REPORT OF

AN INVESTIGATION INTO THE DEATHS OF CHARLES VAUGHN, SR., ON MAY 19, 1998, AND MARVIN NOBLE, ON JULY 16, 1998

Precipitous Use of 5150 by Mental Health Ends in Shooting Deaths of Disabled Men

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.

PROTECTION & ADVOCACY, INC.
INVESTIGATIONS UNIT

449 15TH STREET
SUITE 401
OAKLAND, CALIFORNIA 94612-2821

PHONE: (510) 839-0811 FAX: (510) 839-5780

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INVESTIGATIONS UNIT STAFF

PAUL B. DURYEA
Senior Investigator — Los Angeles

COLETTE I. HUGHES
Supervising Attorney, Investigations Unit — Oakland

STAFF ACKNOWLEDGMENT

REGINA J. KENDRICKS
Office Manager — Oakland
Editing and Production

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I. INTRODUCTION

This report presents Protection & Advocacy, Inc.'s (PAI's) investigation into the tragic shooting deaths of Charles Vaughn, Sr. and Marvin Nobel — two men with psychiatric disabilities who were long-time clients of the local mental health system at the time of their deaths. Both were shot dead by local law enforcement after mental health staff summoned the police to involuntarily transport the men for psychiatric evaluation pursuant to California Welfare & Institutions Code Section 5150. In both situations, the use of deadly force was investigated by other appropriate entities and was found to be justified under the circumstances. Consequently, no criminal action has been brought against law enforcement personnel.

PAI did not reinvestigate whether local law enforcement personnel were justified in using deadly force, but focused its investigation on the events leading up to the shootings and whether local mental health and law enforcement staff acted within acceptable community standards for the involuntary detention of people with psychiatric disabilities. The basis for detention under Section 5150 is probable cause to believe that the person, as a result of a psychiatric disability, is dangerous to self or others, or is gravely disabled (i.e., unable to provide for food, clothing or shelter). Probable cause must be based on reasonable belief that the person meets the criteria for detention, and must be supported by specific and articulable facts. The evidence gathered during PAI's investigation did not substantiate that mental health staff had sufficient credible information to support the contention that Mr. Vaughn met the criteria for detention under Section 5150. Nor does the evidence show that either man presented an objective or quantifiable threat of danger warranting intervention by law enforcement at the time mental health staff sought the assistance of police. Mr. Vaughn was in his apartment refusing treatment, but doing nothing dangerous; and Mr. Noble was in a restaurant drinking a beverage.

PAI's investigation found that mental health and law enforcement personnel acted precipitously and without adequate regard for their respective responsibilities under Section 5150. In both situations, the intervention by mental health and law enforcement personnel helped to create the circumstances resulting in these two deaths. The objective of this report is to prevent similar, unnecessary deaths from occurring in the future.

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

II. EXECUTIVE SUMMARY

Every year, approximately 100,000 Californians are involuntarily detained for psychiatric evaluation and treatment under the state's 72-hour civil commitment statute[1] — namely, California Welfare & Institutions Code Section 5150. A substantial number of these individuals are taken to local psychiatric facilities by the police, at the request of local mental health authorities.

At times, local mental health staff and the police work together as an interdisciplinary team. Mental health staff address the mental health crisis needs of the individual and the police act as back up, in response to an identifiable and quantifiable threat of violence. In a number of counties, specialized interdisciplinary psychiatric emergency teams — comprised of mental health professionals and highly trained, non-uniformed law enforcement personnel — have the primary responsibility for taking people to the local psychiatric facility for evaluation under Section 5150. In other counties, crisis intervention emergency teams — comprised of highly specialized law enforcement personnel who have undergone in-depth, comprehensive training concerning how to effectively manage mental health crises — are primarily responsible for involuntarily transporting people with psychiatric disabilities to local treatment facilities for evaluation under Section 5150. In cities and counties where specialized teams such as these exist, the use of force has decreased.[2]

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[1] Source: "Summary of Involuntary Detentions." California Department of Mental Health. 1998.

[2] Ten years ago, the Memphis Police Department recruited qualified and experienced officers to join special crisis intervention teams. These hand-picked teams underwent intensive training concerning how to respond to people with psychiatric disabilities who are in crisis. As of November 9, 1999, it was reported that Memphis has not had one fatal shooting of a person with a psychiatric disability since the formation of those specialized teams. Injuries to officers have also dropped dramatically, as the officers use effective verbal skills instead of force. Similar crisis intervention teams have been created by law enforcement in San Jose and San Diego,

Unfortunately, many jurisdictions do not have specialized emergency teams; and, all too often, the respective roles and responsibilities of mental health and law enforcement personnel become blurred, and expedience becomes the controlling imperative. When people with psychiatric disabilities experience the consequence of such expedient action, they usually talk about it in terms of a lack of community crisis services; the rupture of trust between them and the mental health professional; or the unnecessary humiliation of being picked up by the police in spite of the fact that they had done nothing wrong nor presented a danger to anyone. However, the deaths of Charles Vaughn, Sr. on May 19, 1998 in Seaside, California, and Marvin Noble on July 16, 1998 in Ukiah, California, demonstrate that far more is at stake when police become involved in the 5150 process. Both men were shot dead by local law enforcement after responding to mental health staff's request for assistance in hospitalizing the men pursuant to Section 5150.

PAI investigated the deaths of these two men to determine what reforms, if any, should be implemented to prevent future deaths of people with psychiatric disabilities during the 5150 process.

PAI investigators found that the following factors contributed to the deaths of Mr. Vaughn and Mr. Noble.

> Inadequate training of police and mental health staff concerning how to interact with and assist people with psychiatric disabilities who are in crisis, and how to de-escalate potentially dangerous situations.

California, and have likewise produced a dramatic reduction in the use of force upon people with psychiatric disabilities and a decrease in injuries to officers.

> Absence of interagency policy and procedures specifying when, how, and under what circumstances law enforcement and mental health personnel should collaborate during the 5150 process.

PAI investigators note that the above deficits are not unique to Monterey or Mendocino Counties and warrant reforms throughout the state. PAI recommends that, in every instance, mental health staff consider that involving the police in the involuntary hospitalization process may have an adverse effect on the person with the disability and may increase the risk of confrontation and the use of force, especially when uniformed officers arrive in marked cars. Policy and procedure should specify that local mental health personnel call the police for assistance only when a real threat of harm exists and all reasonable alternatives have been exhausted.

Further, as a minimum requirement in every community, interagency 5150 policy and procedure should require that mental health staff retain control over crisis treatment issues and local law enforcement take charge only when necessary for the physical safety of the person with a disability or others. Law enforcement and mental health personnel should receive in-depth training concerning how to interact with people with psychiatric disabilities who are in crisis. Such training should focus on how to de-escalate potentially violent situations and pursue all reasonable alternatives so that force is only used as a last resort when no further options exist and it is necessary for the safety of the person with the disability or others.

More unnecessary deaths of people with psychiatric disabilities are sure to follow unless effective crisis management protocol is implemented on a state-wide basis by well-trained mental health and law enforcement professionals.

III. BACKGROUND

A. CHARLES VAUGHN, SR.

Charles Vaughn, Sr. was 60 years old when he was shot dead by members of the Seaside Police Department on May 19, 1998. He was 6'2" and weighed approximately 240 pounds. He is survived by two daughters, a son, and two ex-wives. The deadly confrontation ensued after the Seaside police arrived at Mr. Vaughn's apartment to help Monterey County Department of Mental Health (Monterey County Mental Health) staff hospitalize him involuntarily pursuant to Section 5150.

Charles Vaughn, Sr. was born April 6, 1938 in Shelbyville, Indiana. He served in the United States Army at Fort Ord near Seaside, California, from 1958 to 1962. He received an Associate of Arts degree from Monterey Peninsula College, a Bachelor's degree from the University of Santa Cruz, and a Master's degree from the Monterey Institute of International Studies. He continued his study towards a Doctorate degree in education administration.

While at Monterey Peninsula College, Mr. Vaughn played football, earned All- American honors, and was accepted into the college's African-American Hall of Fame. Mr. Vaughn was also a leader of various community groups, teaching associations, and civil rights organizations. He was also a volunteer mentor for community youth — an activity he cherished until the day he died.

At the time of his death in May 1998, Mr. Vaughn was living independently in an apartment and receiving outpatient mental health services from Monterey County Mental Health. As a client of this program, Mr. Vaughn received case-management and medication monitoring services. He was prescribed 10 mg. of Olanzapine (an antipsychotic medication) on a routine basis. Local mental health staff knew Mr. Vaughn well, as he had received inpatient and outpatient services

from them since the 1980's. Local law enforcement also knew Mr. Vaughn, as he had been stopped and questioned by them on a number of occasions.

B. MARVIN NOBLE

Marvin Noble, a 45-year-old man with a psychiatric disability, was shot dead by Ukiah police officers in the hallway of his apartment building on July 16, 1998. The lethal confrontation ensued after Ukiah police attempted to 5150 Mr. Noble to the local psychiatric facility, at the direction of local mental health staff.

Mr. Noble graduated from high school and served honorably in the United States Navy. He was 5'10" and weighed approximately 310 pounds. He was married twice and is survived by two children. In March 1981, Mr. Noble was found not guilty by reason of insanity for false imprisonment of his wife and two children, and for harboring a firearm during commission of the crime. Mr. Noble was not arrested or convicted of any other crime following that incident. Mr. Noble lived independently in an apartment from November 8, 1989 until the day of his death in July 1998, and would often be seen walking around downtown Ukiah or meeting with his fellow "regulars" at the local Foster Freeze.

Mr. Noble received mental health services through the Conditional Release Program (CONREP), an involuntary outpatient mental health program for people with psychiatric disabilities who enter the program through the criminal justice system. As a condition of his CONREP outpatient status, Mr. Noble was required to take monthly injections of Haldol (an antipsychotic medication) and keep all of his appointments, to the satisfaction of the treatment supervisor. By July 16, 1998, Mr. Noble had missed one group therapy appointment and was two days late for his injection.

Instead of exercising other options, such as further negotiations with Mr. Noble, mental health staff instructed the local police to pick up Mr. Noble and take him to the local psychiatric facility against his will. Although the issue of Mr. Noble's failure to comply with outpatient treatment requirements was clearly within mental health staff's scope of responsibility, CONREP program staff did not accompany the police.

IV. CASE LAW/STATUTES

A. WELFARE & INSTITUTIONS CODE SECTION 5150 — 72-HOUR INVOLUNTARY HOSPITALIZATION

Mr. Vaughn and Mr. Noble were both killed during confrontations with local police officers who were attempting to involuntarily transport them to a psychiatric facility for evaluation pursuant to Section 5150. In both situations, the police acted on the request of mental health staff who represented that the men were dangerous and met the criteria for involuntary detention.

Under Section 5150, peace officers and other professionals designated by the county are authorized to initiate an involuntary 72-hour hold of a person, for psychiatric evaluation and treatment, when there is probable cause to believe that the individual is gravely disabled or is a danger to self or others as a result of a mental disorder. The statutory scheme does not define probable cause. However, California's First District Appellate Court articulated the following legal standard for what constitutes probable cause to detain an individual for psychiatric hospitalization.

> *To constitute probable cause to detain a person pursuant to Section 5150, a state of facts must be known to the peace officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to himself or herself or is gravely disabled. In justifying the particular intrusion, the officer must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant his or her belief or suspicion.*

People v. Triplett, 144 Cal.App.3d 283, 287-288, 192 Cal.Rptr. 537, 550-551 (1983) (citations omitted).

Although probable cause must be determined on the basis of facts and circumstances at the time of detention, the past conduct, character, and reputation

ofcthe person being detained may also be considered. See Triplett at 288. Subsequent to Tripplett, California courts have not clearly stated whether an officer must make an independent assessment of the current behavior of the person being detained nor specified how much reliance a police officer should be allowed to place on information obtained from others.

Thus, while it was not improper for the officers involved in these shootings to rely on mental health staff's representations concerning Mr. Vaughn's and Mr. Noble's purported past conduct, character or reputation for violence, the officers were required to decide if both men met the criteria for involuntary detention; and such belief had to be supported by specific and identifiable facts. Here, the evidence does not indicate that the police officers involved in these two incidents made their own determination based on specific and articulable facts. In fact, the evidence indicates that the officers involved in the Vaughn matter totally deferred to the judgment of mental health staff on the issue of whether Mr. Vaughn met the criteria for detention. This was inappropriate.[3]

While the parameters of probable cause can be difficult to define, it is clear that the police involved in these shootings did have the power and discretion to

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[3] In both circumstances, mental health staff filled out the 5150 Application for involuntary detention. In the Vaughn matter, a Seaside police officer co-signed the Application, but it appears this was done prior to any contact with Mr. Vaughn. In the Noble matter, mental health staff also filled out the 5150 Application specifying the reasons to detain Mr. Noble. In this circumstance, the police officers acted based on telephone representations only, as mental health staff did not accompany the police or forward the document to the police before they proceeded to find Mr. Noble. As the police officers involved in both incidents declined to be interviewed, further evidence on the issue of the officers' beliefs concerning probable cause could not be obtained.

independently assess the circumstances and determine that they did not have sufficient probable cause to justify the intrusion.

B. PENAL CODE SECTION 1610 — CONFINEMENT PENDING DECISION ON REVOCATION

It was inappropriate for mental health staff to attempt to force treatment upon Mr. Noble through the civil commitment process. If mental health staff wanted to enforce Mr. Noble's compliance with outpatient treatment requirements, they should have proceeded under the authority of applicable Penal Code provisions — not Section 5150.

If an imminent risk of harm existed, and Conditional Release Program (CONREP) staff believed that Mr. Noble required instant hospitalization, he should have been involuntarily hospitalized pursuant to California Penal Code Section 1610, which reads, in part:

> *Upon the filing of a request for revocation . . . and pending the court's decision on revocation, the person subject to revocation may be confined in a facility designated by the community program director when it is the opinion of that director that the person will now be a danger to self or to another while on outpatient status and that to delay confinement until the revocation hearing would pose an imminent risk of harm to the person or to another.*

C. PENAL CODE SECTION 1608 — REQUEST FOR REVOCATION OF OUTPATIENT STATUS

California Penal Code Section 1608 is the proper authority to seek extended, involuntary inpatient hospitalization for a person, like Mr. Noble, who is a patient in the CONREP program. Section 1608 reads, in part:

> *If at any time during the outpatient period, the outpatient treatment supervisor is of the opinion that the person requires extended*

> *inpatient treatment or refuses to accept further outpatient treatment and supervision, the community program director shall notify the superior court . . . of such opinion by means of a written request for revocation of outpatient status.*

In fact, it was under the above provisions that staff hospitalized Mr. Noble in the past when he occasionally refused to comply with outpatient treatment requirements. Moreover, an extension hearing on Mr. Noble's outpatient status was scheduled for July 17, 1998 — one day after mental health staff had him 5150'd by the police. Even though Mr. Noble had waived his right to appear, the issue of his recent noncompliance with outpatient treatment requirements could have been brought before the court at that time.

D. PEACE OFFICER TRAINING

Section 13519.2 of the California Penal Code was enacted in 1988 and requires the Commission on Peace Officer Standards and Training to include in the basic training course for law enforcement officers "adequate instruction in the handling of persons with developmental disabilities or mental illness, or both." The statute also requires that the course include "information on the cause and nature of developmental disabilities and mental illness, as well as community resources avail- able to serve these persons." This statute specifies the only mandatory training for police officers regarding how to interact with people who have psychiatric disabilities; and the training is only about four hours long.

Although such training is readily available, PAI could find no indication that Seaside or Ukiah police officers received additional training concerning how to assist people with psychiatric disabilities who are in crises, other than that provided at the academy. Furthermore, at the time of Mr. Vaughn's and Mr. Noble's death, neither Monterey nor Mendocino County had protocols in place to address the

interaction of mental health and law enforcement personnel during the 5150 process.

Legislation is now pending which would provide for in-depth training of law enforcement officers regarding effective methods for interacting with people with psychiatric disabilities, as part of a model project in various locations throughout the state. Assembly Bill 1762 (Villaraigosa).[4] AB 1718 (Hertzberg) would require every city police officer or deputy sheriff to complete, every four years, an advanced course concerning how to interact with people with psychiatric disabilities. These Assembly Bills do not, however, set forth specific training requirements concerning the role of law enforcement in carrying out their

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[4] AB 1762 makes a number of legislative findings and declarations concerning the need for more intensive training of peace officers regarding how to interact with people with psychiatric disabilities, including:

(a) Approximately 40 percent of persons suffering from serious mental illness will be arrested at least once during their lifetimes.

It is imperative that progressive law enforcement agencies assume the responsibility of evaluating situations, recognizing mental illness and the need for treatment and ensuring that the mentally ill person receives the proper treatment resources.

(b) Lawsuits regarding excessive force and related community reaction are significant concerns for local law enforcement agencies, and traditional police methods, misinformation, and lack of sensitivity can cause frustration for both the mentally ill and their families as well as for law enforcement. Peace officers responding to calls involving the mentally ill may be faced with a lack of knowledge about mental illness, resulting in a fear of the unknown, and an increase in the likelihood of physical confrontation.

The Bill specifies the following goals relevant to the issues presented by the deaths of Mr. Vaughn and Mr. Noble:

- Reduce the number of mentally ill persons in custody.
- Decrease the number of mentally ill persons placed into emergency commitment custody.
- Provide better training and education for law enforcement officers and dispatchers regarding mental illness.
- Decrease the use of force during crisis events involving the mentally ill.
- Reduce the number of injuries to both the mentally ill and to law enforcement officers.
- Improve interaction between law enforcement agencies and mental health service providers.

responsibilities pursuant to Section 5150. Nor is there comparable legislation pending which would require advanced crisis management training for mental health professionals.

V. SEQUENCE OF EVENTS

A. OVERVIEW

Both Mr. Vaughn and Mr. Noble had a history of occasionally going off their medications, which was addressed by mental health staff's gaining medication compliance through support and negotiation. On rare occasions prior to their deaths, both men had been hospitalized involuntarily, with and without the assistance of police, but never through the threat or use of extreme force.

PAI found no credible evidence known to mental health staff to support the contention that Mr. Vaughn or Mr. Noble was dangerous at the time that mental health staff called the police. Mr. Vaughn was in his own apartment, apparently in good health, and doing nothing wrong; and Mr. Noble was sitting quietly in a restaurant drinking a beverage, waiting for his food. Clearly, when the Seaside and Ukiah police were first called by mental health staff, no objective or quantifiable threat of harm existed to warrant the intervention of law enforcement.

The evidence does establish that mental health staff was determined to involuntarily hospitalize Mr. Vaughn and Mr. Noble with the assistance of law enforcement. In both situations, it is evident that the overwhelming reason for involuntary hospitalization was the refusal of treatment. This is a mental health matter, not one for law enforcement. Instead of working with Mr. Vaughn and Mr. Noble to address their recent refusal of medication, mental health staff chose the most expedient and potentially dangerous course available to them — calling the police. Unfortunately, in both situations, the evidence does not indicate that the police intervened after making their own probable cause assessment. For both Mr. Vaughn and Mr. Noble, the actions of mental health and law enforcement personnel served only to escalate what should have been a relatively routine mental health situation into an out-of-control, dangerous confrontation with police.

B. VAUGHN: IMMEDIATE DEATH EVENTS

At approximately 9:30 AM on May 19, 1998, two social workers from Monterey County Mental Health contacted Mr. Vaughn at his apartment in Seaside, California, in an attempt to involuntarily hospitalize him under the authority of Section 5150. Mr. Vaughn told them that he no longer required their services and did not want to continue with his medication. One social worker responded "OK," and Mr. Vaughn shut the door. The social workers then contacted the police for assistance; and the police responded. The officers knocked on Mr. Vaughn's door and, again, he refused the services of the social workers. Mr. Vaughn then exited his apartment through a rear bathroom window and went to the roof of the one-story apartment building. According to the officers involved and subsequent investigations that were conducted, Mr. Vaughn had a metal wine-bottle corkscrew in his hand. One officer went onto the roof, attempted to talk with Mr. Vaughn, and sprayed him with pepper spray. When Mr. Vaughn quickly moved towards the officer on the roof, two other officers fearing for the safety of the officer on the roof fired their weapons, striking Mr. Vaughn four times and killing him.

C. VAUGHN: SEQUENCE OF EVENTS

As a client of Monterey County Mental Health, Mr. Vaughn was visited regularly by case management staff. However, by mid-April 1998, the relationship between Mr. Vaughn and mental health staff had become somewhat strained. By May 1998, mental health staff found it increasingly more difficult to find Mr. Vaughn so they could visit with him and see how he was doing. Consequently, they grew concerned about Mr. Vaughn's well-being.

During May 1998, mental health workers received phone calls from friends and relatives who were also concerned about Mr. Vaughn's well-being. In response, mental health staff made numerous attempts to see Mr. Vaughn at his home and in the community, but, for the most part, staff was not successful. Throughout this same time period, as was his routine, Mr. Vaughn regularly visited with a good friend, who is also a mental health professional.[5] Monterey County mental health staff knew of Mr. Vaughn's close relationship with this friend/mental health professional, and had talked to this friend many times in the past regarding Mr. Vaughn's mental and physical health. Mental health staff also knew how to contact this friend, both at home and at work, and knew he could be called upon at any time to assist with Mr. Vaughn; but they failed to call him. PAI investigators found no evidence to explain why mental health staff did not enlist the help of available friends and family members, as had been done in the past.

Actions by Monterey County Mental Health

On April 2, 1998, mental health staff met with Mr. Vaughn at his apartment. The door was open and a female friend was visiting. Mr. Vaughn informed mental health staff that he would not be at his medical appointment because he had plans with his girlfriend who was visiting with him at the time. When mental health staff began questioning Mr. Vaughn regarding whether or not he was taking his psychiatric medication, Mr. Vaughn got offended and told them that they did not have the right to ask such questions.

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[5] Mr. Vaughn's friend is a Master's level social worker who, since 1987, has focused on providing services to people with psychiatric disabilities. This friend has also worked as a psychiatric social worker and director of a short-term mental health crisis intervention program.

On April 3, 1998, mental health staff conducted another in-person visit with Mr. Vaughn, at which time he again refused to talk to them about taking his medication.

The records do not document any activities by mental health staff from April 4th through-April 21st, 1998.

On April 22, 1998, the case manager visited Mr. Vaughn at his home. According to the records, Mr. Vaughn said he would be present at his next doctor's appointment. The records indicate that the next time mental health staff saw Mr. Vaughn at his home was on the day he died.

On April 23, 1998, mental health staff saw Mr. Vaughn at a McDonald's restaurant in Seaside and talked with him. Mr. Vaughn stated that he was not going to see the doctor and did not want to discuss medication compliance or symptoms management issues with mental health staff.

On May 5, 1998, a Monterey County mental health supervisor noted that Mr. Vaughn could soon meet the criteria for involuntary detention, indicating:

> *Treatment planning discussed [with] case manager in light of ct's [client's] recent [increase] in Sx [symptoms] which is impairing his stability & ability to maintain independent living. May meet 5150 criteria soon as gravely disabled. Plan: Supervisor to accompany on H.V. [home visit]. (Emphasis added.)*

It should be noted that from May 5, 1998 until the date of Mr. Vaughn's death on May 19, 1998, mental health staff's activities focused on getting Mr. Vaughn to take his medication, as prescribed, or having him involuntarily committed. No documentation was found to suggest that alternatives to hospitalization were discussed with Mr. Vaughn. Consequently, it is unknown

whether Mr. Vaughn would have responded favorably to the offer of community mental health services (such as support and counseling) if the conversations with mental health staff had involved something other than psychotropic medication compliance and hospitalization. An example of other appropriate topics for discussion would have included Mr. Vaughn's physical health (e.g., his heart condition for which he received treatment), relationships with family members, and mentoring activities with young people in the community.

On May 6, 1998, Mr. Vaughn was seen by mental health staff at a local community care facility. Again, the focus was whether Mr. Vaughn met the criteria for involuntary commitment. Mental health staff documented Mr. Vaughn's psychiatric condition and noted that he did not meet the criteria for involuntary hospitalization.

Ct. [client] maintained organized fluent speech when engaged, exhibiting some grandiose & paranoid delusional thought content in response to direct confrontation that he is decompensating. Ct. told . . . to stop 'checking on' him describing her as intrusive, denying any reason for 'the county' to be concerned. States he is taking '5 mg' of Olanzapine only; was advised to resume therapeutic doses to avoid hospitalization. Agitated moderately — 0 aggressive behavior. 0 grounds for 5150 detention. Appropriately dressed & able to identify plans for shelter & food. Plan: Assess status [everyday] to monitor for ability to care for self safely.

The May 6, 1998 notes do not document any attempted conversation between Mr. Vaughn and mental health staff as to why he was not taking his psychiatric medication, as prescribed, or how he was doing in other areas of his life.

On May 7, 1998, it was noted that Mr. Vaughn was no longer welcomed at the local community care facility because of his pursuance of a female resident who did not want his attention. Mental health staff documented that there were no reports of Mr. Vaughn's being an "imminent danger to self or others — question of grave disability to be further assessed when cl [client] can be located." It was also noted that mental health staff would "facilitate visit w/cl and discuss relationship if appropriate." This discussion never occurred.

On May 8, 1998, mental health staff went to see Mr. Vaughn at his apartment, but he was not there. Mental health staff also looked for Mr. Vaughn at other local spots he frequented, but could not find him. Family members called mental health staff with concerns regarding Mr. Vaughn's well-being. Although those concerns were noted, no assistance from available family members or friends was sought to address those concerns. The focus continued to remain on finding Mr. Vaughn so that he could be involuntarily hospitalized. PAI could find no documentary evidence to explain why the assistance of family members or friends was not obtained at that time; and no information was obtained during interviews with PAI investigators which would suggest that any barriers to such communication existed at that time.

The May 11, 1998 Progress Record indicates that Mr. Vaughn reportedly had been seen at a bus stop outside a McDonald's he frequented, and was talking strangely and seemed confused.

On May 12, 1998, mental health staff checked locations in the community that were suggested by family members, as well as places that Mr. Vaughn often frequented, but could not find him. Eventually, mental health staff saw Mr. Vaughn at the local community care facility and talked with him. During this

conversation, Mr. Vaughn denied having any suicidal thoughts and did not want to go to the hospital. Mental health staff then tried to have Mr. Vaughn 5150'd by requesting the Monterey Police Department to pick up and transport Mr. Vaughn to the psychiatric hospital. The Watch Commander assessed the situation and declined to assist. While mental health staff was enlisting the assistance of law enforcement, Mr. Vaughn boarded a bus and left.

The Monterey County mental health unit supervisor had filled out an Application for 72-Hour Detention for Evaluation and Treatment (the Application), which was subsequently voided when Monterey Police Department personnel did not assist mental health staff in involuntarily hospitalizing Mr. Vaughn. The Application reads, in part:

> *Numerous calls from relatives, friends & interim staff to report bizarre delusional behaviors. Landlord reports ct. [client] has not paid full rent, has 0 food in refrigerator & is disturbing other residents [with] loud music. Refusing meds x 2 [weeks].*
>
> *Ct. grossly psychotic. States he is 'going to God' & is saying his 'last goodbyes to everyone.' States, 'I cannot tell you' how his life will be ended, yet states 'the government will do it.' Tearful.*

On the Application, the boxes "A danger to himself/herself "and "Gravely disabled adult" are checked. The entire form is X'd out, and the words "unable to implement" are written on the face of the form. The form is dated May 12, 1998, at 4:40 PM.

Some of the information in the Application does not appear to be accurate. For example, the statement that Mr. Vaughn had been refusing medication for two weeks is not substantiated by the evidence. The best available evidence indicates

only that (since May 6, 1998) Mr. Vaughn did not take the Olanzapine, as prescribed — he was taking 5 mg. instead of 10 mg.

On May 13, 1998, mental health staff again attempted to reach Mr. Vaughn at his apartment as well as at various locations that he frequented, but were unable to find him. The Progress Record for that date indicates that when Mr. Vaughn was last seen, or there were reports of him, he was extremely paranoid. It also refers to a conflict at a local community care facility — apparently, referring to the fact that Mr. Vaughn was asked not to visit another resident there.

The case manager also documented that she had spoken with Mr. Vaughn's apartment manager, who said she had not seen Mr. Vaughn recently, but that the last time she had seen him, he was talking strangely, was confused, had a lack of concentration, and was delusional. There is no information regarding what the apartment manager meant by the word "recently." In addition, it was not unusual for people to think that Mr. Vaughn talked strangely or was delusional, as those were symptoms of his psychiatric disability. Mental health staff noted that the plans "are to seek help for [client] at hospital or CH [crisis house] to encourage [client] to take his meds." The Progress Record also documents that: "Client has refused meds two [weeks] now since he first said he doesn't need meds are not taking them."

On May 14, 1998, the case manager again tried to reach Mr. Vaughn at home, but there was no answer, so she left her business card. It is also documented that on May 14th, Mr. Vaughn was seen at the community care facility with a resident that he had a personal relationship with, and that a staff member had expressed concerns about Mr. Vaughn. Although the specifics of those concerns

are not delineated, the case manager was "encouraged to seek and find [client] to 5150 for safety and to get stable."

On May 15, 1998, mental health staff sought to locate Mr. Vaughn again, but was unsuccessful. And, again, the case manager left her card on Mr. Vaughn's apartment door, but did not receive a call from him.

All during this time in May 1998, when mental health staff were attempting to find Mr. Vaughn to have him evaluated on an involuntary basis, he was visiting with his friend/mental health professional at least three times a week. Sadly, it appears that Monterey County mental health staff did not know this, as the assistance of Mr. Vaughn's friend was never elicited as had been done in the past. In fact, Mr. Vaughn's friend visited with him in the community for at least one-half hour on May 17, 1998 — just two days before Mr. Vaughn's death — and obtained no information or observed any unusual behavior which indicated that Mr. Vaughn met the criteria for 5150. During interviews with PAI investigators, Mr. Vaughn's friend/mental health professional stated that Mr. Vaughn was lucid and very much himself during this final conversation between them, and that Mr. Vaughn had never been suicidal and certainly gave no signs of being so at that time.

On May 18, 1998, community care housing staff called the Monterey County mental health unit supervisor and confirmed that they had not seen Mr. Vaughn since May 12th.

On May 19, 1998, there was another home visit to Mr. Vaughn's apartment. This time, Mr. Vaughn was at home and he asked the Mental Health workers to go away. One of the mental health workers said "OK," but instead of leaving, they

drove around the block and telephoned the police. Again, none of Mr. Vaughn's family members or friends were contacted, not even the close friend/mental health professional who lived nearby and had worked with Mr. Vaughn successfully in the past to address concerns expressed by Monterey County Mental Health.

Confrontation with Police

The Progress Record documents how mental health staff obtained the assistance of law enforcement:

> *H.V. [home visit] to see cl [client]. Checked several sights first for cl. . . . When at cl's home, I knocked on door. Cl answered after several knocks and I identified who I was. Cl said just a minute. Cl opened door and stated I don't need your services. I have told you I don't want your help. I don't want to take meds. I'm alright. I responded OK, and he shut the door. I drove around the corner where cl couldn't see me. I parked and called ambulance co. and 911 for police backup on car phone. Ambulance said 15 minutes. 911 couldn't hear call, went across the street and called 911 on pay phone. Called 911 for Seaside City . . . dispatcher for 5150 support backup. Waited for Coast Ambulance and police. Seaside Police arrived first; after about 15 mins. they left, said to call, they would be in area. Only 2 officers on duty they said. Ambulance called again, they arrived 10 minutes later.*

Monterey County Mental Health records also document the confrontation between Mr. Vaughn and the police, including the second visit to the scene and the final minutes preceding the fatal shooting.

> *After a total of 38-40 mins. wait police arrived after 2nd TC [telephone call]. Police knocked on cl's door, asked cl to come out, 'we want to help' I said. Cl responded 'no, I won't' come out — Police officers and [case manager] tried to ask cl and encourage cl*

> *to come out and get in vehicle. Cl refused, cl climbed out of back door and went up on roof.*
>
> *Cl up on roof with metal corkscrew in his hand. 2-3 police tried to get cl down. He refuse[d] to come down. Said: come get me, I'm with the FBI. You . . . know I'm w/FBI. Cl continued for 15- 25 minutes refusing to come down. Police sprayed cl w/pepper spray, after several minutes and several times. Cl stopped and rested at certain points. Police continued to ask cl to come down off roof.*
>
> *. . . [O]fficer got on roof and seriously tried to get cl to cooperate. Cl walked toward officer after a few minutes and still had metal corkscrew in his hand. Officer on lower level shot cl.*
>
> *Cl was shot 4-5 times w/gun. Shots didn't seem to penetrate deeply but not certain. Cl fell to floor, on roof. Officer tried to apprehend and cuff cl. He resisted and was finally cuffed. CM [case manager] supported cl verbally. Officers tried to support and not harm cl any further. Ambulance crew came up on roof to assist in care of cl. There was blood. Cl's clothing was cut and removed enough to give medical treatment to cl. Cl was treated for 20-40 minutes before being transferred to ambulance and taken to Community Hospital.*

The Application, which was used to justify the assistance of law enforcement to get Mr. Vaughn involuntarily committed from his home, reads, in part:

> *Numerous calls from family members and friends. Cl's apt manager noticed no food in apt, plumbing backed up & overflowed for days, rent not paid in full. Refuse meds.*
>
> *Cl grossly psychotic. Statements about going to God. 'I don't want to be bothered. I don't want your services or help.' Couldn't tell how he was going to God. Unable to take care of basic needs, food, clothing, shelter. Jeopardy of losing a [patient].*[6]

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[6] The statement "[j]eopardy of losing a [patient]" raises a question as to whether this or preceding statements contained in the Application, and used to justify the 5150, were written post-mortem. The possibility of making such a predictive statement just prior to Mr. Vaughn's

On the Application, the boxes "A danger to himself/herself" and "Gravely disabled adult" are checked. The Application is dated May 19, 1998, at 9:30 AM, and was signed by a Monterey County mental health staff member. It was co-signed by an officer from the Seaside Police Department prior to that officer's having any contact with Mr. Vaughn that morning. Mental health staff also tried to get ambulance staff to sign the Application; however, that request was refused, as ambulance staff do not have 5150 authority.

While it is clear that on May 19, 1998 Mr. Vaughn did not want mental health services, the evidence does not indicate why mental health staff deemed it urgent that Mr. Vaughn be hospitalized on that day, or why it was necessary to call the police, or why family members or friends were not contacted. A rational inference to be drawn from the facts and circumstances is that all of the efforts, energy and frustration involved in monitoring Mr. Vaughn's well-being during May 1998 culminated in a strong subjective feeling on the part of mental health staff that it was important and necessary to hospitalize Mr. Vaughn as soon as the opportunity presented itself. If this inference is correct, it underscores that such important decisions should be based solely on the clinician's objective assessment regarding the needs of the client, and not based on subjective feelings.

Following Mr. Vaughn's death, the Monterey County District Attorney conducted an investigation to determine whether the shooting was justified. In conducting that investigation, police officers were interviewed at the scene about

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death was quite unlikely, as neither Monterey County Mental Health nor law enforcement had significant or weighty evidence which signaled an imminent lethal risk of suicide. And, certainly, no one at the scene on May 19, 1998 anticipated the confrontation with police that would end in Mr. Vaughn's death. As mental health and law enforcement personnel declined to be interviewed, PAI investigators did not have the opportunity to clarify this issue.

their interaction with mental health staff; and those interviews were taped and transcribed. A review of those post-mortem interviews offers some insight regarding the state of mind of the officers prior to the shooting, their interpretation of information obtained from mental health staff, as well as their past contacts with Mr. Vaughn.The statements reveal the following:

That law enforcement knew of Mr. Vaughn.

That law enforcement knew Mr. Vaughn had a psychiatric disability and a history of inpatient hospitalizations and contacts with police.

That law enforcement believed, based on information from Monterey County Mental Health, that Mr. Vaughn was either becoming combative or was combative at the time they were dispatched to the scene.

That the officers were afraid of Mr. Vaughn because of his large size and past contacts, as well as rumored contacts with police.

That the officers were on a heightened sense of awareness.

That the officers assumed that because Monterey County Mental Health had requested backup for a 5150, that Mr. Vaughn met the criteria for a 5150.

That Mr. Vaughn was thought to be delusional and a danger to himself and others.

That the officers expected resistance and trouble from Mr. Vaughn and believed he had been violent in the past.

Despite all of the above information and concerns about safety, effective tactics were not implemented to address those concerns.

According to Seaside Police Department records, on May 19, 1998, at 10:28 AM, the officers arrived at Mr. Vaughn's apartment for the second time that morning. At 10:50 AM that morning, Mr. Vaughn was shot dead — a total of only 22 minutes between the arrival of police officers and the actual shooting and

subsequent death of Mr. Charles Vaughn, Sr. A basic tenet of crisis management is to slow down the pace of events so that appropriate action can be taken in an effort to de-escalate the situation. Here, the opposite was done.

The actions of Monterey County Mental Health and law enforcement raise a number of troubling issues. Law enforcement should not be called by mental health staff unless an identifiable and quantifiable danger exists. And, even then, the police should be there for the purpose of keeping the peace. On May 19, 1998, when mental health staff enlisted the assistance of the local police, that standard was not met. Nor did the police question whether it was appropriate for them to assist mental health staff in forcing involuntary hospitalization upon Mr. Vaughn. Barry Perrou[7], an independent consultant who provided PAI with technical assistance, explained:

> *Had mental health staff and law enforcement asked themselves why now, after Mr. Vaughn's first refusal, they would have possibly considered other alternatives — such as assistance from family or friends, and, most specifically, his trusted friend, the mental health professional — and this tragedy may have been averted.*

In addition, no one person was in charge of communicating with Mr. Vaughn, as two mental health workers on the ground and the officer on the roof continued to yell at Mr. Vaughn. Instead of considering other alternatives, there appeared to have been an unnecessary rush to get on the roof to apprehend Mr. Vaughn. These actions only escalated an already dangerous confrontation.

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[7] Dr. Perrou holds a Doctorate degree in Clinical Psychology and is a 30-year member of the Los Angeles County Sheriff's Department. He is the coordinator of the Sheriff's Department's mental health services, addressing mental health policy and procedure for a 3.8 million population service area.

D. NOBLE: IMMEDIATE DEATH EVENTS

Marvin Noble was shot dead on July 16, 1998 by Ukiah police, who sought to involuntarily detain and transfer him to a local psychiatric facility.

On July 16, 1998, a staff member from the Mendocino County Mental Health Conditional Release Program (CONREP) had a phone conversation with Mr. Noble regarding his failure to take his monthly injection of Haldol on July 14th and his refusal to attend a group meeting on July 15th. Clinical notes reflect that during that conversation, Mr. Noble continued to refuse to comply. Following the conversation with Mr. Noble, all three CONREP program staff had a telephone discussion to decide how to address Mr. Noble's noncompliance with outpatient treatment requirements. They decided that Mr. Noble should be involuntarily hospitalized under Section 5150 and that the Ukiah Police Department should carry out their decision.

A CONREP staff member contacted the Ukiah Police Department and instructed them to locate Mr. Noble and transport him to the Mendocino County Psychiatric Health Facility (PHF) under the authority of Section 5150. Three Ukiah police officers located Mr. Noble at a Foster Freeze restaurant not far from where he lived. At the time of initial contact, Mr. Noble was sitting at a table drinking ice tea and waiting for an order of food. When requested to go outside with the officers, Mr. Noble refused, stood up, displayed a knife, and exited the restaurant. At this point, the police were dealing with a crime in progress and responded accordingly. The police officers attempted to talk Mr. Noble into dropping the knife. They also pepper- sprayed him and tried to knock the knife out of his hand with a baton, but were unsuccessful. Mr. Noble, along with the police officers, walked down the street to his apartment building where, after entry, Mr. Noble

stood at the top of the stairs and a police dog was unleashed in an attempt to apprehend him. Mr. Noble stabbed the dog twice and was then shot dead by a single bullet fired by a Ukiah police officer.

It is unknown why officers chose to make contact with Mr. Noble while inside a crowded restaurant full of customers, rather than wait for him to leave. It is unknown whether a change in tactic would have made a difference.

E. NOBLE: SEQUENCE OF EVENTS

Mr. Noble had a history of occasionally refusing to comply with certain outpatient requirements of his treatment program. Unfortunately, it was mental health staff's response to this recent refusal which helped produce the circumstances that culminated in Mr. Noble's being shot to death by police on July 16, 1998.

Over a two-day period, between July 14th and July 16th, 1998, the following events occurred, in succession, regarding Mr. Noble: He failed to show up for his monthly injection of Haldol. Mr. Noble also failed to show up for a group therapy session. During a telephone call with a CONREP staff member, Mr. Noble reportedly stated that he wanted nothing to do with CONREP mental health staff. Following a subsequent phone call between all CONREP staff regarding Mr. Noble's continued refusal to comply with outpatient requirements, the Ukiah Police Department was called and instructed to pick up Mr. Noble and take him to the local psychiatric health facility, at which time three Ukiah police officers proceeded to find him.

According to records obtained and interviews conducted by PAI investigators, what follows is the sequence of events in July 1998, which led to Marvin Noble's tragic death on July 16th.

Actions by CONREP Mental Health Staff

As required by law, on July 1, 1998, CONREP staff submitted a Quarterly Progress Report to the Superior Court regarding Mr. Noble, which reads, in part:

> *CONREP TREATMENT ASSESSMENT: Under CONREP supervision and treatment (including medication), Mr. Noble is fairly stable, though recent 'psychotic mania' related to diet medication. At times, he is particularity guarded about his thinking and emotional process, and resistant to therapeutic intervention or support.*

The report documents Mr. Noble's dislike for psychiatric medication and the manner in which it was addressed by CONREP mental health staff.

> *He has expressed his dislike for taking medication, both in the injectable and oral forms and he has voiced the desire to get off injectable medication. He is suspicious about the content of his injection and raises legitimate issues regarding power and autonomy, nevertheless it is unlikely he would comply with oral medication. The CONREP team continues to believe injectable medication ensures that he receives the medication he needs. He expresses regret for his crime, though he continues to harbor anger and resentment toward his ex-wife. He downplays the potential danger towards his children and ex-wife during the offense incident. He needs continued support to overcome his lack of motivation and fear or reintegration into the community. Even while on medication, Mr. Noble has experienced delusions, and he has limited ability to discern the validity and accuracy of these thoughts. This paranoia and guardedness have been noted by a number of clinicians. Recent experience makes it clear that caution must be employed in providing any medications with the potential to induce mania.*

The report explains that while Mr. Noble had a fairly debilitating psychiatric disability, and was the subject of some mistreatment in the community, he nonetheless handled himself quite well.

> *While in CONREP group and in interactions with CONREP staff, Mr. Noble displays clear signs of his mental illness and rather poor affective control. However, consistent reports from collat- erals indicate that in the community Mr. Noble's symptoms are not evident and his affect is generally well-controlled. And undoubtedly, Mr. Noble is a target of teasing and discrimination in Ukiah.*

Based on the above assessment, CONREP staff recommended that the Court renew Mr. Noble's CONREP outpatient supervision and treatment for the year 1998-99. Mr. Noble informed CONREP staff that he did not wish to be present at his upcoming court hearing and did not want to contest the extension.

Also, on July 1, 1998, Mr. Noble participated in a group meeting at the local PHF. Interdisciplinary Notes point out that Mr. Noble followed his usual pattern in the group, of starting out appropriately and then rambling off the subject and being tangential. Mr. Noble was further described as having grandiose ideas, which is consistent with previous documentation in the clinical records.

On July 8, 1998, Mr. Noble again attended a group session at the local PHF. The Interdisciplinary Notes indicate that Mr. Noble resisted "pressure to get involved in anything," and that he "offered no feedback to others." It is further noted that Mr. Noble remained after the session to sign the Waiver for the extension hearing mentioned above. He was also reminded of his Social Security appointment, which was scheduled for July 12th, and he indicated that he would not miss the appointment. It is further documented that Mr. Noble was concerned

about his recent Social Security interview during which he was told he was doing rather well. As a result, he had become anxious about losing his benefits.

During interviews with PAI investigators, CONREP treatment staff noted that patients often become more stressed when their involuntary outpatient status is going to be extended for another year, even if they waive their right to a hearing. In this situation, there were two significant hearing-related stressors: the extension hearing and the upcoming Social Security benefits review. Another situation of considerable significance was that primary responsibility for Mr. Noble's outpatient treatment was being transferred from his long-time therapist, with whom he had a therapeutic relationship of trust and rapport, to a new therapist who had been with the CONREP program for only six weeks. There is no evidence that any of these concomitant stressors were weighed by staff in evaluating how to respond to Mr. Noble's noncompliance with outpatient treatment requirements.

On July 13, 1998, Mr. Noble met with his long-time therapist at the Mendocino County PHF. The Interdisciplinary Notes for that day indicate that Mr. Noble appeared well and was clean. The Notes go on to document that Mr. Noble said he had a beer a few days ago, but denied drinking alcohol regularly. As is consistent with prior Interdisciplinary Notes, Mr. Noble stated his concerns about perceived threats from his fellow regulars at the Foster Freeze where he spent a lot of his time. According to the Interdisciplinary Notes, Mr. Noble repeated his familiar warning, which was: "[Y]ou touch me I'll kill you."

During interviews with PAI staff, Mr. Noble's long-time therapist confirmed that it was not unusual for Mr. Noble to make such bravado statements; that the statements were addressed in group sessions; and that he never felt threatened by those statements. The therapist confirmed that he had no concern that Mr. Noble

would ever act on those familiar statements. In fact, the therapist emphasized that even though Mr. Noble was aware of social prejudice toward him in Ukiah, he always handled himself well in the community.

On July 14, 1998, the Interdisciplinary Notes document that Mr. Noble failed to go to the local PHF for his monthly injection of Haldol.

On July 15, 1998, it is documented that Mr. Noble failed to show up for a scheduled group therapy session. Subsequent to this documented noncompliance, Mr. Noble's new therapist reportedly had a conversation with one of Mr. Noble's friends, who was also a CONREP patient. The Interdisciplinary Notes regarding this "collateral contact" indicate that Mr. Noble's friend described him as quite delusional and paranoid. This friend also reportedly promised to try and convince Mr. Noble to get in touch with CONREP program staff since Mr. Noble was overdue for his Haldol injection. CONREP mental health staff did not allow much time for Mr. Noble's friend to influence him about medication compliance, as CONREP staff decided to have the police bring Mr. Noble in the next day. Also, on July 15th, a CONREP staff member made a home visit to Mr. Noble to bring him in for his shot, but Mr. Noble was not at home; nor was he seen anywhere in town.

On the morning of July 16, 1998, that same CONREP staff person had a telephone conversation with Mr. Noble, at which time he reportedly refused his medication and any further treatment from the CONREP program. Following this conversation with Mr. Noble, all CONREP program staff had a teleconference regarding how to address Mr. Noble's continued resistance to treatment. During that teleconference, a decision was made to involuntarily hospitalize Mr. Noble under Section 5150. Interdisciplinary Notes for that day state that: "Due to client's

paranoid ideation that others are a threat to him & statements that he'll have to kill someone if they touch him; involuntary hospitalization is needed. Requesting Ukiah PD [Police Department] bring Marvin to PHF 5150."

PAI investigators interviewed all CONREP program staff regarding the circumstances surrounding the decision to involuntarily hospitalize Mr. Noble on July 16, 1998. No staff member could articulate a specific, credible reason why it was important or urgent to have Mr. Noble hospitalized that day. When PAI investigators asked CONREP program staff how often they call the police to have patients picked up, they confirmed that such situations were rare and should only be done as a last resort when all available alternatives are exhausted. CONREP staff confirmed that they pursued three different alternatives before calling the police to pick up Mr. Noble. Those three alternatives consisted of: (1) talking to Mr. Noble on the telephone; (2) asking one of Mr. Noble's friends to urge him to take his shot and come back into the program; and (3) going to Mr. Noble's apartment on one occasion, at which time Mr. Noble was not home.

On July 16, 1998, after completing the above pre-detention alternatives and following a teleconference among all CONREP mental health staff, the Ukiah Police Department was called by CONREP staff and instructed to pick up Mr. Noble and involuntarily hospitalize him under Section 5150. The Ukiah police then proceeded to find Mr. Noble at a nearby restaurant he frequented.

In a taped and transcribed interview with Mendocino County Sheriff's detectives following Mr. Noble's death, the officer who took CONREP's call on July 16th talked about his conversation with CONREP mental health staff. Relevant parts of that interview demonstrate that CONREP staff repeatedly emphasized that Mr. Noble was dangerous, had committed violent felonies, and

was criminally incompetent. (CONREP staff failed to clarify that the serious and dangerous felonies referred to during that conversation had occurred over 17 years ago and that no violent criminal behavior whatsoever had followed.)

The officer who spoke with CONREP mental health staff on July 16th stated, in pertinent part, the following:

> *I got a call from . . . Mental Health. . . . She called and said that she had a client who needed to be brought in to Mental Health . . . [a]nd that he was off his medication . . . he had a tendency toward violence, had a violent history. She told me his name was Marvin Noble . . . approximately five foot ten, over three hundred pounds. . . . She said that he's been volatile with law enforcement in the past, he's been volatile with people in the past . . . [h]e actually was declared criminally incompetent, or incompetent to be tried criminally for serious violent felonies . . . [h]e had raped and false imprisonment sometime in the past . . . [t]hat he also frequents the Foster Freeze and a place on . . . Lane. She asked that if we could get officers to go out and apprehend him and bring him in to PUFF, Mental Health, she would appreciate that. She quoted me a section: ten, twenty six of the Penal Code, which was basically an authority to do this . . . and it also described what area of mental health status he fell under. . . . [S]he called him a CONREP client. And if I thought I wasn't entirely clear on how their system works — but I was sufficiently satisfied based on her expertise. And that we would facilitate getting him there because of his violent tendencies and they didn't have the personnel to do that. She reiterated to me before I got off the phone with her, to be safe and she was concerned about us being careful with this guy, because of the violent potential.* (Interjections omitted; punctuation added.)

A July 16, 1998 Crisis Intervention Contact form was completed by CONREP mental health staff, which stated why staff felt Mr. Noble's refusal of treatment warranted the imposition of a 5150.

> *Marvin has become more paranoid & uncooperative in the last week. He missed his injection (Haldol 150 mg 4 wks) on 7/14/98 and then an appointment 7/15/98. He states there are people at Foster Freeze that are a threat to him & some who think he is homosexual & states 'If they touch me, I have to kill them.'*
>
> *Today he states he did not forget his appointment for the shot, 'I decided I don't need any of that medication & will not take it anymore.' Refuses to consider any treatment options saying 'You'll have to send the man to get me.' He speaks calmly but firmly; unable to reason [with] him.*
>
> *Status: PC 1026 court ordered [outpatient] treatment with CONREP.*
>
> *Placed on a 5150 for invol. hospitalization @ PHF. UPD called to pick up & transport to PHF.*
>
> *Plan: Hopefully resuming medication will avoid a revocation to state hospital.*

An Application For 72-Hour Detention for Evaluation and Treatment (the Application), dated July 16, 1998, at 12:00 noon, was also completed, which states, in pertinent part:

> *Refusal of client to come to clinic for scheduled injection and appointments. PC 1026 — in CONREP.*
>
> *Showing increase in paranoid symptoms, saying 'You touch me, I'll kill you,' relates that other customers at Foster Freeze are a threat to him & he'll have to defend himself. Has suddenly dropped out of treatment cooperation.*

On the Application, mental health staff checked the box *"A danger to others."*

The only signature on the Application is that of a CONREP program staff member. No member of law enforcement reviewed or signed the Application, as it remained with CONREP mental health staff while the officers went out in the community to find Mr. Noble and take him to the local PHF.

During interviews with PAI investigators, CONREP staff stated that the only mental health worker available that day did not accompany the police to pick up Mr. Noble because of concerns that the presence of mental health staff would have inflamed Mr. Noble. When PAI investigators questioned CONREP mental health staff as to why they did not wait until the next day for Mr. Noble's long-time therapist to try and obtain Mr. Noble's compliance with outpatient requirements, the only staff member available on July 16th responded that it would have been futile, as Mr. Noble had stated so. However, no further explanation was given for not trying that alternative. Moreover, CONREP mental health staff told PAI investigators that, given Mr. Noble's known negative response to the police in the past and the nature of his psychiatric disability, there was a possibility that a confrontation would ensue between Mr. Noble and the police. In spite of that identified possibility, CONREP staff nevertheless proceeded with their request for police intervention on July 16th, rather than waiting until the next day to try further negotiations.

Confrontation with Police

On July 16, 1998, at approximately 12:00 PM, three members of the Ukiah Police Department contacted Mr. Noble at the local Foster Freeze restaurant. One officer went into the restaurant and spoke with Mr. Noble long enough to verify his identity, and then left and contacted the other two officers. There was no indication of a potential problem at that time. Two officers then approached Mr. Noble at the booth where he was sitting. Although Ukiah Police Department procedures prohibit the use of canines when interacting with people with psychiatric

disabilities, a third officer and his canine stood at the door. PAI investigators could find no reason for this deviation from procedure.[8]

One of the officers asked Mr. Noble to step outside to speak with them. Mr. Noble then stood and pulled out a fixed-blade knife, gestured with it to the officers, and stated that he was not going anywhere with them. Two officers stepped back, pulled their weapons, and yelled for people to get out of the way and for Mr. Noble to put down his weapon. The canine officer also yelled for people to get out of the way, pulled his weapon, and moved through the door with his canine to join the other officers. By this time, there were a number of crimes in progress, and the officers responded accordingly.

Mr. Noble then began walking towards the north door, with one officer backing away from him and the other officers following behind. Once in the parking lot of the restaurant, the officers surrounded Mr. Noble, demanding that he drop the knife. Reportedly, Mr. Noble would point the knife at one officer and move towards him, then turn and point at another officer and then move towards him. He reportedly did this several times, which resulted in the group's moving near the sidewalk.

Two officers pulled out their pepper spray and sprayed Mr. Noble, but it appeared to have very little effect on him, other than causing him to wipe his eyes with his left hand.

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[8] Since canines are not able to distinguish between voluntary and involuntary movements, it is inappropriate to use this animal when confronting people with psychiatric disabilities, as involuntary movements caused by psychotropic medications or the person's disability may trigger a response from the canine. Under such circumstances, the tactic could result in an unnecessary escalation of force.

The officers continued walking with Mr. Noble, yelling at other people in the area to get out of the way and, again, for Mr. Noble to drop the knife. At approximately the south end of the Foster Freeze, Mr. Noble turned north and began walking in the street. Mr. Noble was attempting to go home to his apartment. One officer walked in the street beside Mr. Noble, warning people to get out of the way, while the other two officers and the canine followed about 15 feet behind. Mr. Noble continued walking north, periodically making gestures with the knife towards the officers. One officer pulled his baton in an attempt to knock the knife out of Mr. Noble's hand, but was unsuccessful.

The group eventually reached Mr. Noble's apartment building. Mr. Noble opened the door with his key and entered. At that time, an officer unleashed the canine and ordered him to stop Mr. Noble. The canine moved forward, but the door closed, not allowing the dog access to Mr. Noble's apartment building.

One officer pushed various apartment buzzers until one of the occupants buzzed him into the building. The canine was again released and started climbing the stairs, with the three officers following behind.

By this time, Mr. Noble had reached the top of the stairs near the landing. The 20 stairs to the landing are fairly narrow and steep. The landing is about five feet long, then turns left into a hallway leading to at least five apartments. With the knife in his hand, Mr. Noble stopped on the landing at the top of the stairs, then turned and faced the officers. As the canine reached the top of the stairs, Mr. Noble bent down and stabbed him. Mr. Noble then stabbed the dog a second time, at which point the canine turned around and ran. Mr. Noble remained standing at the top of the stairs, facing the officers with the knife in his hand. By this time, one of the officers was on about the 15th step, moving quickly up the stairs towards Mr.

Noble.[9] The officer in charge then ordered that Mr. Noble be shot. One round of bullets was fired, and Mr. Noble dropped to the floor.

At the scene of the shooting, Mr. Noble was treated by Ukiah Valley Fire Department paramedics in an attempt to resuscitate him. He was then transported to the Ukiah Valley Medical Center, where he was pronounced dead.

The last entry in the Interdisciplinary Notes by CONREP mental health staff regarding Mr. Noble, dated July 16, 1998, states:

> *2 PM Received information that Marvin resisted the police & a confrontation occurred in which Marvin was shot & killed. Hospital has confirmed his death.*

On July 16, 1998, at approximately 3:30 PM, mental health staff reported Marvin Noble's death to the California Department of Mental Health, CONREP Operations.

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[9] Again, as in the Vaughn case, the tactic of compressing the zone between the officer and the subject can be called into question. However, unlike the circumstances in the Vaughn case, here, the officers were facing a slight but real possibility that other residents of the apartment building could be in peril.

VI. INVESTIGATIONS BY OTHERS

A. VAUGHN

1. MONTEREY COUNTY CORONER'S OFFICE

The Monterey County Coroner's Office conducted an investigation into the death of Charles Vaughn, Sr. and concluded:

> *Based on the findings at autopsy and information provided by the Coroner's investigation it is my opinion that the decedent died as a result of multiple gunshot wounds, one to the left back, one to the top of the right buttock, one to the left chest, and a graze of the right chest. Evidence of severe underlying atherosclerotic cardiovascular disease was observed by autopsy. No other significant recent traumatic injuries were observed at autopsy.*

A Toxicology Report by the Institute of Forensic Sciences, dated June 10, 1998, indicates that, at the time of death, Mr. Vaughn's blood contained no alcohol or common drugs of abuse.

2. MONTEREY COUNTY DISTRICT ATTORNEY'S OFFICE

At the request of the Seaside Police Department, the Monterey County District Attorney's Office (the Monterey District Attorney) conducted an extensive investigation into the shooting death of Mr. Vaughn. The purpose of the investigation was to determine whether or not the shooting was justified under applicable penal statutes. The Monterey District Attorney determined that the use of deadly force was justified, and therefore no criminal charges were filed. The Monterey District Attorney's investigation is contained in an investigative report (which is over 300 pages).

In reviewing the facts and circumstances surrounding the death of Charles Vaughn, Sr. on May 19, 1998, the Monterey District Attorney found that no criminal statutes were violated at the precise moment that officers shot Mr.

Vaughn. The Monterey District Attorney found that the officers involved in the shooting believed that Mr. Vaughn intended to kill or inflict great bodily injury upon their fellow officer, and that this belief was reasonable under the circumstances. The Monterey District Attorney's analysis was strictly limited to whether the shooting was justified under applicable criminal statutes. The Monterey District Attorney's evaluation of the facts and circumstances surrounding the death of Charles Vaughn, Sr. did not include, for example, whether appropriate police tactics were utilized or whether appropriate standards were followed for the detention of people with psychiatric disabilities.

3. MONTEREY COUNTY MENTAL HEALTH

A newspaper article, dated Monday, July 20, 1998, makes reference to a Monterey County Department of Mental Health (Monterey County Mental Health) internal investigation into the conduct of the mental health workers involved in the attempt to involuntarily hospitalize Mr. Vaughn on May 19, 1998. The short article states:

> *County officials say their internal review shows that the caseworker acted properly when she tried to have Charles E. Vaughn Sr., 60, hospitalized against his will.*

PAI made requests to obtain a copy of all reports and documentation regarding the internal investigation referred to in the above newspaper article. Counsel for the County of Monterey responded in writing that no documents existed which were "produced as part of an internal investigation by the Monterey County Department of Health officials."

Although not required, the better practice would have been for the Director of Monterey County Mental Health to request the California Department of Mental

Health (DMH) or another appropriate independent agency to conduct an investigation into the professional conduct of all mental health staff involved in the decision- making process concerning the involuntary detention of Mr. Vaughn. However, since no such request was made, no external independent, quality assurance investigation was conducted.

B. NOBLE

1. MENDOCINO COUNTY CORONER'S OFFICE

The Mendocino County Coroner's Office conducted an investigation into the death of Marvin Noble. On July 17, 1998, at approximately 1:00 PM, Mr. Noble's mother was contacted by the Coroner's Office and advised of her son's death. On July 17, 1998, an autopsy was conducted and the cause of death found to be "Gunshot of Abdomen," and the Classification of the death to be "Homicide."

None of the following drugs were present in Mr. Noble's system at the time of death:

- Opiates
- Barbiturates
- Cocaine
- Methamphetamines
- Phencyclidine
- Antihistamines
- Antidepressants
- Propoxyphene
- Methadone

2. MENDOCINO COUNTY SHERIFF'S DEPARTMENT

At the request of the Ukiah Police Department, the Mendocino County Sheriff's Department conducted an extensive investigation into the shooting death of Marvin Noble. The results of this investigation are contained in a report (over

200 pages), which was forwarded to the Mendocino County District Attorney's Office (the Mendocino District Attorney) for review.

3. MENDOCINO COUNTY DISTRICT ATTORNEY

The Mendocino District Attorney's Office reviewed the investigation conducted by the Sheriff's Department and found the Ukiah Police officers' shooting of Mr. Noble to be justified under applicable criminal standards.

In an August 5, 1998 Press Release, the District Attorney identified the following ten factors known to the officers at the time of the shooting, which tended to show that the use of deadly force was justified under the circumstances.

1. Mr. Noble could be violent.
2. Mr. Noble had committed numerous criminal acts, including felonies, between the time he was first contacted and the time he was shot.
3. Mr. Noble was willing and able to use the knife in his hand.
4. The stairwell was narrow and steep
5. Mr. Noble had the superior position.
6. Mr. Noble had not responded to verbal commands for him to drop the knife.
7. Mr. Noble was not deterred by OC spray [pepper spray].
8. There were people in the apartments down the hallway to the north of Mr. Noble.
9. It was not known if there were people in the hallway.
10. It was not known if Mr. Noble had access to other weapons.

4. MENDOCINO COUNTY MENTAL HEALTH

According to records received by PAI, the former Mendocino County Mental Health Services Director wrote the California Department of Mental Health (DMH) on July 27, 1998 and requested that a review be conducted of the actions taken by Mendocino County mental health staff involved in the events which led to the death of Mr. Noble.[10]

On July 30, 1998, the Mendocino County mental health staff member who instructed the Ukiah police to pick up Mr. Noble completed a Special Incident Report (SIR), which was forwarded to DMH. The SIR, which served as the basis for DMH's review, specifies five factors that resulted in the action taken by Mendocino Mental Health, which culminated in Mr. Noble's death.

1. *The appearance of paranoid symptoms on 7/13/98 after weeks of appearing free of significant paranoid ideation.*
2. *Missed his Haldol . . . injection on 7/14/98.*
3. *No show for the group therapy 7/15/98.*
4. *Program Director and myself tried to find him at his apartment and in town, with no success same day 7/15/98.*

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[10] In statements made to the press, the Mental Health Services Director indicated that he could not discuss the specifics of Mr. Noble's case, but stated that his department "will call police if it has reason to believe the patient is looking for or may cause trouble." "It has to do with whether the person will cooperate, "the Mental Health Services Director said. "In general, there's always room for improvement but I wouldn't say there's any blame in this incident. People did what they had to do." These statements indicate a lack of understanding concerning what constitutes probable cause for a 5150 and under what circumstances the police should be called. That the patient may cause trouble or not cooperate is too vague and speculative to justify the intervention of law enforcement.

5. *Phone contact 7/16 — Marvin was clearly paranoid about numbers of people, could not be convinced to continue his treatment, could not be reasoned with, warned me not to try to get him or I would be hurt.*

The SIR goes on to explain:

> *As a result of Marvin's statements about resisting and warning CONREP not to come get him, we decided that the presence of mental health clinicians would incense and inflame Marvin more and create more danger. Therefore a clinician did not accompany the police.*
>
> *The question about whether or not he was suicidal in telling me 'you'll have to send the man' is significant but unanswered. We saw no suicidal signs in his contacts with the program. He was always making plans and optimistic. It is a guess why he was carrying a knife, but it seems he was fearful and did so for protection.*
>
> *The responding officer talked with me at length before acting — he gathered information — appearance, history, current problem, instant offense [referring to the 1981 incident that brought Noble into the mental health system]. Marvin having a weapon was not addressed. He had not been known to carry a knife. It was not the first time the police had been used to detain him.*

The SIR identifies four areas of change to be implemented in the future:

1. *Consider more aggressive medication regime.*
2. *Consider going out to find client at the first no show event.*
3. *Consider meeting in person with all the officers that will respond in preparation for a potentially explosive situation.*
4. *Consider hospitalization at the first sign of any threatening self-defensive response to paranoid ideation for evaluation of what may appear to be bravado.*

5. CALIFORNIA DEPARTMENT OF MENTAL HEALTH

In the Mendocino County Mental Health Services Director's request to DMH for review of the circumstances surrounding Mr. Noble's death, he asked DMH staff to "conduct an objective review of the actions of the staff of the Mendocino County Department of Mental Health in requesting law enforcement intervention," and asked "whether there is need for improvement either in . . . policies and procedures or in the judgement of the clinicians involved." It was also requested that DMH respond directly to the Chair of the Board of Supervisors and the County Administrative Officer.

DMH's review consisted of analyzing all relevant documentation and case records, as well as a visit to Ukiah on August 26, 1998, where interviews were conducted with the Mental Health Director and all CONREP program staff involved in the care and treatment of Mr. Noble.

On September 25, 1998, copies of a report prepared by DMH were forwarded to the County Administrative Officer and the Chair of the Mendocino County Board of Supervisors. The report, entitled "Critical Incident Review of the Events Leading to the Shooting of a Mendocino County Forensic Conditional Release Program Patient," contained the following conclusions relevant to the facts and circumstances of Mr. Noble's death.

> *III. Overall Assessment:*
>
> *This case is a culmination of a collection of actions by the patient, during an episodic increase in his symptoms, resulting in a growing concern on the part of his treatment team which was exacerbated by incremental disengagement from the program, communicated concerns of friends, and his expressed suspicions about people he*

> *met. In the end, CONREP's decision to bring him in for assessment seems warranted and should not have been forestalled.*
>
> *They were dealing with a patient who, though verbally skilled, had poor skills at reading his environment, and whose paranoid defensive stance was to 'talk big' and menacingly when threatened. He 'dis-invited' CONREP from coming out to see him and told them to 'Send the man (police).' CONREP staff reported that they were concerned about not inflaming him by going out with police in the face of his statements. They seemed to rely on an over-estimation of the beneficial outcome of his contact with the police ('fearful compliance'). As a result he did not have the benefit of their presence to act in any way as a 'de-escalator' to the situation (presuming that both he and the police would have allowed that).*

DMH goes on to explain how CONREP staff must weigh the community's interest in public safety against the possibility that interjecting the police into an already volatile situation adds the possibility of lethal force; and that there is a need for mental health and law enforcement personnel to make such decisions based on appropriate protocol.

> *In calling the police, CONREP programs have to make a calculated decision weighing the timely need for public safety against the fact that for some the police are a negative stimulus. Finally, adding police to the relationship with the mentally ill adds lethal force to an already volatile equation. In this case, the combination appears to have set loose a wave of events that no one foresaw, contemplated or desired.*
>
> *The usefulness of mental health staff going out with police to apprehend a patient would typically be determined by protocol (there was none), prior working relationships and training (none existed), and police decisions (whether to collaborate with mental health workers or to 'take charge'). One must note that the minute the patient produced a knife in the crowded restaurant, the role of the mental health worker would have ended and the encounter would have followed its course as a police matter.*

Based on the above assessment, DMH made a number of recommendations, all of which are consistent with those made by PAI, as follows:

> The need for mental health staff and law enforcement to find collaborative ways to problem-solve.
>
> The need for interagency protocols and training.
>
> The need for Mendocino County CONREP staff to develop their own protocols governing when and how CONREP patients should be hospitalized under the Penal Code, and under what circumstances staff will or will not accompany the police.
>
> The need for mental health staff to develop a Psychological Autopsy procedure separate and distinct from the Critical Incident Stress Debriefing process.

6. MENDOCINO COUNTY GRAND JURY

In response to complaints from citizens, the Mendocino County Grand Jury conducted an investigation into the Ukiah Police Department's shooting death of Marvin Noble. This investigation consisted of:

> Reviewing all records and reports pertaining to this incident;
>
> Reviewing relevant Commission on Peace Officer Standards and Training (POST) manuals; and
>
> Interviewing personnel from the Ukiah Police department, Mendocino County Sheriff's Department, Mendocino County Mental Health, Protection & Advocacy, Inc., and the Commission on Peace Officer Standards and Training.

In June 1999, the Grand Jury issued an eight-page report that contained findings and recommendations consistent with those made by PAI, which read, in pertinent part, as follows:

Mental Health Involvement Findings

1. The client was under the care and supervision of the MH Department for 12 years as a CONREP client and received multiple services including group and individual therapy sessions. . . .

2. MH Department is required to provide the Court with quarterly reports on CONREP clients. These reports demonstrate that this client:

    a. Remained on the same psychotropic medication in increasing dosages, finally receiving Haldol 150 mg. monthly;

    b. Exhibited the same symptoms of his mental illness; and

    c. Had the same therapeutic goals set each year.

3. There was no documented evidence of progress during the 12 years. Despite not attaining any of the goals set for him, mental health services were reduced on a predetermined time table.

4. In the 12 years between July 18, 1986 and his death July 16, 1998, the client was threatened three times with revocation of his out-patient status due to non-compliance with his medications. Each time, the revocation was rescinded with his renewed promises of compliance with the terms and conditions of his contract.

. . .

5. At the time of his death, the client was under additional emotional stress. He was to have a court hearing July 17, 1998, regarding his continued participation in CONREP and he had an upcoming hearing on his Social Security benefits. The MH Department documented increased symptoms of his mental illness and anxiety attacks.

The Grand Jury made a number of findings critical of the 5150 process used by mental health staff to detain Mr. Noble, which are supported by the evidence PAI obtained during its investigation.

Welfare and Institutions Code Section 5150 Findings

1. The MH Department rationale for instituting involuntary detention under a 5150 was that the client 'had refused to come to the clinic for scheduled injection and appointments.' This rationale uses non-compliance of the CONREP contract as the reason for the detention.

2. The client met the standard for revocation as he was in noncompliance. Revocation of his out-patient status under CONREP could have been initiated under Penal Code 1610 at the Court hearing scheduled the next day (July 17) or the Court could have ordered the client detained under Penal Code 1608. These provisions grant authority for detention of CONREP clients.

3. A MH Department supervisor stated in a UPD interview 'safety may have been a factor but primarily it was the matter of compliance to get him into the hospital.'

4. A review of his medical history reveals that the behavior noted to support a 5150 was behavior that the client had exhibited throughout his mental illness.

5. To support its contact of the client under 5150, police officers relied on a MH Department assessment rather than relying on their own judgment. However, police officers cannot be deprived of their authority in the field and cannot give up their own judgement. . . .

6. When the client did actually exhibit aberrant behavior that would have supported use of 5150, the police viewed that behavior as being criminal and reacted to the client as a felon, not a mental patient.

The Grand Jury also identified problems with the training of police and the need for law enforcement to develop and implement appropriate and updated policies for interacting with people with psychiatric disabilities who are in crisis.

The Grand Jury specifically found that the Ukiah Police Department failed to follow its own procedure regarding the use of canines, which states, in pertinent part: "Canine teams should not be used to apprehend . . . the mentally disturbed if no crime is involved."

The Grand Jury further noted that the Ukiah Police Department did not take advantage of an existing procedure which allowed officers to obtain the assistance of mental health staff when a determination is made that the person does not meet the grounds for commitment. The 1975 procedure states:

> *In a case where an officer feels the person contacted is mentally disturbed and there is no justification for an emergency commitment, the officer is authorized to notify the Watch Commander who will relay the information to the psychiatric unit at MH Department. Arrangements have been made by that agency to send a member of the psychiatric staff to confer with the person.*

Finally, the Grand Jury noted that officers made tactical decisions that may have deprived them of the ability to more effectively negotiate with Mr. Noble.

The Grand Jury finds that the UPD officers decided:

1. *[N]ot to report the client's location to MH Department or ask them to effect their own detention or to assist the police. (Without a mental health clinician present with the police officers, the ability of someone familiar to the client to negotiate was lost.)*
2. *[T]o proceed in a 5150 detention based on the assessment provided by a mental health clinician rather than assessing under their own authority.*
3. *[T]o proceed into taking the client into custody. . .*

VII. PROTECTION & ADVOCACY, INC.'S INVESTIGATION INTO THE DEATHS OF CHARLES VAUGHN, SR. AND MARVIN NOBLE

PAI evaluated all available relevant evidence concerning these two deaths, including but not limited to:

Reviewing extensive mental health, medical, and case management records.

Reviewing pre- and post-mortem mental health and law enforcement policies and procedures concerning the implementation and standards for involuntary hospitalization pursuant to Section 5150.

Reviewing Coroners' Autopsy and Toxicology Reports.

Reviewing reports regarding whether or not police officers were justified in using deadly force.

Analyzing taped interviews of mental health staff and police personnel involved in these incidents.

Conducting on-scene assessments at the locations where Mr. Vaughn was shot and killed in Seaside, California, and where Mr. Noble was shot and killed in Ukiah, California.

Conducting interviews with family members, friends, witnesses, and relevant others.[11]

Reviewing the literature concerning the use of deadly force upon people with psychiatric disabilities.

Reviewing state-of-the-art training materials, videotapes, and model procedures concerning how peace officers should interact with people with psychiatric disabilities.

Consulting with Barry Perrou, Ph.D., an independent expert who evaluated whether or not police and mental health professionals acted within appropriate guidelines for exercising their authority pursuant to Section 5150.

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[11] Monterey County mental health workers who were at the scene when Mr. Vaughn was shot on May 19, 1998, declined to be interviewed by PAI investigators. Mendocino County mental health workers involved with the care and treatment of Mr. Noble cooperated and were interviewed. None of the police officers involved in these two deaths agreed to be interviewed.

A. INVESTIGATORS' SUMMARY OF ISSUES

PAI's investigation focused on the disability-related events leading up to the deaths of Mr. Vaughn and Mr. Noble, and not on the shootings themselves. There were two main issues of focus in PAI's investigation:

(1) Whether the actions of mental health personnel, in their attempts to involuntarily hospitalize Mr. Vaughn and Mr. Noble, met acceptable professional standards for the provision of mental health crisis services and for interaction with police, as contemplated by Section 5150.

(2) Whether the actions of police officers, in attempting to detain these two men, met current professional standards for interacting with people with psychiatric disabilities and for carrying out law enforcement responsibilities under Section 5150.

B. ISSUES CONCERNING THE DEATH OF CHARLES VAUGHN, SR.

Mental Health Issues

The actions of Monterey County Mental Health workers, in their attempt to involuntarily hospitalize Mr. Vaughn, raise a number of serious and troubling questions that warrant review. After Mr. Vaughn refused to comply with Monterey

County mental health workers' request that he accompany them to the hospital, the question becomes: What other options did Monterey County mental health workers have?

First, Mr. Vaughn was inside his own residence, apparently in good health, and doing nothing dangerous or threatening. Monterey County mental health workers could have left and, perhaps, returned another day to talk with him.

Second, Mr. Vaughn had numerous friends and relatives living in the area — including a daughter, two former wives, and a long-time friend/mental health

professional — who could have been called upon for assistance. In an interview with PAI investigators, Mr. Vaughn's friend/mental health professional related that he had known Charles Vaughn since the early 1960's and that several times a week, he would check on Mr. Vaughn to see how he was doing. He further related that a Monterey County mental health worker at the scene on the morning that Mr. Vaughn was shot dead knew the nature of this long-time relationship and how to reach him.

The option chosen by Monterey County mental health workers, to call the Seaside Police Department for assistance to have Mr. Vaughn involuntarily committed, interjected the possibility of deadly force being used by the police; and, that is precisely what eventually occurred.

Police Issues

There are also a number of troublesome questions surrounding the actions of the Seaside Police Department in their effort to involuntarily hospitalize Mr. Vaughn on May 19, 1998.

First, it does not appear that Seaside police officers made their own determination that Mr. Vaughn met the criteria for involuntary commitment. An officer at the scene signed the Application For 72-hour Detention For Evaluation And Treatment on May 19, 1998, at 9:30 AM, prior to talking with or observing Mr. Vaughn. When the police officers had their initial contact with Mr. Vaughn, he was inside his residence, doing nothing to indicate that he was a danger to himself or others, or that he was gravely disabled. Upon answering the door, Mr. Vaughn talked briefly with the officer and refused the officer's request to

accompany him to the local psychiatric health facility. Mr. Vaughn's refusal was not a basis for a 5150 commitment.

Second, could Seaside police officers have acted differently once Mr. Vaughn was on the roof of the building? There were a number of alternatives available to them, including using crisis interveners, family members, or close friends to attempt to talk Mr. Vaughn into coming off the roof. Instead, an officer quickly went up on the roof in an attempt to apprehend Mr. Vaughn and began spraying him with pepper spray. Only 22 minutes lapsed from the second time Seaside police officers arrived at Mr. Vaughn's residence until the time Mr. Vaughn was shot to death.

Third, did Seaside police officers have sufficient training regarding people with psychiatric disabilities? Other than the approximate four-hour training received by Seaside police officers while they were in the academy, PAI found no evidence that the Seaside Police Department provided its officers with any additional training concerning how to interact with people with psychiatric disabilities. This is inadequate for a career that brings officers into frequent contact with people in mental health crises. PAI's independent consultant, Dr. Barry Perrou, confirmed that training on this subject was developed in 1990 by the Commission on Peace Officer Standards and Training and is readily available to law enforcement, including a series of videotapes produced by the California Alliance for the Mentally Ill. Additionally, it is PAI's understanding that such training was offered to all law enforcement agencies in Monterey County, but that the Seaside Police Department declined to attend.

Finally, at the time of Mr. Vaughn's death, there were no interagency policies, procedures or protocols regarding how Monterey County Mental Health

and the Seaside Police Department should work together in carrying out their respective 5150 responsibilities. There was, however, a 5150 manual which outlined the law regarding 5150 detention and explained how to fill out the forms, among other things.

C. ISSUES CONCERNING THE DEATH OF MARVIN NOBLE

Mental Health Issues

The actions of the mental health workers in their attempt to involuntarily hospitalize Mr. Noble also raise a number of troublesome questions, many of which are similar to those talked about above concerning Mr. Vaughn.

The evidence does not substantiate that Mendocino County Mental Health Conditional Release Program (CONREP) staff had reasonable or probable cause to involuntarily hospitalize Mr. Noble under Section 5150. As stated earlier in this report, the criteria for a 5150 commitment is danger to self, danger to others, or gravely disabled.

PAI's investigation found no evidence to suggest that Mr. Noble was ever suicidal; and, therefore, he was not a danger to himself. There also is no evidence to suggest that Mr. Noble was gravely disabled. At the time of his death, he was living in an apartment by himself and, according to the records and interviews with CONREP personnel, was taking care of his personal needs, such as food and shelter.

On the Application For 72-Hour Detention for Evaluation and Treatment (the Application), completed and signed by a staff member of the Mendocino County Mental Health CONREP program, "A danger to others" box is checked. The only information offered on the Application in support of the contention that

Mr. Noble was a danger to others was noted as: “[Mr. Noble’s] showing increase in paranoid symptoms, saying ‘you touch me, I’ll kill you,’ and that he indicated “other customers at Foster Freeze are a threat to him and he will have to defend himself.” There is substantial credible evidence that these statements by Mr. Noble were fairly common and, in the opinion of professional clinical staff who knew Mr. Noble best, did not indicate that he really was dangerous. In fact, in an Interdisciplinary Note written by Mr. Noble’s long-time therapist on July 13, 1998, the therapist comments that Mr. Noble repeats this familiar warning: “You touch me I’ll kill you." In interviews with PAI investigators, the same therapist related that Mr. Noble made a lot of such bravado statements, but that he did not believe that Mr. Noble would act on any such statements.

On July 15, 1998, the day before Mr. Noble died, the same staff member who had Mr. Noble picked up on July 16th had been out looking for Mr. Noble, but could not locate him. This same staff member even went to Mr. Noble’s home to give him a ride to the psychiatric health facility for his shot. Significantly, if the staff member went out the day before and did not feel threatened, then what specifically occurred for it to become necessary for CONREP staff to call the police to have Mr. Noble 5150’d the following day? The only change was based on a telephone conversation with Mr. Noble, during which he continued to refuse to attend group therapy or receive his injection of Haldol. His failure to comply with these two outpatient requirements were the actual reasons for the 5150 on July 16th. Although such noncompliance may have been grounds to revoke Mr. Noble’s outpatient status under applicable Penal Code provisions, it was not grounds for an involuntary commitment under Section 5150.

Dr. Perrou, PAI's independent expert, questioned whether there was sufficient probable cause to 5150 Mr. Noble on July 16, 1998. He is also of the opinion that if the CONREP mental health workers wanted to revoke Mr. Noble's CONREP status, then they should have used the appropriate legal statutes to address his noncompliance — not Section 5150.

Dr. Perrou is also of the opinion that on July 16, 1998, CONREP mental health workers should have initially talked with Mr. Noble, rather than the police, as noncompliance with outpatient treatment was a mental health issue and not one for law enforcement.

As in the circumstances surrounding Mr. Vaughn's death, the most disturbing question regarding this case is why there was a rush to 5150 Mr. Noble on July 16, 1998. There is no substantial evidence that imminent hospitalization was necessary. In fact, during interviews with PAI investigators, one staff member noted that the use of Section 5150 was more expedient than following the Penal Code procedure for revoking Mr. Noble's outpatient treatment.

Police Issues

There are also a number of questions regarding the actions of Ukiah police officers. First, the evidence does not indicate that Ukiah police officers made an independent determination that Mr. Noble met the criteria for a 5150 commitment. At the time of the initial contact with the police at the Foster Freeze, Mr. Noble was sitting quietly at a table drinking a beverage and waiting for his order of food. To the officers' personal knowledge at that time, Mr. Noble was not a danger to himself, to others, or gravely disabled. However, once Mr. Noble displayed the knife, it then became a police matter, and they had to take action.

Second, could the Ukiah police officers have exercised other options when they first contacted Mr. Noble at the Foster Freeze restaurant? They could have requested that Mendocino County mental health staff accompany them. They could have waited until Mr. Noble exited the restaurant before approaching him. They could have refused to involuntarily hospitalize Mr. Noble because, at the time of their first contact with him, he did not appear to meet the criteria for a 5150 commitment.

Third, did Ukiah police officers have sufficient training regarding how to interact with people with psychiatric disabilities who are in crisis? The Mendocino County Grand Jury found the following regarding this issue: "Other than basic training at academies, the officers had no additional training in dealing with the mentally ill. . . ."

At the time of this incident, the Ukiah Police Department had no policies or procedures regarding how to interact with people who have psychiatric disabilities. When requested by PAI to provide such documents, the Ukiah Police Department produced an outdated copy of Section 5150.

VIII. FINDINGS AND CONCLUSIONS

PRECIPITOUS USE OF POLICE

The shooting deaths of Mr. Vaughn and Mr. Noble demonstrate why it is imperative that mental health staff call the police only when an objective and quantifiable threat of harm exists. No dangerousness existed to justify the intervention of the police to effectuate the immediate, involuntary hospitalization of Mr. Vaughn on May 19, 1998 or Mr. Noble on July 16, 1998. At the time mental health staff called the police to pick these men up, Mr. Vaughn was in his apartment trying to refuse mental health services, but posing no danger to anyone; and Mr. Noble was sitting quietly in a restaurant drinking a beverage. Instead of addressing the reasons underlying the men's recent refusals of treatment or attempting to negotiate a less drastic solution by enlisting the assistance of family or friends, mental health personnel helped escalate these rather marginal and common mental health situations of treatment refusal into dangerous confrontations with the police.

FAILURE TO EXERCISE INDEPENDENT JUDGMENT

The evidence does not indicate that either Seaside or Ukiah law enforcement made their own determination regarding whether Mr. Vaughn or Mr. Noble met the criteria for 5150 at the time officers attempted to detain them. Instead, it appears that the Seaside and Ukiah police relied on the representations of mental health staff that the two men met the criteria for 5150 detention and were dangerous, and that intervention by the police was necessary. In fact, the evidence substantiates that Seaside officers totally deferred to the judgment of mental health staff. The evidence indicates that a Seaside officer signed the 5150 Application before he even had the opportunity to speak to or observe Mr. Vaughn. This was inappropriate and dangerous. And, when Ukiah police first made contact with Mr. Noble, they personally observed him sitting quietly in a restaurant. Had the officers

questioned whether it was appropriate to 5150 Mr. Noble at that time and called mental health staff to discuss the matter, as permitted by long-standing procedures, mental health staff may have been reminded that compliance with treatment was an issue for them which warranted further effort on their part — not a 5150 by police.

LACK OF TRAINING FOR POLICE

The minimum statutory requirement for the training of law enforcement personnel is grossly inadequate and requires only about four hours of training while the officers are in the academy. This minimum four-hour requirement does not begin to prepare officers for their important responsibilities in the civil commitment process and a career that brings them into repeated contacts with people in mental health crises. During PAI's investigation, neither the Seaside or Ukiah police produced evidence to show that their officers had received any additional training concerning how to interact with people with psychiatric disabilities. Moreover, when Seaside police were offered training, they reportedly declined to accept it. However, following the death of Mr. Vaughn, Monterey County began taking significant steps to ensure that its peace officers are properly trained. Following Mr. Noble's death, the Ukiah Police Department also began taking steps to ensure that its officers are more properly trained in how to interact with people with psychiatric disabilities who are in crisis. These actions are summarized below in the Recommendations section.

ABSENCE OF PROTOCOL

At the time Mr. Vaughn and Mr. Noble were killed, neither Monterey or Mendocino Counties had interagency policies and procedures which addressed the roles and responsibilities of mental health staff and law enforcement during the 5150 process. Monterey County had a manual summarizing applicable statutes and

how to fill out forms, etc., but it did not address how and when mental health staff and the police should work together. When PAI asked the Ukiah Police Department for their policies and procedures relating to 5150, PAI received an outdated copy of Section 5150. Both counties have now adopted interagency protocols which meet standards for determining when and how mental health staff should enlist the assistance of law enforcement.

IX. RECOMMENDATIONS

AVOID MISUSE OF POLICE THROUGH EFFECTIVE COMMUNITY MENTAL HEALTH CRISIS SERVICES

It should not be presumed that because an individual is a mental health professional that he/she has sufficient training and expertise to effectively manage mental health crises in the community or work in collaboration with law enforcement. Mental health staff should receive advanced, ongoing training to improve their ability to provide effective crisis mental health services in the community. This training should focus on enhancing mental health staff's ability to resolve conflict and de- escalate tense situations so that the necessity for police intervention is minimized and the risk of lethal harm diminished. Procedure and related training should provide guidance about how to develop and implement effective strategies for addressing the refusal of treatment that may lead to deterioration of a person's psychiatric disability or unwanted involuntary hospitalization. Community mental health services protocol should also address how to proactively involve family and friends to help their loved ones resolve problems and avoid unnecessary hospitalization.

EXERCISE PROFESSIONAL JUDGMENT

All 5150-related policies, procedures, protocol and training should emphasize that law enforcement must exercise their own judgment regarding whether or not an individual presently meets the criteria for involuntary detention. Protocols should anticipate the potential for disagreement between mental health staff and the local police regarding whether or not law enforcement should be involved, and should specify interagency guidelines for resolving such conflict.

PROVIDE EFFECTIVE TRAINING

As noted above, following Mr. Vaughn's death, local officials began taking significant action to ensure that Monterey police officers are properly trained

regarding how to handle crisis situations involving people with psychiatric disabilities. To date, a number of training activities have occurred, including but not limited to:

A four-hour program on how to properly respond to people with psychiatric disabilities was attended by over 400 officers.

A two-hour POST training video was completed and shown.

Local law enforcement leaders are now in the process of developing a "Crisis Intervention Team (CIT) Academy." The CIT Academy is an innovative, vigorous training program that provides law enforcement personnel with a deep understanding of how to respond to people with psychiatric disabilities who are undergoing a crisis. Where such programs have been implemented, the use of force has decreased. The first CIT training reportedly took place on May 2, 2000 and involved ten hours of training for four days, for approximately thirty-five officers. It is imperative that the CIT continuing education program be fully implemented and its results monitored.

Mendocino County has also begun providing more extensive training to its officers concerning how to effectively interact with people with psychiatric disabilities who are in crisis. Following Mr. Noble's death, the Ukiah Police Depart-ment began providing its officers with specific additional training concerning how to provide more competent police services to people with psychiatric disabilities. Trainings have focused on, among other topics, developing officers' skills in de-escalating potential confrontations using effective verbal skills rather than physical force. These training activities represent a good start; however, far more in-depth crisis intervention training is needed on a county-wide basis to

adequately prepare officers for a career of responding to mental health crises in the community.

Until appropriate mandatory police training requirements exist, counties throughout the state who have not implemented such in-depth programs, as noted above, should do so promptly. In addition, every county should ensure that all mental health professionals responsible for providing mobile or other crisis services in the community receive ongoing, intensive training in de-escalating conflict, situation management, and working effectively in collaboration with law enforcement.

IMPLEMENT INTERAGENCY PROTOCOL

As noted earlier, following the deaths of Mr. Vaughn and Mr. Noble, both Monterey and Mendocino Counties promulgated interagency policies and procedures which address the respective roles and responsibilities of mental health staff and the police during the undertaking of a 5150. Every jurisdiction should have such an interagency protocol as a minimum requirement. All interagency protocol should recognize that involving the police in a mental health crisis may have a negative impact on the person with a disability and increase the potential for violence and lethal harm. Guidelines should specify that mental health staff involve the police only when there is an objective and quantifiable threat of physical danger and all reasonable alternatives have been exhausted. Every local community should also have an effective quality assurance mechanism to monitor compliance with interagency protocol and to assist authorities in providing needed changes and related training.

The deaths of Mr. Vaughn and Mr. Noble demonstrate the compelling need to provide all mental health and law enforcement personnel with intensive training

concerning how to assist people with psychiatric disabilities who are in crisis. Mental health and law enforcement authorities should ensure that local practice only allows for the involvement of police officers in the 5150 process when necessary for the safety of the person with a disability or others, and only after mental health staff have exhausted all reasonable alternatives. Adherence to these basic guidelines may have prevented the deaths of Charles Vaughn, Sr. on May 19, 1998 in Monterey, California, and Marvin Noble on July 16, 1998 in Ukiah, California.

Questions or comments concerning this report may be directed to Colette I. Hughes, Supervising Attorney, Investigations Unit, (510) 839-0811.