, and a doctor sees him and gets as much information as we can and then starts him on treatment which includes medication."

Mr. Kiefer again stressed the importance of talking to Dr. Outpatient about Marc's medications and the amounts he had been taking.

The Kiefers called Psychiatrist #1's exchange at around 8:45 PM and left a message saying that they were concerned about Marc and that he was hospitalized at EBH. The Kiefers left their phone number and requested that Psychiatrist #1 call back "shortly."

Psychiatrist #1 called the Kiefers back at about 9:15 PM. Mrs. Kiefer asked about Marc's condition. Psychiatrist #1 described Marc as very psychotic, disorganized, and very agitated, adding, "And I think he'd been off his medications a bit."

Psychiatrist #1 also told the Kiefers that Marc needed "to go into restraints this afternoon because of how agitated he was." Psychiatrist #1 indicated that once Marc took some medication, he became more cooperative and that he seemed to be "doing a little bit better." Psychiatrist #1 further stated that Marc had been prescribed and was receiving Haldol and Ativan.

Mrs. Kiefer asked about the Ativan and Psychiatrist #1 explained that it was a minor tranquilizer, prescribed to help Marc clam down and relieve his anxiety. Mrs. Kiefer then asked whether Marc had received any other medications since his admission to EBH. Psychiatrist #1 responded that when Marc came in, one of the other doctors saw him (referring to Psychiatrist #3), and at that point Marc was unwilling to agree to take medication. Psychiatrist #1 added that Marc had remained "unmedicated at least until early this afternoon."

Mrs. Kiefer asked about the restraints. Psychiatrist #1 explained that Marc "had to be, you know, strapped down, because he was very threatening, very agitated, he was very confused. He thought he was on a cable car, for instance."

Mrs. Kiefer then informed Psychiatrist #1 that this kind of behavior was "new." Mr. Kiefer then asked whether Psychiatrist #1 had spoken to Dr. Outpatient. Psychiatrist #1 indicated that he had received a message from Dr. Outpatient but that he had not been able to get back to him yet. The Kiefers then underscored the importance of talking to Dr. Outpatient, noting that this psychiatrist had treated Marc on an out-patient basis for some eighteen (18) years. Psychiatrist #1 indicated he would contact Dr. Outpatient.

The Kiefers asked Psychiatrist #1 about how long they could expect Marc to be hospitalized. Psychiatrist #1 then asked: "When was the last time he had to be in the hospital?" Mrs. Kiefer replied: "He's never been in the hospital before." Psychiatrist #1 repeated: "He hasn't been in before?"

Mrs. Kiefer then relayed that Dr. Outpatient had indicated that Marc may have been taking too much Artane and that maybe Marc had "overdosed" on it. Psychiatrist #1 suggested that too much Artane could account for the degree of Marc's confusion, noting: "I was wondering if he ..., I asked him if he was using drugs of any kind, in fact, cuz that was my initial impression. But certainly if he'd been taking too much artane, that could produce the same kind of effect."

Psychiatrist #1 also indicated that if Marc's confusion was due to Artane, that the problem should have been clearing "fairly quickly -- within a day or two." The Kiefers indicated that Dr. Outpatient had indicated likewise and that they were getting "really concerned," as Marc was described as still very confused and agitated.

The Kiefers also told Psychiatrist #1 that they had experienced a very difficult time getting through to EBH staff, and summarized their communication problems of that day. Mrs. Kiefer also stated that Dr. Outpatient had made quite a few calls to EBH too, adding, "it's very disturbing."

Psychiatrist #1 promised to look into the communication problems the next day and apologized to the Kiefers. Psychiatrist #1 further stated that he would see Marc the next day and that if "he's calmed down considerably, we'll have a much better idea of where things are." Mrs. Kiefer then asked if Psychiatrist #1 would be able to call back. Psychiatrist #1 responded that he would try to call them back the next day.

Frank Kiefer again repeated: "It would be of value to talk to [Dr. Outpatient]." Psychiatrist #1 responded that he would be doing so, and the conversation ended.

At 8:00 AM the next morning, Psychiatrist #1 called and informed the Kiefers that Marc had died.

- **Dr. Gladman**

According to a February 2, 1993, 10:00 AM Note by Dr. Gladman: "After ct. [client] reportedly admitted to East Bay Hosp. (yest. pm.), called today to F/U [follow-up]. Left message c [with] front desk [phone number omitted] for treating psychiatrist to call me."

A 12:00 noon note by Dr. Gladman states:

Called back to EBH & was connected to [female] S.W. [social worker] that front desk believed was caring for ct. This S.W. said not to count on M.D.'s returning my call (front desk said she had forwarded my message to M.D., that he had picked it up, & that he had already left EBH). S.W. said she'd leave a message for appropriate, treating SW to call me before 3 pm."

Dr. Gladman's 2:00 PM note states:

Phoned EBH and spoke c [with] 2nd [treating] SW, who said she'd just received my message and had not seen ct. I told her of DTC's [Day Treatment Center's] concerns for ct: Wernicke's,? [sic] aphasia, NMS [neuroleptic malignant syndrome, a potentially life-threatening reaction to neuroleptic medications], subdural hematoma. She said she'd F/U c MD + [follow up with M.D. and] call back before 3 pm.

At 3:00 PM on February 2, 1993, Dr. Gladman wrote: "Left word c DTC [Day Care Center] that EBH would call to F/U re: ct."

A February 5, 1993, Gladman Center Weekly Summary Note by a social worker indicates that Gladman Center was called by EBH, for the first time, on February 3rd, and informed that "Marc was found dead there Wed. a.m. At this point, no one has any idea what the cause of death is."

- **Dr. Outpatient**

On the morning of February 2nd, Dr. Outpatient called JGP and was told that Marc had been transferred to EBH. Dr. Outpatient then called EBH and talked to a "clerical person" who said Psychiatrist #3 was Marc's physician. Dr. Outpatient then left a message for Psychiatrist #3 to call him

back. According to Dr. Outpatient, he never received a call back from Psychiatrist #3.

When Dr. Outpatient got through to EBH a second time, he was told that Psychiatrist #2 was Marc Kiefer's physician but that Psychiatrist #2 was not available to take his call. Dr. Outpatient stated that he left a message that he wanted to discuss Marc's medications, "what had gone on," and Marc's treatment at EBH.

Dr. Outpatient stated during interviews that he was concerned that Kiefer may have been toxic on his out-patient medications because Marc, according to the family, was confused and disoriented. According to Dr. Outpatient, in the more than eighteen (18) years he had treated Kiefer, he had "never seen Marc confused or disoriented." Dr. Outpatient also indicated that while Kiefer had at times experienced auditory hallucinations, he never had visual hallucinations, adding: "Visual hallucinations in adults generally indicate an organic problem such as toxic delirium or drug poisoning."

By Tuesday evening, Dr. Outpatient indicated "that the Kiefers were still not clear who Marc's doctor was." (The Kiefers and Dr. Outpatient had communicated by telephone in the afternoon and evening to update one another.) Dr. Outpatient said he was becoming increasingly "frustrated" and "concerned" and that he was "irked by their lack of professionalism" (referring to the failure of EBH's medical staff to contact him).

Dr. Outpatient called EBH again and talked to a woman he described as "quite helpful." This EBH staff person reportedly told Dr. Outpatient that "things don't run smoothly in that facility" (apparently referring to the locked Psychiatric Intensive Care Unit). Dr. Outpatient was also told that Psychiatrist #1 was the physician in charge but that Psychiatrist #1 would not be in the hospital until the next morning. Dr. Outpatient left a message for Psychiatrist #1 to call him as soon as possible.

Dr. Outpatient and the Kiefers discussed the situation again at around 9:00 PM.

Dr. Outpatient indicated that he never spoke with any EBH medical or other responsible treatment staff until after Marc died. That telephone conversation was an "abbreviated one" with Psychiatrist #1 and an unidentified "administrator."

E. MONITORING HISTORY OF EAST BAY HOSPITAL BY LICENSING

A review of Licensing's files beginning in 1984 indicates that most of the deficiencies noted prior to 1988 were relatively minor in nature and did not pose any significant threat to the health or safety of persons receiving acute in-patient psychiatric services at EBH.

In 1988, however, following a November 8-9 facility survey, deficiencies concerning the provision of skilled nursing care were identified. Licensing noted, among other things, that: "A significant number of evening and night shifts are staffed with only one R.N., thus limiting the possibility that the R.N. will be available to perform all needed functions." This one R.N., Licensing noted, is "frequently ... shared among the three psychiatric units."

In 1989, no serious patient care deficiencies were identified.

During complaint visit surveys completed on November 2, 1990, Licensing identified deficiencies in three (3) basic care areas: (1) failure to document the methodology for making decisions about how nursing staff were assigned to care for patients on various units; (2) failure to ensure that medical staff completed discharge summaries in a timely manner; and (3) failure of EBH to report unusual occurrences to Licensing as soon as reasonably practicable. Licensing records indicate that:

> *Two incidents of suicide efforts by patients R.J. on 10/18/90 and M.N. on 10/28/90 were not reported to the Department until 11/1/90. Reports within reasonably practical tme [sic] by telephone or telegraph were not made to the Department.*

By 1991, EBH became the focus of considerable monitoring by Licensing. During 1991, according to Licensing's public records, the agency received thirty (30) complaints and/or special incident reports. Licensing responded by conducting at least eight (8) separate facility surveys. A number of

serious patient care deficiencies and patterns of deficiencies were identified. Starting in 1992, however, monitoring by Licensing became less frequent and intensive.

During interviews with regional licensing personnel, PAI investigative staff was told that the frequent monitoring by Licensing in 1991 was the result of a "validation procedure" conducted at the request of the U.S. Department of Health and Human Services Health Care Financing Administration (HCFA), San Francisco office. PAI investigative staff was also told that such "validation procedures" are conducted when consideration is being given to suspending a facility's license to operate. Licensing also indicated that HCFA's request that Licensing conduct these "validation" reviews was the result of reports generated by Licensing.

In responding to inquiries concerning why revocation of EBH's license was not initiated, regional licensing personnel indicated that in 1992 and 1993, EBH was "in compliance" and that "Licensing did not receive as many complaints" during 1992 and 1993 (as it had during 1991). A medical consultant to Licensing indicated that the intensive licensing activity at EBH during 1991 was the result of a "concerted effort" to close the facility. This consultant further indicated that such intensive reviewing of EBH ceased in 1992 "because the word came down from Sacramento" (referring to Licensing Headquarters) that, under the circumstances, revocation was not appropriate.

Those deficiencies and problems identified by Licensing for the years 1991 through 1993 which are most relevant to the review of Marc Kiefer's death are summarized below.

- **Failure to follow proper restraint and seclusion procedures**

During the surveys completed on March 6, 1991 and May 13, 1991, Licensing identified a number of deficiencies involving basic seclusion and restraint requirements. Deficiencies included failing to obtain and document appropriate physician's orders and failing to document the specific reason justifying the imposition of seclusion or restraint.

On 3/1/90 [sic], patient M.W. fell and sustained a left scalp laceration. She was placed in 2 point restraints without a documented order. The reason for the need for restraints was not documented.

On 2/27/90 [sic] at 9:05 a.m., patient #216581 was placed in 2 point restraints and was not taken out until 2/28/90 at 7:00 a.m.There was no written order by the physician or evidence of a registered nurse being involved in the decision to restrain this patient (e.g., obtaining a verbal order from the physician, making and documenting an assessment for the need of restraints via progress notes or the restraint and seclusion record).

On 2/28/91 ... [a]t 10:15 p.m. the patient [M.W.] was put in 2 point restraints.... Again there was no R.N. evaluation of the patient or the necessity of restraints.

On 5/6/91 patient #201-67-22, according to the 'Seclusion, restraint and emergency medication record', the patient was noted to be put into seclusion. The justification for seclusion is documented 'Patient paranoid and agitated'. No behavioral description of what 'paranoid' or 'agitated' meant for this patient.

On 5/14/91 at 9:15 a.m., observed patient #216711 in locked seclusion. Staff stated she was placed there without direction of an R.N. because the R.N. was 'away from the unit at morning meeting.' Additionally, there was no physician's verbal order obtained by an R.N. at the time the patient was locked in seclusion.

During a June 24, 1991, facility certification follow-up survey visit, the following restraint and seclusion-related problems were found by Licensing.

Patient #2503184, was noted to be experiencing bilateral ear pain and threw the water pitcher at the staff. The patient was then restrained.

> *Chart #216796 (open chart) included two seclusion and restraint records dated 6/10/91 which indicated the patient was in two point restraint and seclusion for 10 hours. There was no physician's order, nor was there an indication for need of restraint other than 'history of being violent.'*

Because these problems occurred prior to the June 24, 1991, plan of correction, they were not formalized into a statement of deficiencies. However, according to Licensing records, the facility was made aware of these problems "via exit conference."

- **Failure to conduct sufficient monitoring of persons in seclusion and restraint**

Existing regulation requires that "patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes." CCR, Title 22, § 70577(j)(3). Regulations do not specify, however, how staff is to conduct such observations. (E.g., "face to face" interaction with restrained or secluded persons is not generally required under existing law.) EBH policy does specify that these observations be conducted in a manner that ensures assessment of, among other things, the person's level of consciousness and circulation. EBH policy also requires that persons in restraints or seclusion be assessed by an R.N. at least every four (4) hours.

During the survey completed August 14, 1991, Licensing identified these monitoring deficiencies:

> Patient 201-68-18 was in seclusion and restraints multiple times during her admission. Registered Nurse, (R.N.) documentation is not consistently available to indicate that the patient was assessed by an R.N. during the period of seclusion and restraint, or that the patient was put into seclusion and restraint under the supervision of an R.N., e.g.
>
> 1) On 8/4/91, the patient was in seclusion and/or restraint for 7 hours; there was no R.N. assessment.
> 2) On 8/1/91, the patient was in seclusion and/or restraint for 6 hours; there was no R.N. assessment.

The patient signed in as a voluntary patient on 7/17/91 and 7/19/91. R.N. assessment is necessary to justify holding a voluntary patient in seclusion and/or restraint.

On September 8, 1992, approximately five (5) months prior to Kiefer's death, Licensing identified noncompliance with these basic seclusion and restraint monitoring requirements:

Two of two patients in restraints did not have current documentation of 15 minute observations of required areas of concern during a walk through the psychiatric unit on 9/8/92 at 1345. One had last documentation of one hour before at 1245.

- **Failure to perform adequate and timely medical evaluations and diagnostic testing**

Existing regulation requires that:

> *Medical evaluations shall be performed as often as indicated by the medical needs of the patient as determined by the patient's attending psychiatrist. Reports of all medical examinations shall be on file in the patient's medical record. (Title 22, CCR § 70577(d)(2))*

In addition, EBH's own policies and procedures require that a complete physical examination be performed by a medical doctor within twenty-four (24) hours of admission.

Licensing identified these medical assessment-related deficiencies during the survey completed on May 16, 1991:

a. Patient #2166411 admitted on 3/28/91 did not have a history and physical performed and dictated until 4/1/91, four days later.

b. Patient #216533 admitted on 3/28/91 did not have a history and physical performed and dictated until 3/11/91, three days later.

c. Patient #216745 admitted on 5/10/91 did not have a history and physical performed and dictated until 5/13/91, three days later.

d. Patient #2016680 admitted on 4/9/91 did not have a history and physical performed and dictated until 4/12/91, three days later.

e. On 5/11/91 and 5/12/91 there was no physician available to perform history and physical examinations.

The patient W.S. (201-62-68) was readmitted to the facility on 4/17/91 with persistent hematuria (blood in urine).

The attending psychiatrist noted the lack of work up from the prior admission and noted the need for further evaluation. Cultures were taken and the patient was discharged without further medical work up.

Hematuria (blood in the urine), is not a normal condition and could be indicative of a serious medical problem.

In another situation where the patient died, Licensing documented during its survey completed on August 14, 1991:

> *The patient G.S. medical record 201-68-18 was admitted to the Psychiatric Service on 7/16/91 and died unexpectedly on 8/14/91. The medical record has an ECG (heart electrical exam) record for 7/18/91 and again on 8/9/91 that indicated changes compatible with heart damage. No clinical note is in the chart to indicate that the attending psychiatrist made [a] clinical correlation as requested by cardiologist or asked for a medical consultation although the psychatrists [sic] initials were on the ECG records.*

- **Failure to prescribe and monitor the effects of psychiatric medications appropriately**

During the survey completed March 6, 1991, Licensing identified these medication-related practices deficiencies:

> *There has not been an evaluation of the patient's [L.W.'s] condition and or a response to the PRN medications prescribed in the patient's record since admission, 2/20/91 by*

> *the registered nurse. For example, from 3/1/91 to 3/5/91, 10 nursing progress notes were written, none of which were written by a registered nurse.*
>
> *Patient M.W. was admitted on 2/26/91; orders were written for Lithium Carbonate 300 mg three times daily, Haldol 5 mg three times daily, Artane 5 mg three times daily, Haldol 5 mg concentrate and Ativan 1.0 mg orally every 3 hours as needed for agitation, and Dalmane 30 mg orally as needed for insomnia. Haldol was increased to 10 mg three times daily on 2/27/91....*
>
> *On 2/26/91 regular dosages of Lithium, Haldol, and Artane were given at 9:00 a.m. PRN (as needed) Ativan and Haldol were given at 5:00 p.m., and Ativan and Dalmane were given at 9:00 p.m. There was no documented evaluation of the patient's response to the medication by an R.N.*

In describing the medication-related care deficiencies pertaining to M.W., Licensing further documented:

> *... after 9:00 p.m. or during the night shift. On 2/27/91, the patient [M.W.] received PRN Ativan and Haldol at 9:00 a.m., 1:00 p.m. 5:00 p.m., and 9:00 p.m. as well as regularly scheduled doses of Lithium, Haldol and Artane. PRN Dalmane was also administered for sleep.*
>
> *There was no documented R.N. evaluation of the patient's response to medication at all on 2/27/91.*
>
> *On 2/28/91, the patient received PRN Ativan at 9:00 a.m., 1:00 p.m., 5:00 p.m. and 8:00 p.m.; and Haldol at 9:00 a.m., 5:00p.m. and 8:00 p.m., as well as regularly scheduled doses of Lithium, Haldol, and Artane. Dalmane was given for sleep.*
>
> *There was no documented R.N. evaluation of the patient's response to medication at all on 2/28/91.*

During the survey completed May 16, 1991, Licensing remained critical of EBH's quality assurance guidelines and practices pertaining to the administration of psychiatric medications, stating, in part:

According to the facility's plan of correction to be implemented 4/8/91 a plan was developed for the ongoing evaluation of medication therapy. This plan does not ensure an adequate evaluation of polypharmacy psychoactive drug use i.e. the criteria for the review of polypharmacy psychoactive drug use is not based upon accepted National or Community standards.

The facility's criteria for review of psychoactive polypharmacy is only when more than two drugs (three or more) of the same class are ordered for a patient on a routine basis.

The following patient's [sic] drug regimen met the American Psychiatric Association guidelines for review but were not reviewed by the hospital-wide quality assurance program:

a. *Patient 2016706 was receiving four different classes of any psychoactive drugs (Haldol, Klonopin, Lithium and Tegretol).*

b. *Patient 2016739 was receiving two antipsychotic drugs (Prolixin and Thorazine).*

c. *Patient 2012561 was receiving three different classes of psychoactive drugs (Haldol, Lithium and Klonopin).*

Licensing also identified further specific deficiencies concerning the administration of medications given "as needed" for "agitation," noting:

Patient #201-67-38 also had an order for Klonopin 1 mg PRN 'agitation' every three hours and was given to the patient, for example:

On 5/9/91 at 8:00 a.m., the patient received Klonopin 1 mg. It was not documented in the patient's record that the patient was 'agitated' or displayed any unusual behavior warranting a need for the PRN.

On 5/14/91, staff nurse #2 stated that he gives PRN medications when the patient asks for them. When the

> *evaluator asked what is the behavior displayed that indicated agitation, the nurse stated, 'Pacing or grabbing out'.*

- **Failure to monitor vital and neurological signs**

During its facility survey completed on March 6, 1991, Licensing described the following deficiencies:

> *The facility ... failed to take vital signs for patient L.W. as prescribed by the physician as follows: on 2/20/91, the physician ordered 'vital signs BID x 3 days' [2 times per day for 3 days]. Vital signs were only documented as taken two of six times, during those three days.*

There was also "no evidence that [M.W.'s] vital signs were taken as ordered on 2/28/91."

> *On 3/1/91, at approximately 6:00 a.m. the patient fell and sustained a laceration to the left front scalp which required suturing at Brookside Hospital. A blood pressure of 110/60 was recorded at 6:00 a.m., and after the patient was put to bed, 130/90....*
>
> *Another R.N. noted [sic] at 6:45 a.m. indicated, 'she told me on first exam that she had been feeling "woozy" for several days'.*
>
> *The patient returned from Brookside Hospital on 3/1/91 at 2:30 p.m. There was no documented assessment by an R.N. at that time or for the rest of the day.*
>
> *At 4:30 p.m. on 3/1/91, the M.D. ordered neuro checks every four hours and vital signs every four hours while the patient was awake for 24 hours.*
>
> *There was no indication that any neurological assessments were done until 6:00 a.m. on 3/2/91. No vital signs were recorded until 9:00 a.m. on 3/2/91. There is no documentation that an R.N. did these assessments. An R.N. did not record an assessment on 3/2/91 until 4:40 p.m.*

> *On 3/3/91, a staff member noted 'vital signs stable'; no vital signs were recorded for 3/3/91.*
>
> *On 3/4/91, there was no documented R.N. assessment.*

Following a survey completed on January 2, 1992, a little over one (1) year before Kiefer's death, Licensing found:

> *Patient #201-29-70 who was admitted on 11/3/91 with multiple head wounds and alcohol intoxication did not receive frequent and consistent assessment of her neurological status. Although the facility implemented a 'Neurological Signs' assessment sheet in October 1991, which indicates specific and frequent monitoring of vital and neurological signs, there was no evidence that this assessment tool had been utilized or implemented.*

V. FOLLOW-UP INVESTIGATIONS

A. CORONER'S INVESTIGATION

The Office of the Sheriff-Coroner of Contra Costa County (hereinafter "Coroner") conducted an investigation of Kiefer's death (Case No. 93-0156). According to the Coroner's report, Kiefer's death was reported to the Coroner at 9:05 AM on February 3, 1993. The time of death is listed as 8:20 AM and the cause of death classified as "natural."

In the section concerning Kiefer's medical history, the report states: "Acute exacerbation of chronic paranoia schizophrenia -- meds -- Thorazine, Ativan, Benadryl, Haldol," and then refers the reader to the medical records for further information.

The investigation report states: "[t]his report concerns the death of a 38 year old male that died at East Bay Hospital (Intensive Care Unit Second Floor Seclusion Room)." The report notes that Kiefer had no significant medical history except for treatment of his mental disability.

The Coroner's investigation report further stated:

> *[Psychiatrist #1] admitted Marc on a 72 hour hold for psychiatric care and was admitted to the locked intensive care unit. Marc was highly agitated and confused and said that he had used crack cocaine in the recent past. The toxicology test proved negative.*
>
> *Marc had to be placed in four point restraints because of his marked agitated confused state of mind, and hyperverbal condition, for his own safety. Marc was placed in the restraints at approx. 0100 hrs this morning. Marc was in the seclusion room by himself and checked on by the staff approx. every fifteen to twenty minutes. Marc was last seen alive by staff at approx. 0730 hrs. Marc was diccovered [sic] unresponsive at 0747 hrs and was pronounced dead by [Psychiatrist #1] at 0820 hrs.*

An autopsy was performed by a forensic pathologist, on February 4, 1993, at 12:30 PM. The autopsy report lists Kiefer's diagnoses as:

1) Chronic schizophrenia (by history)

a. Recent exacerbation of schizophrenia (by history)

b. Status post placement of four-point restraints (by history)

c. Multiple superficial blunt force injuries, extremities

2) Bilateral pulmonary congestion

3) Multiple arteriosclerotic cardiovascular disease

a. Mild coronary atherosclerosis

Evidence of injury involving both of Marc Kiefer's arms and legs, consistent with damage from "struggling with and against" leather restraints for a prolonged period of time, was detailed in the report of autopsy. Extensive bruising and abrasions were noted. For example, a wide area of purple-red bruising involving "most of the skin surfaces" of the middle part of the "right lower leg," starting with the knee and extending all the way down to the right ankle, and on to the right foot was documented. The area of this injury was described as "19 inches in overall length" and "up to 3-1/2 inches in maximum width." A number of abrasions, ranging from 1/8 to 3/8 of an inch in diameter, some open and some not, some irregular in shape and some quite precise in shape, were noted on all four extremities, including, but not limited to, multiple areas on Kiefer's legs, ankles, heels and toes, as well as his upper arms, elbows, forearms, and wrists.

Specimens of blood and body tissue were collected and sent to the Institute of Forensic Sciences Toxicology Laboratory in Oakland for further analysis.

The cause of death was listed as "acute exacerbation of chronic paranoid schizophrenia" with "Clomipramine (Anafranil) intoxication" described as an "other significant condition." In commenting on this toxicity, the forensic toxicologist wrote in a letter to the forensic pathologist at the Coroner's Office:

> *In general, like most tricyclic antidepressants, it is felt that a combined peripheral blood concentration of the parent drug (clomipramine) (i.e., Anafranil) and its metabolite (desmethyl-clomipramine) exceeding 1.0 mcg/mL may be fatal. In*

> *Keifer's [sic] case, the peripheral blood showed an elevated clomipramine concentration of 1.46 mcg/mL. Also, a subsequent analysis of the liver determined a significant clomipramine concentration at 31.1 mcg/gm. Given the fact that the blood in this case was collected from a peripheral site, and the blood and liver showed significantly elevated concentrations, I feel that clomipramine may have had a significant contribution in this fatality.*

B. LICENSING INVESTIGATION

Licensing also conducted an investigation of Kiefer's death on February 16, 1993, and issued a statement of deficiency. A medical consultant from Licensing conducted the special incident investigation and determined that EBH had not complied with the nursing service requirements of Title 22, California Code of Regulations (CCR), § 70749(a)(C)(A), concerning the contents of patients' health care records. That regulation requires that Nurses Notes be a concise and accurate record. The deficiency specifies:

> *The patient M.K. #201-81-9 was found without vital signs, cold and stiff at 0730, 2/3/93. The nursing record for restraint and seclusion notes only sleeping during the time from 0200 to 0730 with every 15 minutes checks. The 0630 note does not mention any problems. Stiffness and coldness requires [sic] several hours after death. Concise and accurate record of nursing notes not maintained. (Emphasis added.)*

As the medical consultant for Licensing explained, the agency could not, under existing regulations, find EBH nursing staff deficient for failing to implement resuscitative efforts because when Kiefer was discovered dead, "such efforts would have been futile and thus not clinically indicated as rigor mortis had begun."

VI. EAST BAY HOSPITAL

A. FINDINGS AND CONCLUSIONS

EBH medical staff failed to conduct an adequate admissions evaluation and physical examination.

Marc Kiefer did not receive a proper medical evaluation after being admitted to EBH. Nor was an adequate history obtained, even though Kiefer's parents, his out-patient psychiatrist of over eighteen (18) years, and the Gladman psychiatrist who referred Kiefer for crisis evaluation attempted to convey such information repeatedly. In addition, the physical examination required to be completed within twenty-four (24) hours of admission was deferred in its entirety while Kiefer was in locked seclusion and restraints, suffering from unremitting agitation, visual hallucinations, and increasing confusion and disorientation because Kiefer was "uncooperative."

These omissions violated EBH's policy directives concerning "Admission of a Patient Physician Assessment" which require that:

> *Each patient admitted to the Psychiatric Unit must have a complete physical examination within the first 24 hours after his/her admission, or on the next working day unless otherwise indicated.... The physical examination will include but it not limited to, lab work, dental assessment, a systems overview, sensory and motor development and neurological assessment.*

That same policy says:

> *The attending physician will perform a personal history, family and marital history, work record, mental status examination, psychodynamic appraisal diagnostic evaluation and a description of the patient's behavior and psychological presentation.*

The psychiatrist PAI consulted underscored the importance of obtaining a sufficient history and of conducting an adequate medical assessment, stating: "A fundamental failing was that a good history was not obtained in a timely manner. That coupled with an inadequate medical and neurological assessment made an appropriate course of treatment unlikely." This medical consultant further stated: "EBH assumed or acted as

if the initial assessment and screen for illicit drugs at John George constituted a comprehensive medical and toxicologic evaluation, which it did not."

EBH medical staff failed to identify and respond to a life-threatening medical condition.

As indicated above, an adequate admissions medical screening was not conducted. By the early afternoon of February 2nd, however, the evidence indicates that Kiefer's condition was deteriorating rapidly. According to the psychiatrist PAI consulted:

> *The steady deterioration of Kiefer's condition over a short period of time should have raised serious concerns about potential medical factors and the appropriateness of the course of treatment being implemented. And, unfortunately, East Bay, given the patient's condition of anticholinergic toxicity, chose exactly the wrong course of treatment. Haldol, Thorazine, Benadryl and Cogentin all possess anticholinergic properties and were not safe to prescribe. In addition, Haldol was specifically contraindicated given the fact that it is known to increase the blood level of Anafranil.*

The psychiatric consultant explained: "Although not one symptom alone raised a red flag about the problem of probable drug toxicity or anticholinergic poisoning, the cumulative clinical picture by that afternoon did." According to the consultant, that "cumulative clinical picture" included:

> *The patient's loss of insight and decreased alertness and sudden downhill course; reports of visual hallucinations; falling against the walls on the unit and later falling out of bed while in seclusion and restraint; increasing confusion and disorientation (for example, while in the restraints, thinking 'he was driving a car' and in a 'rowboat'); and, persistent dangerous levels of agitation to the point of breaking his skin from struggling with the restraints.*

Disturbingly, even when Kiefer's treating physician received information critical to Kiefer's care, no appropriate response occurred. For example, at

approximately 9:15 PM on February 2nd, Psychiatrist #1 was informed that Marc Kiefer may have "overdosed" on Artane, an anticholinergic medication, prior to his hospitalization. As pointed out by the psychiatrist PAI consulted: "At this point, [Psychiatrist #1] knew or should have known that Kiefer had been and continued to receive psychiatric medications with anticholinergic properties, and should have taken appropriate action to end this inappropriate course of treatment and to avert a potentially life-threatening medical crisis."

Instead of ensuring that Kiefer was evaluated medically and appropriate lab testing done, at 10:00 PM a medical doctor deferred even the routine admissions physical examination until "pt. cooperative." As pointed out by all of the physicians PAI interviewed, although a complete physical examination may not have been possible at that time, a number of important clinical indicators could have been assessed. The psychiatrist PAI consulted with explained:

> *It is not unusual that a patient is too agitated for a full physical examination. But the physician should do as much as can be done under the circumstances, such as taking vital signs; listening to the heart and lungs and abdomen; assessing the neurological status, by, for example, seeing if the patient's pupils are reactive to light, moving the neck to see if it's supple or stiff and checking gross motor reflexes; as well as feeling and observing the skin to see if it's flushed, wet or dry, cool or warm.*

In addition, according to the "Rules and Regulations" implementing EBH's physician's assessment requirements: "Laboratory tests for patients admitted to the psychiatric service shall be ordered in the best clinical judgement of the attending physician." But, according to the psychiatrist and the forensic toxicologist PAI consulted, no EBH physician responsible for Kiefer's care exercised adequate professional judgment when it came to needed laboratory testing. Both of these consultants emphasized that comprehensive, qualitative laboratory testing for prescribed medications should have occurred by February 2nd. The forensic toxicologist said:

> *For this situation basic laboratory screening was not done. While relying on a screen for three different illicit street drugs may be adequate in certain arrest situations, it is not adequate when you have a psychotic patient who may have been taking illicit as well as prescribed medications that may be causing a medical problem. Simple reliable tests for qualitative compre- hensive toxicological evaluation are readily available and should have been obtained. The results could have been turned around in as little as two hours.*

The initial and ongoing justification for secluding and restraining Kiefer was questionable.

The inattention to basic seclusion and restraint procedures appears to have started prior to 2:15 PM, February 2, 1993, when EBH records indicate that Kiefer was put in seclusion and restraint for "threatening staff and kicking the door to the yard while in w/w [wrist to waist] restraints." EBH records contain no order or justification whatsoever for the imposition of wrist to waist restraints. Nor do EBH records indicate the duration of their use. Such disregard for basic requirements for the imposition of this restraint was then followed by nearly eighteen (18) hours of increasingly inadequate monitoring of Kiefer's condition by nursing and medical staff while Kiefer was in locked seclusion and leather bed restraints.

The evidence does not indicate that Kiefer remained in restraints for the next eighteen (18) hours because he was dangerous and because there was no less restrictive method for providing needed safety or protection. Rather, during the afternoon shift of February 2nd, the evidence suggests strongly that he remained in locked seclusion and leather restraints because he was agitated, incoherent and decompensating, even to the point of falling out of bed. It thus appears that seclusion and restraint were used for the convenience of staff and in lieu of appropriate, less restrictive treatment.

During the night shift, the evidence indicates that Marc Kiefer remained in locked seclusion and restraint not because of any dangerous conduct, but rather because staff failed to assess him for release and failed to assess his physical condition.

EBH nursing staff failed to monitor Kiefer's condition adequately while he was secluded and restrained.

EBH nursing staff repeatedly failed to follow the facility's own monitoring and documentation procedures while Kiefer was in seclusion and restraint. The stated purpose of EBH's Seclusion and Restraint Record is to "ensure that an accurate record of the patient's condition while in seclusion and/or restraints is maintained." According to that policy, nursing staff is required to monitor secluded or restrained persons as follows:

> *... an assessment of circulation (skin condition and color, skin temperature), level of consciousness, interactions and security of restraints. Patients will be monitored for food and fluid intake. Toileting, ROM [range of motion], and repositioning will be provided for every two (2) hours. Vital signs will be taken every four (4) hours. The patient's condition will be assessed by a Registered Nurse at least every four (4) hours.*

On February 2, 1993, throughout the afternoon shift, the Seclusion and Restraint Record indicates that Kiefer's circulation was checked every fifteen (15) minutes, range of motion done only twice, and fluids and food offered. Fluids were documented as taken for a total of 760 cc but the record does not indicate that toileting was offered or whether Kiefer had any urinary output. In addition, no body temperature was taken due to "pts. refusal." Nor is it documented whether Kiefer's skin was flushed, wet or dry, or cool or warm.

The Seclusion and Restraint Record indicates that Kiefer was "agitated" and "confused/incoherent" throughout the entire afternoon shift and that he fell out of bed at 10:45 PM. Nonetheless, R.N. #3 signed off as having "assessed and approved" of the direct care being provided Kiefer during those eight (8) hours pursuant to policy entitled "R.N. Assessment of Patients Secluded or Restrained." This R.N. assessment policy was developed following Licensing's reviews of EBH in 1991 and states that "[t]he Registered Nurse is directly responsible for ensuring the well-being of critically ill patients [undergoing seclusion or restraint]." This policy specifies certain documentation and supervision requirements, including:

> *The Registered Nurse is responsible for reviewing the Restraint and Seclusion record throughout the shift and for episodically verbalizing with the staff member(s) performing more frequent assessments to maintain an awareness of the ongoing condition of the patient in seclusion/restraint.*

There is no indication that Kiefer's treating physician or any physician was called by nursing staff during the afternoon shift to evaluate Kiefer's deteriorating condition, even after he fell out of bed when the number of restraints were reduced and even though he "struggled against the restraints almost constantly to the point of breaking skin in the area around cuffs."

During the night shift, Kiefer did not receive basic nursing care and monitoring, as evidenced by the Seclusion and Restraint Record. Although the mental health worker indicated (by means of check marks) that he assessed Kiefer's circulation every fifteen (15) minutes throughout the night, that is not possible. First, under EBH policy, although not required by law, those observation checks must include an assessment of circulation and color as well as skin temperature, security of restraints, and level of consciousness. Second, it is documented that Kiefer was found dead at 7:47 AM and that rigor mortis had begun. It takes hours, not minutes, for rigor mortis to set in. Thus, it appears that neither the night shift mental health worker nor the R.N. responsible for ensuring Kiefer's "well-being

... during a critical period of care" actually assessed him in person for at least a few hours. During a part of the night (the exact number of hours is unknown) when Kiefer was "observed" as "sleeping," the evidence indicates that he was, in fact, dead.

B. RECOMMENDATIONS

EBH should ensure that all persons admitted to its psychiatric intensive care service receive timely and appropriate medical evaluations.

EBH should improve its policies, procedures, directives, "rules and regulations," and quality assurance mechanisms pertaining to the physician assessment requirements for persons admitted for acute in-patient care so

that medical assessments, including adequate histories and complete physicals as well as appropriate laboratory and other diagnostic studies, are conducted in a timely manner. In Kiefer's situation, it appears that no physician was even identified as the responsible "attending psychiatrist" until the afternoon of February 2, 1993. Procedures and practices must be improved to assure accountability for the overall delivery of medical and psychiatric care from the time the person is admitted until the time the person is discharged.

Special attention should be given to ending the practice of "deferring" physical examinations until an individual is "cooperative." Deferring a physical examination is especially dangerous when a disabled individual's condition is deteriorating while struggling against restraints, as was the situation with Kiefer. Physicians responsible for conducting such examinations should receive specialized training in examining agitated persons undergoing seclusion or restraint.

In addition, EBH should develop appropriate policies and procedures to ensure that confidentiality requirements are not misused, as they were in this situation, to abrogate the responsibility for obtaining an adequate history. Confidentiality requirements, under specified circumstances not evident from the review of Kiefer's death, prohibit treatment staff from disclosing certain private mental health information about the person being treated. Those requirements do not prohibit staff from receiving historical information about the person. EBH should also develop a specific procedure for implementing the patients' consent and notification requirements of WIC § 5328.1. All medical and nursing staff should receive prompt, comprehensive training and education concerning how to carry out their responsibilities of protecting disabled persons' confidentiality while obtaining needed medical histories.

EBH should improve its capacity to identify and respond to potentially life-threatening conditions involving psychosis and agitation.

All medical and psychiatric staff should receive periodic ongoing education and evaluation of their clinical competency concerning the emergency treatment of acute psychosis and agitation. Such education should include the important diagnostic role of timely, comprehensive qualitative

toxicological services when, as was the situation with Kiefer, poisoning or drug toxicity may be causing the person's decompensation.

Toxicological training, education, and policy development for EBH physicians should address: (1) the criteria necessary for the initiation of a comprehensive toxicological evaluation; (2) the importance of obtaining urine samples when a maximum amount of information is needed in a short time frame; and (3) how to interpret results (e.g., the absence of certain drugs or poisons may be as significant as their presence). See, e.g., Bradford, et al., "Role of the Toxicology Laboratory in the Treatment of Acute Poisoning," Concepts in Toxicology Review (1986).

As explained by the forensic toxicologist PAI consulted:

> *The fact that the patient's initial screen for three street drugs was negative should not have ended the inquiry. At least by the time Kiefer continued to deteriorate at East Bay, those previous negative test results should have raised the issue of whether he was toxic on other substances, especially prescribed medications.*

Physician education should focus on reversing the dangerous assumption that a medical (as opposed to "psychiatric") condition is not playing a factor in the decompensation of a mentally disabled person. As emphasized by the psychiatrist PAI consulted, in order to help avoid dangerous misdiagnosis: "In cases of acute psychotic decompensation, it is important to consider medical causes. Medical causes for such decompensation can include everything from drug toxicity to malignancies." According to all of the psychiatrists PAI conferred with, as well as the literature, physician education regarding the emergency treatment of acute psychosis and agitation should increase clinicians' skills to implement a simultaneous three-pronged effort on behalf of the mentally disabled person: (1) ensuring the individual's safety; (2) conducting needed assessments and laboratory testing to determine the cause of the agitation (i.e., in this situation, anticholinergic drug toxicity); and (3) initiating appropriate treatment. See, e.g., Sanders, Kathy M., M.D., "Emergency Treatment of Acute Psychosis and Agitation," Guest Transcript, Practical Reviews in Psychiatry, Volume 17, Number IX, December 1993.

EBH should implement effective strategies to protect individuals from excessive or inappropriate seclusion and restraint.

Compliance with basic seclusion and restraint requirements, such as justifying its initiation and continued use and obtaining proper physician's orders, should be assured. EBH should implement effective strategies so that restraint or seclusion is not used as punishment or, as the evidence indicates it was with Marc Kiefer, for the convenience of staff or as a substitute for a timely and appropriate evaluation and course of treatment.

More vigorous competency-based training should occur on a regular basis. This training should focus on increasing staff's ability to develop and utilize sound de-escalation techniques to meet EBH's stated objective of avoiding the use of seclusion and restraint whenever possible. This training should also emphasize the health and safety risks of seclusion and restraint and the ongoing need to assess persons for release. Such assessment should be an explicit component of each regular 15-minute observation.

Although EBH policy, procedures, and directives should be improved for purposes of clarity, internal consistency and the cross-referencing of staff responsibilities, this alone will not correct the pattern of inattention identified during the inquiry into Kiefer's death. The fundamental principles underlying policies, procedures, and directives pertaining to basic seclusion and restraint requirements must be understood and implemented by responsible staff who view those responsibilities as important and necessary.

EBH management should develop effective oversight and accountability mechanisms to monitor compliance with basic requirements, to identify incidents and patterns of misuse, and to ensure implementation of appropriate remedial measures. Such remedial measures should include effective peer review and more active supervision by management and senior nursing staff. In addition, EBH should make sure that employees who do not carry out their seclusion and restraint responsibilities properly are disciplined and, when appropriate, their conduct referred to appropriate external investigatory and licensing bodies for review.

EBH should immediately ensure that all persons undergoing seclusion or restraint receive proper care and monitoring by qualified medical and nursing staff.

Seclusion or restraint, as recognized under EBH policy, is an intrusive and potentially dangerous intervention. Risks can be ameliorated through close monitoring of the person's condition. Although not required by existing law, EBH should modify its policies, procedures, and directives to state explicitly that required observations by nursing staff must involve face-to-face interaction with the secluded or restrained person on a regular basis. In addition, the role of the R.N. in "assessing" and "approving" the seclusion and restraint of persons should be redirected. The R.N.'s role should involve more active supervision of other staff and bring the R.N.'s clinical expertise to the bedside of the restrained or secluded person where it is needed. Clinical guidelines concerning the R.N.'s role in assessing the person's condition should be specified. Those guidelines should include a review of the person's biophysical condition and needs at least every four (4) hours (e.g., assessment of vital signs, level of consciousness, circulation, overview of intake, output and hydration needs, as well as attention to concerns such as potential adverse medication reactions and, as in Kiefer's case, unreviewed polypharmacy and dangerous levels of unremitting agitation).

All nursing staff should receive periodic ongoing training and education concerning how to identify and respond to at-risk individuals, such as Marc Kiefer. That training and education should focus on the specific dangers of inappropriate or prolonged seclusion and restraint. It should also increase nursing staff's capacity to understand and respond to the increased dangers posed by seclusion or restraint and concomitant adverse medication reactions or toxicity and other conditions, especially agitation.

Under existing EBH policy, it is possible for a person to be secluded or restrained for twenty-four (24) hours before being required to be evaluated medically. EBH policies, procedures, and directives should also be modified to require that all persons undergoing seclusion or restraint be "medically cleared" by a qualified physician immediately before or at the time seclusion or restraint is initiated, or no later than one (1) hour of when these interventions are initiated at the discretion of an R.N. Persons

undergoing seclusion or restraint should be evaluated by a qualified physician at least every eight (8) hours to determine whether the medical risks to the person outweigh the indications for the continued use of seclusion or restraint. Had such an assessment been conducted by a qualified physician while Kiefer was being secluded and restrained, he might still be alive today.