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IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA WESTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF CALIFORNIA, *et al.*, Defendants.	Case No.: CV06-2667 GPS (Ex) **UNITED STATES' MEMORANDUM IN SUPPORT OF ITS MOTION TO ENFORCE THE AMENDED CONSENT JUDGMENT** HEARING: January 23, 2012, 10:00AM Hon. Audrey B. Collins Chief United States District Judge

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On May 8, 2006, the United States and the State of California entered into a Consent Judgment that required reform in the State's Hospitals for people with mental illness. The purpose of this decree was to ensure that people confined to the Hospitals were ensured safety and treatment as required by the Constitution and other federal laws. The settlement was reached against the backdrop of horrifying conditions in which people languished and died from violence and neglect.

After five years, Defendants still have not come into compliance with critical provisions of the Consent Judgment relating to basic safety and treatment concerns at Napa State Hospital and Metropolitan State Hospital. As a result, people confined in these two hospitals have died or suffered serious harm, and will remain at an unreasonable risk of serious harm, including death, absent further orders from this Court. Accordingly, the United States moves this Court to find Defendants in violation of its Amended Consent Judgment, and for an order that extends the relevant provisions of the Amended Consent Judgment that Defendants have continually violated until Defendants come into compliance and maintain such compliance.

I. FACTUAL BACKGROUND AND STATEMENT OF THE CASE

In May 2006, the United States filed a Complaint pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, alleging that Defendants were engaging in a pattern or practice of conduct that violated the constitutional and federal statutory rights of people confined within the two California State Mental Health Hospitals that are the subject of the instant motion—Metropolitan State Hospital ("Metropolitan") and Napa State Hospital ("Napa"). ECF No. 1. Simultaneously with this original Complaint, the Parties filed an original Consent Judgment, which the Court approved on May 15, 2006.

ECF No. 3. The United States filed an Amended Complaint in February 2007, that added two more Hospitals—Atascadero State Hospital and Patton State Hospital. Simultaneously with the Amended Complaint, the Parties filed an Amended Consent Judgment that extended the requirements of the original Consent Judgment to the two additional Hospitals. This Court approved the Amended Consent Judgment on February 27, 2007. ECF No. 9.

The Amended Consent Judgment ordered Defendants to make comprehensive reforms at those four State Mental Heath Hospitals, including, *inter alia*, improvements to their integrated therapeutic and rehabilitation services (in areas that included psychiatric, psychological, nursing, nutrition, medical, dental, and special education services); discharge planning and community integration; documentation; use of restraints; and protection from harm. *See generally* Amended Consent Judgment. The Amended Consent Judgment ordered Defendants to implement those reforms within 36 months of November 1, 2006. Amended Consent Judgment § IV.A; Letter from Benjamin O. Tayloe, Jr. to Frank S. Furtek, Jan. 9, 2008 (Exhibit 1) (stipulating to effective date of October 31, 2006). The Amended Consent Judgment also appointed an independent Court Monitor, who has submitted semi-annual reports to the Parties evaluating Defendants' compliance with the Court's Order regarding each Hospital.

Five years after this Court's Order,[1] people confined to the Hospitals are still in danger because Defendants continue to violate the Amended Consent Judgment by failing to implement required reforms at Napa and Metropolitan that are critical to the care and safety of people. Defendants' failure to comply with the Court's

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[1] Defendants have failed to implement the terms of the Amended Consent Judgment at Napa and Metropolitan for five years because the original Consent Judgment, before it was amended to include two other Hospitals, applied to Napa and Metropolitan when this Court ordered it in May 2006.

Order not only constitutes contempt, but also puts people confined in these two Hospitals at unreasonable risk of serious harm, including death. Defendants' violation of the Amended Consent Judgment has continued despite semi-annual findings by the independent Court Monitor that Defendants remained out of compliance. Pursuant to the terms of the Amended Consent Judgment, on September 30, 2011, the United States officially notified Defendants with specificity that they had failed to comply with the Amended Consent Judgment and, to date, Defendants have not cured their non-compliance. Letter from Jonathan M. Smith to Cynthia Rodriguez, Sept. 30, 2011 (Exhibit 2). Because the Amended Consent Judgment is currently set to expire automatically on December 2, 2011, ECF. No. 64, people in the Hospitals remain, and will remain, at unreasonable risk of harm absent another Order from this Court.

To protect these people from serious harm, the United States now moves this Court to find Defendants in violation of its Amended Consent Judgment, and for an order extending the Amended Consent Judgment's protections at Napa and Metropolitan until Defendants come into compliance and maintain compliance.[2]

II. ARGUMENT

A. Legal Standards

The United States moves to Enforce the Amended Consent Judgment, and asks this Court to extend the provisions of the Amended Consent Judgment that Defendants have continually violated. To modify the Consent Judgment, the United States must show "that a significant change in circumstances warrants

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[2] This Court dismissed Atascadero State Hospital and Patton State Hospital from this action based upon the Parties' stipulation that those hospitals had achieved substantial compliance with the bulk of the Amended Consent Judgment's terms. *See* Stipulation to Extend Court's Jurisdiction, ECF No. 63; Order, ECF No. 64.

revision of the decree." *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 385, 112 S. Ct. 748, 756, 116 L.Ed.2d 867 (1992). The United States cannot rely "upon events that actually were anticipated at the time it entered into a decree." *Id.* After proof of a change in circumstances, this Court may modify the Amended Consent Judgment if the modification is "suitably tailored to the changed circumstance." *Id.* at 383.

Courts find that a party's failure to substantially comply with a consent judgment's terms represents an unanticipated change in circumstance warranting a revision of the consent judgment. *See Labor/Community Strategy Center v. Los Angeles County Metropolitan Transp. Authority*, 564 F.3d 1115, 1120-21 (9th Cir. 2009) ("The failure of substantial compliance with the terms of a consent decree can qualify as a significant change in circumstances that would justify the decree's temporal extension"); *Thompson v. U.S. Department Of Housing & Urban Development*, 404 F.3d 821, 831 (4th Cir. 2005); *Holland v. New Jersey Dep't of Corr.*, 246 F.3d 267, 284 (3d Cir. 2001) ("Courts have extended a decree or parts of a decree when ... one party was in substantial non-compliance with the decree."); *David C. v. Leavitt*, 242 F.3d 1206, 1213 (10th Cir. 2001) ("[I]t would defy logic for Appellees to agree to include the four-year Termination Provision in the Agreement if they actually foresaw that Utah would not be in substantial compliance with the terms of the Agreement at the end of the four-year period.").

Alternatively, the United States asks for an Order to Show Cause Why Defendants Should Not Be Held in Contempt. This Court has the inherent and statutory power to enforce and sanction the flouting of its orders through a finding of civil contempt. *Shillitani v. United States*, 384 U.S. 364, 370, 86 S. Ct. 1531, 1535, 16 L. Ed. 2d 622 (1966). The United States has the initial burden of showing by clear and convincing evidence that the contemnors violated an order of the Court. *Balla v. Idaho St. Bd. Of Corrections,* 869 F.2d 461, 466 (9th Cir.

1989). The burden then shifts to Defendants to demonstrate why they were unable to comply. *Donovan v. Mazzola*, 716 F.2d 1226, 1240 (9th Cir. 1983). Defendants must show they took every reasonable step to comply. *Sekaquaptewa v. MacDonald*, 544 F.2d 396, 406 (9th Cir. 1976). Because the purpose of civil contempt is remedial, the United States is not required to prove that Defendants intended to violate the order. Even Defendants' unintentional failure to comply with the Amended Consent Judgment constitutes civil contempt; Defendants' good faith is not a defense. *See McComb v. Jacksonville Paper Co.*, 336 U.S. 187, 191, 69 S. Ct. 497, 499, 93 L. Ed. 599 (1949); *Stone v. City and County of San Francisco*, 968 F.2d 850, 856 (9th Cir. 1992) ("good faith is not a defense").

B. Defendants Have Failed To Comply with the Court's Amended Consent Judgment at Napa State Hospital and Metropolitan State Hospital

The men and women confined to Napa and Metropolitan are needlessly subjected to violence, are not protected from suicide, needlessly suffer from undetected physical health conditions, and are exposed to improper restraints. The Amended Consent Judgment requires Defendants to address each of these fundamental problems, the independent Court Monitor has established that they have not done so, and people are suffering – and will continue to suffer – grievous harm as a result. People at Napa and Metropolitan, both those residing and those working there, are seriously assaulted on a continuing basis. Although these Hospitals have inherent risks, Defendants have identified and acknowledged the need for protective measures, such as a campus-wide alarm system and a treatment unit with enhanced staffing at Napa, to prevent avoidable risks. Defendants, however, have not implemented these measures. Although this case began in 2006 amongst allegations of preventable suicides, the Court Monitor has

established that preventable suicides continue. Nursing failures to assess changes in people's physical condition, previously identified in 2006, continue today. Harmful restraint practices, identified as a significant problem at the outset of this case, continue to result in injury and death.

In Letters of Findings provided to Defendants regarding Metropolitan and Napa in February 2004 and June 2005, respectively, the United States detailed very similar inadequacies to those that still exist. Letter from R. Alexander Acosta to Gov. Arnold Schwarzenegger, Feb. 19, 2004 ("Metropolitan Findings Letter") (Exhibit 3); Letter from Bradley J. Schlozman to Gov. Arnold Schwarzenegger, June 27, 2005 ("Napa Findings Letter") (Exhibit 4). For example, at Napa, persons with histories of dangerous behavior repeatedly assaulted other persons, including an incident when an individual strangled his roommate to death, (Napa Findings Letter at 5-6); a historically suicidal person committed suicide even as the individual's family repeatedly pled to staff about his worsening condition, (Napa Findings Letter at 3); staff excessively restrained people without proper justification, used inappropriate restraint techniques, and poorly monitored the restraint usage, including an incident in which staff placed someone in a prone restraint, causing him to choke and die, (Napa Findings Letter at 10-12); and staff provided nursing care that failed to identify and treat life-threatening conditions, including for a person whose complaints about breathing problems went unaddressed before his death, (Napa Findings Letter at 13-15). Similarly, at Metropolitan, persons were regularly exposed to dangerous assaults, (Metropolitan Findings Letter at 37); staff excessively restrained patients, (Metropolitan Findings Letter at 34-35); and staff repeatedly failed to identify and treat suicidal patients or keep them out of dangerous environments, (Metropolitan Findings Letter at 42-43). Accordingly, given the continued existence of such unlawful and harmful conditions, this Court should find Defendants in violation of its Amended Consent

Judgment, and, to prevent future serious harm to people at Napa and Metropolitan, order the extension of the relevant Amended Consent Judgment protections until Defendants achieve and maintain compliance.

1. **Defendants Have Violated the Amended Consent Judgment by Placing People in Prone Restraints, Resulting in Serious Harm, including Death.**

The use of prone restraints in the psychiatric hospital setting is unreasonably dangerous. Restraining a person in a prone (face-down) position causes extreme danger of death from positional asphyxiation. Declaration of independent Court Monitor Dr. Mohamed El-Sabaawi ("El-Sabaawi Decl.") ¶ 11 (Exhibit 5). The practice is a clear violation of generally accepted professional standards of care. El-Sabaawi Decl. ¶ 11. The Amended Consent Judgment specifically prohibits prone restraints. Amended Consent Judgment § I.H.1 ("In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use."). In addition, the Amended Consent Judgment requires Defendants to "ensure that restraints . . . are used consistent with generally accepted professional standards of care." *See generally* Amended Consent Judgment § I.H.

The danger of restraints is not hypothetical. In April 2011, Napa staff placed a person in prone restraints, resulting in cardiac arrest and death. El-Sabaawi Decl. ¶ 12. Tragically, this was not an isolated incident. Just a few months earlier, in January 2011, two Napa staff forcefully subdued a person on one-to-one observation who had become agitated, and put the person in a prone restraint. El-Sabaawi Decl. ¶ 13. During the course of the restraint, this person suffered a broken arm and likely an injury to his leg that was only diagnosed as a break several days later. El-Sabaawi Decl. ¶ 13. Moreover, staff did not mention the

prone restraint in the person's Inter-Disciplinary Note, but incorrectly indicated only that "proper TSI [Therapeutic Strategies and Interventions] techniques" were used. El-Sabaawi Decl. ¶ 13. Six months after the incident, Napa's analysis of this prone restraint was still unfinished and did not address fundamental considerations, such as review of the person's psychiatric care. El-Sabaawi Decl. ¶ 14. The analysis also incorrectly indicated that a necessary participant in the review, the Medical Director's designee, had participated in the review. El-Sabaawi Decl. ¶ 14. Napa's corrective action regarding this January 2011 prone restraint was also untimely; Napa set the implementation of changes in the nursing policy (regarding interventions for assaultive people) for September 2011, nine months after the unlawful restraint. El-Sabaawi Decl. ¶ 14.

In addition to its prohibition against prone restraint, the Amended Consent Judgment contains requirements that staff use the least restrictive measures to exercise control over a person, document all uses of restraint or force, collect and analyze data on uses of restraint, and ensure that staff are properly trained on the use of restraint. Compliance with these provisions facilitates accountability and allows the Hospitals to identify operational breakdowns and implement corrective action to avoid systemic deficiencies leading to harm. The above incidents not only violate the Amended Consent Judgment's outright prohibition of prone restraints, but also show systemic violations of the requirements that restraints only be used when there is no less restrictive means, that they be fully documented, and that staff be adequately trained. Amended Consent Judgment § I.H. They also illustrate Defendants' failure to implement systems to protect people from harm. Amended Consent Judgment § I.I. Moreover, these incidents demonstrate that Defendants' documentation systems are ineffective and, as a result, Defendants are ignorant of significant events occurring at Napa, and show Defendants' failure to

implement an effective risk management system to protect people from preventable harm.

2. Defendants Have Violated the Amended Consent Judgment by Failing To Fully Implement an Effective System To Protect People from Harm, Subjecting People to an Unreasonable Risk of Harm, Including Death.

Particularly at Napa, a significant increase in admissions of persons with a history of severe sociopathy and acts of violence places persons confined there at a greater risk of harm from violence. El-Sabaawi Decl. ¶ 18. Such individuals pose unique risks, are often ill-suited for the current physical setting at Napa, and also are often responsible for a disproportionate share of violence. El-Sabaawi Decl. ¶ 18. Despite an obligation to implement corrective measures to prevent avoidable harms, Defendants have failed to implement necessary corrective mechanisms that they have identified, such as a campus-wide alarm system and a unit with enhanced staffing and other protections to house particularly violent persons in a safe and therapeutic setting. El-Sabaawi Decl. ¶ 20. More fundamentally, in violation of the Amended Consent Judgment, neither Napa nor Metropolitan has an effective system to identify high-risk situations and institute corrective actions to protect people from preventable harm. El-Sabaawi Decl. ¶¶ 15-20. As a result, Defendants subject people confined in those Hospitals to an unreasonable risk of harm, including death. El-Sabaawi Decl. ¶¶ 15-20.

In large mental health facilities, such as Metropolitan and Napa, having a system to identify and correct high-risk situations in a timely fashion is critical to prevent serious harm to people. Accordingly, the Amended Consent Judgment requires each State Hospital to:

develop, revise as appropriate, and implement performance

> improvement mechanisms that enable it to comply fully with this [Amended Consent Judgment], to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State Hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:
>
> (a) Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems . . .
>
> (b) Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. . .
>
> (c) [The Hospitals to] [u]tilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.

Amended Consent Judgment § I.I.2.

After five years, Defendants still have not implemented an effective system as this Order requires. El-Sabaawi Decl. ¶ 15. Persons who commit repeated acts of serious aggression, meaning aggression requiring more than first aid to treat, pose a particularly great risk of harm because of the likelihood they will continue to harm others. El-Sabaawi Decl. ¶ 19. Yet, Defendants are only beginning to develop a reliable means of identifying persons who commit repeated acts of aggression leading to serious harm and fail to implement appropriate corrective

steps to remedy deficiencies that place people at risk of unreasonable harm. El-Sabaawi Decl. ¶ 15-17. For example, Napa has determined that it needs to implement a campus-wide alarm system and a treatment unit with enhanced staffing to serve individuals at heightened risk of violence, but it has yet to do so. El-Sabaawi Decl. ¶ 20. As explained below, these failures have caused at least one person's death and place many others at continued risk of serious harm and death.

The failure of Napa and Metropolitan to implement their identified corrective actions causes unacceptably high rates of incidents of serious injury, (i.e., requiring more than first aid), from residents harming themselves and others. El-Sabaawi Decl. ¶ 17. For instance, as noted above, Napa has significantly increased its admissions of persons with severe sociopathy and histories of violence. El-Sabaawi Decl. ¶ 18. Yet officials at Napa have currently acknowledged in internal reports that the facility has significant safety vulnerabilities and that Napa has not taken necessary steps to address those risks.[3] El-Sabaawi Decl. ¶ 18.

The Hospitals' failure to identify and take action to prevent unnecessary risks of harm indicates a fundamental failure in risk management and performance improvement mechanisms that exposes people to unreasonable harm. El-Sabaawi Decl. ¶ 15-20. In fact, Defendants ignored repeated warnings from the Monitor, and waited until a person killed a staff member in October 2010 before starting to institute a performance improvement system to protect people from preventable harm. El-Sabaawi Decl. ¶¶ 19-20.

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[3] Napa's Chief of Medical Staff, on behalf of Napa's 177 medical staff, went so far as to write this Court that Napa was not compliant with this performance improvement requirement and urged this Court to extend the Amended Consent Judgment because of the associated risk of harm to Napa residents and staff. Letter from Shakeel Khan, MD, Chief of NSH Medical Staff to Chief Judge Collins, Nov. 7, 2011 (Exhibit 6).

In July 2010, the Monitor discovered that repeated acts of recorded aggression at Napa, including aggression against staff, had increased significantly, and that Napa had not identified this significant increase in aggression, nor, more fundamentally, developed mechanisms to address repeated acts of aggression. El-Sabaawi Decl. ¶ 19. He alerted Napa to the failure of its risk management and performance improvement system and warned Napa that this failure placed people and staff at risk of harm from aggression. El-Sabaawi Decl. ¶ 19. In his report, he wrote:

> NSH did not adequately review and assess its data regarding trends and patterns in aggression data during this review period. These trends/patterns were clearly evident to this monitor and his performance improvement expert during pre-tour and onsite reviews of the facility's data. This deficiency deprived the facility of a critical tool in assessing and addressing factors that contributed to an increase in the incidence of aggression compared to the previous review period.

Monitor's NSH Report 9 at 4.[4] Napa should have examined why reported rates of aggression were increasing and identified steps that it needed to take in response, but it did not do so. El-Sabaawi Decl. ¶¶ 19-20. Nevertheless, despite the Monitor's warnings, Napa did not undertake steps toward the development of an effective performance improvement system, including necessary measures to reduce risk of harm to people from aggressive behavior, until after the October 2010 murder. El-Sabaawi Decl. ¶¶ 19-20.

Napa also has ignored obvious patterns and warnings from the Monitor regarding suicide prevention, resulting in avoidable suicide deaths. El-Sabaawi

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[4] This Report excerpt is attached to Monitor El-Sabaawi's Declaration as "Excerpts from the Introduction."

Decl. ¶¶ 21-24. In December 2009, a person at Napa made a serious attempt at suicide by hanging. El-Sabaawi Decl. ¶ 21. Napa did not conduct a root cause analysis of the incident to discover how it occurred or how it could be prevented in the future. El-Sabaawi Decl. ¶ 21. Just four days later, another person at Napa committed suicide by hanging. El-Sabaawi Decl. ¶ 22. Napa's analysis of this second incident was again deficient because, among other things, it did not identify as a contributing cause of the suicide that unclear staff assignments resulted in no psychiatrist actively following the individual's condition in the period before the death. El-Sabaawi Decl. ¶ 22. When the Monitor reviewed the incident, he discovered that Napa does not have clear expectations regarding precisely which psychiatrist was responsible for an individual's care during the anticipated absences of the regularly attending psychiatrist. El-Sabaawi Decl. ¶ 23. Napa's review had not identified this deficiency. El-Sabaawi Decl. ¶ 23. The Monitor alerted Napa to this breakdown in care and warned that it needed correction because it places people at serious risk of harm, including death. El-Sabaawi Decl. ¶ 23.

Despite this warning, Napa did not correct these breakdowns, which contributed to another person's suicide. El-Sabaawi Decl. ¶ 24. In February 2011, a person at Napa committed suicide by jumping. El-Sabaawi Decl. ¶ 24. This person recently had made an identical suicide attempt. El-Sabaawi Decl. ¶ 24. The nurses' notes document that the person continually reported that voices were telling him to jump. El-Sabaawi Decl. ¶ 24. Yet his psychiatrist did not reassess his condition or adjust his treatment as clinically indicated - even after the person's first attempt. El-Sabaawi Decl. ¶ 24. The breakdowns in psychiatric coverage and failure to conduct needed reassessments that the Monitor had warned Napa about were strong contributing factors to this person's death. El-Sabaawi Decl. ¶ 24. This significant breakdown in care, and failure to address the previous problem, is

further evidence of Napa's failure to implement a functional risk management and performance improvement system. It separately demonstrates that psychiatric reassessments currently are deficient at Napa in violation of the Amended Consent Judgment. El-Sabaawi Decl. ¶ 22-24; *see also* Amended Consent Judgment § I.D.1 (requiring provision of "routine and emergency psychiatric assessments and reassessments"). Indeed, Napa's Chief of Medical Staff wrote this Court a letter admitting that Napa was not compliant with this specific requirement and asking for the extension of the Amended Consent Judgment. Letter from Shakeel Khan, MD, Chief of NSH Medical Staff to Chief Judge Collins, Nov. 7, 2011 (Exhibit 6).

Similarly, Metropolitan ignored the Monitor's warnings that one of their physicians was failing to provide people with minimally adequate care. El-Sabaawi Decl. ¶ 25. The Monitor alerted Metropolitan officials that this physician needed more medical oversight, but Metropolitan failed to institute this corrective action. El-Sabaawi Decl. ¶ 25. Subsequently, this physician failed to provide medical care to a person who suffered a full body system failure over the course of several months and eventually died. El-Sabaawi Decl. ¶ 25. The same physician delayed treatment for several hours to a person with a broken spine. El-Sabaawi Decl. ¶ 25. This delay likely caused the person's permanent disability. El-Sabaawi Decl. ¶ 25. Metropolitan did not remove this physician until after the Monitor's warning and these two events. El-Sabaawi Decl. ¶ 25. This example shows Metropolitan's failure to monitor and institute corrective action through an effective risk management and performance improvement system to protect people from preventable harm. El-Sabaawi Decl. ¶ 25.

During the Court Monitor's August 2011 tour of Metropolitan, he discovered that the facility had not conducted a review of psychiatric care for an individual suffering from severe depression after her serious and potentially lethal

suicide attempt of running into the path of a moving vehicle. El-Sabaawi Decl. ¶ 28. The failure to conduct such a review occurred even after the Monitor warned the facility during his previous inspection about its failure to conduct adequate reviews of contributing factors to harmful "sentinel" events. El-Sabaawi Decl. ¶ 28. In particular, Metropolitan did not examine contributing factors for two successive events that involved the same person, who was found hanging, unable to breathe and unresponsive, between the upper and lower side rails of his bed, and two weeks later was found on the floor next to his bed. Moreover, Metropolitan did not even implement the corrective actions that it had identified following these two incidents until the monitoring team noted that fact. El-Sabaawi Decl. ¶ 28. During the same tour, the Court Monitor had warned Metropolitan about its failure to conduct an adequate mortality review of the choking death of an individual to identify important factors that may have contributed to this mortality. El-Sabaawi Decl. ¶ 28. Metropolitan's failure to conduct timely and adequate reviews of sentinel events despite repeated warnings illustrates its lack of a functional risk assessment and performance improvement system. Such as system is necessary to protect people from serious but preventable harm. El-Sabaawi Decl. ¶ 28.

Recent attacks on restrained people also demonstrate Metropolitan's failure to implement an effective risk management and performance improvement system that protects people from preventable harm. El-Sabaawi Decl. ¶¶ 26-27. In late May 2011, Metropolitan permitted a person who was immobilized and defenseless in mechanical restraints, and who should have been under continuous protective observation, to be attacked and viciously beaten by group of people. El-Sabaawi Decl. ¶ 26. Later that night, while he was still restrained, they returned and beat him again. El-Sabaawi Decl. ¶ 26. By the end of his ordeal, the restrained person had suffered a fractured jaw. El-Sabaawi Decl. ¶ 26. Even more shocking, about a week later, Metropolitan permitted another assault on a restrained person. El-

Sabaawi Decl. ¶ 27. These repeated similar incidents demonstrate Defendants' failure to implement an effective mechanism for detecting and preventing aggression at Metropolitan in violation of the Court Order. El-Sabaawi Decl. ¶ 27.

After five years, Defendants have only just started to identify trends and high risk situations, and for the most part, have yet to use these trends to take corrective actions. El-Sabaawi Decl. ¶ 15-16. As a result, people at Napa and Metropolitan have suffered harm, including serious injuries and death, and Defendants continue to subject people to an unreasonable risk of harm. El-Sabaawi Decl. ¶¶ 15-17.

3. Defendants Have Violated the Amended Consent Judgment's Requirement That They Provide Adequate Nursing Services, Causing an Unreasonable Risk of Harm from Untimely and Inappropriate Treatment, and from Undiagnosed Pain.

A fundamental issue identified in the United States' findings and that the Consent Judgment was designed to address was the failure of nursing staff to assess and respond to changes in people's health status, causing unnecessary suffering and preventable harm. *See, e.g.*, Napa Findings Letter at 13-15 (nursing staff failed to identify and treat life-threatening conditions). Nursing services at both Napa and Metropolitan have continually violated the requirements of the Amended Consent Judgment, subjecting people to harm and unreasonable risk of harm. Amended Consent Judgment § I.F.3 requires the State Hospitals to "provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services." The most troubling violations of these nursing requirements at Napa and Metropolitan involve their consistent failure to perform required nursing reassessments regarding changes in people's health condition or "status" (e.g.,

increased temperature, symptoms of pain, psychiatric symptoms, etc.). Declaration of Court Monitor Consultant Victoria E. Lund, Ph.D., MSN, ARNP, BC ("Lund Decl.") ¶ 9 (Exhibit 7).

Amended Consent Judgment § I.F.3.e requires Defendants to "ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health and mental status of people in a manner that enables interdisciplinary teams to assess each person's status and respond to interventions, and to modify, as appropriate, people's therapeutic and rehabilitation service plans" and to "ensure that all nursing shift changes include a review of changes in status of individuals on the unit." Despite this order, nurses at Metropolitan and Napa continually fail to adequately recognize, document, assess, and alert physicians to people's change of health condition, and this results in the Hospitals depriving people of timely and appropriate treatment. Lund Decl. ¶ 9-19; *see also* Monitor's NSH Reports 6-10, § I.F.3.e; Monitor's MSH Reports 6-10, § I.F.3.e.[5] Since the Amended Consent Judgment's effective date, nurses at Napa and Metropolitan have never achieved better than partial compliance for this critical requirement. Lund Decl. ¶ 11.

The Monitor's reviews of people's charts show a systemic pattern of failures to identify changes in people's symptoms of, *inter alia*, pain, constipation and other bowel irregularities, lung problems, elevated temperatures, significant cognitive and behavior changes, seizures, and bone fractures, leading to unnecessary and preventable pain and suffering and risk of serious harm. Lund Decl. ¶ 12; Monitor's NSH Reports 6-10, § I.F.3.e; Monitor's MSH Reports 6-10, § I.F.3.e. Many times nurses documented a person's change in health condition, but did not recognize the change as a symptom of a medical problem, and, therefore, did not respond appropriately. Lund Decl. ¶ 13. Nurses also commonly

[5] These Report excerpts are attached to Monitor El-Sabaawi's Declaration.

gave repeated as-needed ("PRN") medications, such as laxatives for constipation or medications for pain, without recognizing that the need for a PRN was a change of health condition that required a reassessment. Lund Decl. ¶ 14. Nurses also commonly failed to conduct assessments at the onset of symptoms to establish a baseline point of comparison regarding the person's condition, making later determinations regarding the effectiveness of interventions extremely difficult. Lund Decl. ¶ 15. Nurses also failed to assess hospitalized people upon the persons' return to the facility for the conditions that precipitated the hospitalization. Lund Decl. ¶ 16. Significant gaps in documentation existed even after nurses identified people as experiencing a change of health condition. Lund Decl. ¶ 17. Additionally, the Monitor's review of charts showed that these Hospitals' self-audit findings for nursing reassessments were inaccurate, demonstrating Defendants' inability to identify and correct this problem. Lund Decl. ¶ 18; Monitor's NSH Reports 6-10, § I.F.3.e; Monitor's MSH Reports 6-10, § I.F.3.e.

Nurses' failure to document and assess changes in health conditions adequately can deny people timely and appropriate medical care. Lund Decl. ¶ 19. These failures result in real harm to people, including their suffering unnecessary pain for extended periods. Lund Decl. ¶ 19. For example, a person at Metropolitan suffered a seizure and failed to regain consciousness/responsiveness. Lund Decl. ¶ 20. The nursing notes documenting the person's condition following the seizure, however, incorrectly described the person as "resting comfortably with no complaints of distress." Lund Decl. ¶ 20. This normally active person laid in bed with his eyes closed for 48 hours without regaining consciousness. Lund Decl. ¶ 20. Although the nursing notes documented that this person had a dangerously low sodium level, nurses did not recognize that it was rendering him unconscious.

Lund Decl. ¶ 20. The failure to recognize this person's dangerously low sodium level denied him appropriate treatment for 48 hours. Lund Decl. ¶ 20.

Another example involves a person at Napa discovered lying on the ground screaming. Lund Decl. ¶ 21. Staff failed to realize that the person had a broken bone even though the nursing notes indicate that his leg was abnormally rotated and a bulge protruded from his hip. Lund Decl. ¶ 21. The notes indicate that no one checked his temperature or circulation, or administered any basic first aid. Lund Decl. ¶ 21. Without immobilizing the person's leg, staff lifted him and placed him in a wheelchair, causing the person to scream in pain. Lund Decl. ¶ 21. The fracture was not discovered until the person was transferred to an outside hospital two hours later. Lund Decl. ¶ 21.

Despite the Monitor's findings over the last few years that Napa and Metropolitan continue to violate the Amended Consent Decree's nursing provisions, Defendants have failed to correct the violations. Lund Decl. ¶ 22; Monitor's NSH Reports 6-10, § I.F.3.e; Monitor's MSH Reports 6-10, § I.F.3.e.

C. This Court Should Extend the Relevant Provisions of the Amended Consent Judgment and Order Defendants To Come into Compliance.

Defendants' continuous violation of this Court's Amended Consent Judgment for years, despite repeated warnings from the independent Court Monitor, has seriously harmed the individuals in the Hospitals and continues to risk further harm. As illustrated above, Defendants have failed to prevent murders of staff, assaults, and suicides, despite urgent warnings from the Monitor that their failures would result in such serious harms. Defendants have shown their inability or unwillingness to achieve compliance through self-reform. Therefore, this Court

should not release Defendants from their obligations until they demonstrate sustained compliance.

Accordingly, this Court should:

1) Extend those substantive Amended Consent Judgment provisions Defendants have continually violated at Napa and Metropolitan, namely § I.H (restraints), § I.I.2 (performance improvement system), § I.D.1 (psychiatric assessments and reassessments), and § I.F.3 (nursing services and assessments);
2) Extend the Enforcement provisions of the Amended Consent Judgment, namely § II (Enforcement).
3) Order these extensions until Defendants achieve sustained substantial compliance with these provision for 12 months, as documented by reports from the independent Monitor; and
4) Order any other just and proper relief.

III. CONCLUSION

For the reasons set forth above, the Court should find Defendants in violation of the Amended Consent Judgment and should order the reqested relief to extend the Amended Consent Judgment.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that, on December 2, 2011, a true and exact copy of this Memorandum in Support of Motion to Enforce was served via email, (and by U.S. Mail, first-class postage prepaid, on December 3, 2011), to:

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