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**REPORT OF**  
**AN INVESTIGATION INTO THE CIRCUMSTANCES**  
**SURROUNDING THE DEATH OF**  
**KAYE L. ON FEBRUARY 4, 1997**  
**AT THE MENDOCINO COUNTY JAIL**

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

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**PAI thanks Mendocino County Officials for their cooperation with this investigation.**

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## I.

### **INTRODUCTION**

**This report presents the results of the investigation conducted by Protection & Advocacy, Inc. (PAI) into the circumstances surrounding the suicide death of Kaye L.<sup>1</sup> on February 4, 1997, at the Mendocino County Jail. PAI releases this report as part of its efforts to improve care and treatment, as well as prevent abuse and neglect, of people with psychiatric disabilities in California jails and mental health facilities.<sup>2</sup>**

**On January 25, 1997, following a suspected suicide attempt the night before, the Ukiah Police Department transported Kaye L. to the Mendocino County Psychiatric Health Facility, where she was evaluated at the Crisis Stabilization Unit (CSU) and denied inpatient hospitalization, which she had requested. An altercation ensued between Kaye L. and facility staff after she was told she would have to leave the facility. As a result, staff placed Kaye L. under citizen's arrest and called the police. She was booked and incarcerated at the Mendocino County Jail, and released five days later on her own recognizance. The next day, on January 31, 1997, she was arrested on an outstanding warrant and booked into the Mendocino County Jail once again. Four days later, on February 4, 1997, Kaye L. was found dead in her cell — the result of hanging herself with a piece of clothing.**

**PAI is an independent, private, nonprofit agency which protects and advocates for the rights of persons with disabilities. Under federal and California state law, PAI has the authority to investigate incidents of abuse and neglect of persons with disabilities. 42 U.S.C. §§ 794e, 6000 and 10801, *et seq.*; 34 C.F.R. § 381.1, *et seq.*; 42 C.F.R. § 54.1, *et seq.*; 45 C.F.R. § 1385, *et seq.*; Cal. Welf. & Inst. Code § 4900, *et seq.***

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<sup>1</sup> PAI has elected to use pseudonyms throughout this report.

<sup>2</sup> Another inmate committed suicide at the jail on January 23, 1998. Although the decedent reportedly had a psychiatric history, PAI did not investigate, as eligibility for PAI services could not be established.

## **II.**

### **EXECUTIVE SUMMARY**

On January 25, 1997, Kaye L.'s friend called the police after Kaye L. told her she had taken a handful of Elavil. Police officers then took Kaye L. to the Mendocino County Psychiatric Health Facility (PHF) to be evaluated pursuant to California Welfare and Institutions Code Section 5150. Crisis Stabilization Unit (CSU) staff examined Kaye L. for approximately two hours and determined that she did not meet the standards for involuntary commitment. Kaye L. subsequently asked to be admitted voluntarily to the In-patient Unit, but her request was denied and staff told her to leave the building. When Kaye L. refused to leave, a physical altercation ensued. Kaye L. assaulted two staff members and broke a window. After being placed under citizen's arrest by a staff member, she was transported to the Mendocino County Jail and incarcerated for five days.

On January 30, 1997, Kaye L. was released on her own recognizance, but arrested one day later on an outstanding warrant for an unrelated probation violation. She was returned to the Mendocino County Jail, where she remained another four days, until her suicide death on February 4, 1997. She was discovered by a guard at approximately 4:30 PM. One end of her nightgown was tied around her neck and the other end tied around a post that was supporting a wall-mounted table. There were no signs of life. She was pronounced dead shortly thereafter.

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#### **A. SUMMARY OF FINDINGS AND CONCLUSIONS**

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**PAI's investigation concluded:**

- ❑ There is no evidence to suggest that Kaye L.'s death was anything other than a suicide.**
- ❑ Although the Mendocino County PHF staff's decision to deny Kaye L.'s request for in-patient hospitalization may have been justified, the crisis evaluation services provided Kaye L. did not appear to sufficiently weigh the benefits of respite and sanctuary (i.e., rest and a safe place to stay) nor sufficiently probe the underlying reasons for her condition.**
- ❑ Mendocino County Jail facility staff violated the jail's policy and procedure by failing to give Kaye L. the housing classification required for inmates with a history of psychiatric hospitalizations and inmates who use psychotropic medications.**
- ❑ There is a conflict in the evidence as to whether correctional or mental health staff at the jail knew or should have known that Kaye L. was at risk for suicide the day she took her life.**
- ❑ A conflict of interest existed with regard to Kaye L. and the mental health worker at the Mendocino County Jail who acted as the primary gatekeeper to the jail's psychiatrist (and hence to psychotropic medications) because she had been assaulted by Kaye L. at the CSU just prior to Kaye L.'s first incarceration on January 25, 1997.**
- ❑ Kaye L. should have been promptly evaluated by a qualified physician at the Mendocino County Jail to determine whether her requests for psychiatric medication should have been honored.**
- ❑ On February 4, 1997, Mendocino County Sheriff's correctional personnel failed to make hourly walk-through checks of Kaye L. and other inmates between the hours of 1:30 PM and 4:30 PM (when Kaye L.'s body was discovered), in violation of Mendocino County Sheriff's Department policy and procedure.**

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## **B. SUMMARY OF RECOMMENDATIONS**

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**Based on its findings and conclusions, PAI recommends a number of actions be taken by Mendocino County Mental Health, Mendocino County correctional staff and jail mental health providers.**

**◆ EVALUATING THE THERAPEUTIC VALUE OF RESPITE AND SANCTUARY IN PROVIDING CRISIS SERVICES**

**PAI questions the necessity of forcing Kaye L. to leave the CSU after two hours of evaluation. The CSU is authorized to keep patients for 23 hours. Kaye L. had swallowed a handful of prescription antidepressants the previous night, was experiencing underlying stressors of an unknown origin, and was desperate to stay. Had staff further evaluated the stressors underlying Kaye L.'s condition, and weighed the therapeutic value of respite and sanctuary, the altercation which resulted in staff being assaulted and Kaye L. being arrested and jailed may have been avoided. County Mental Health staff should receive training concerning the therapeutic value of respite and sanctuary. Providing rest and a safe place to stay can be an effective crisis intervention. Admission policies and procedures should be amended so that proper attention is given to the benefits of respite and sanctuary when staff is deciding whether to admit a patient to the CSU or PHF.**

◆ **DEVELOPING A RELIABLE INMATE HOUSING CLASSIFICATION SYSTEM**

**The Mendocino County Jail should develop an effective quality assurance mechanism to ensure that its policies and procedures regarding inmate housing classification are followed. Particular attention should be given to ensuring that persons with psychiatric disabilities are appropriately housed. More thorough training of correctional staff concerning inmate classification requirements should be provided during orientation and at least annually thereafter.**

◆ **ENSURING ACCESS TO PSYCHIATRIC MEDICATIONS**

**The Mendocino County Jail's gatekeeping system for access to psychiatric medications interferes with inmates' rights to adequate mental health services. The procedure in place at the time of Kaye L.'s death allowed a licensed psychiatric technician to determine whether an inmate would have access to a psychiatrist for purposes of obtaining psychotropic medications. This is inappropriate. Psychiatric technicians are not trained to determine whether the administration of psychotropic medications is medically necessary. Procedure should be changed so that inmates requesting psychiatric medications have access to the jail's psychiatrist within eight hours of making the request. This will ensure that needed psychotropic medications are prescribed by a qualified physician in a timely fashion.**

◆ **AVOIDING CONFLICT OF INTEREST**

**Mental health and other care staff who have been assaulted by an inmate should not be responsible for the care, treatment, or assessment of that inmate. A protocol should be implemented to safeguard against inmates being evaluated or cared for by clinical staff whose objectivity may have been compromised by such an incident.**

◆ **ENSURING COMPLIANCE WITH INTERNAL WALK-THROUGH POLICY**

**Jail management should adopt a quality assurance system that ensures walk-throughs are performed by staff on an hourly basis as required by current internal policy. This may require the hiring of more correctional staff.**

### **III.**

## **BACKGROUND**

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#### **A. KAYE L.**

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According to records obtained by PAI, Kaye L. was well-known by local mental health workers. She was first hospitalized for symptoms related to her psychiatric disability in 1995. Over the next year and a half, she was admitted to the Mendocino County Psychiatric Health Facility (PHF) for brief in-patient stays, lasting for two to nine days. She participated marginally in treatment programs during these in-patient stays and usually requested discharge shortly following her admission. Kaye L. generally complained of auditory hallucinations, paranoia and insomnia, but did not usually display signs or symptoms of a psychotic disorder. At times, she was depressed and suicidal, and took more than the prescribed dosage of psychotropic medication. Kaye L. received out-patient medication management services from Mendocino County Mental Health.

Kaye L. was diagnosed with “*Borderline Personality Disorder*” (her primary diagnosis) and “*Polysubstance Abuse, By History.*” At times, blood and urine tests conducted during Kaye L.’s admissions at the Mendocino County PHF revealed the presence of illegal drugs. Substance abuse contributed to her involvement with the criminal justice system from 1995 until her death in February 1997.<sup>3</sup>

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<sup>3</sup> People with psychiatric disabilities sometimes have substance abuse problems and are commonly referred to as “dually diagnosed” by the mental health system of care.

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## **B. MENDOCINO COUNTY PSYCHIATRIC HEALTH FACILITY**

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The Mendocino County PHF is a 12-bed psychiatric health in-patient unit located at 860 North Bush Street in Ukiah, California. The facility is operated by the Mendocino County Mental Health Services Department and regulated by the California Department of Mental Health. The most recent licensing survey of the facility revealed no significant regulatory deficiencies. Patients can be admitted on a voluntary basis although most are hospitalized involuntarily pursuant to California Welfare and Institutions Code Section 5150, *et seq.* Kaye L. was not admitted on either basis, and was arrested following an altercation which ensued when she refused to leave.

◆ **INVOLUNTARY ADMISSIONS**

The PHF's policy on Involuntary Admissions states:

Persons transported to the Psychiatric Health Facility under 5150 applications for evaluation will be subjected to a procedure of assessment that will give full faith and credit to all 5150 applications. All applications will be assessed thoroughly, erring in the direction of safety of the patient and community, to determine whether the person will be admitted into the Psychiatric Health Facility or returned to the community.

Mendocino County Mental Health Services Policy & Procedure, Involuntary Admissions to Psychiatric Health Facility III. B-1.

On February 25, 1997, following two hours of evaluation, Mendocino County Mental Health staff determined that Kaye L. did not meet the criteria for involuntary in-patient hospitalization.

◆ **VOLUNTARY ADMISSIONS**

**Mendocino County Mental Health Services has procedures for admitting patients voluntarily to the PHF. A patient may be admitted voluntarily if he or she “is assessed to be suffering from a mental disorder and/or experiencing an acute life crisis which requires treatment in an acute 24-hour residential treatment setting.”**

**Admission criteria for voluntary in-patient treatment includes:**

- **Client is in need of 24-hour residential services;**
- **Client will not be able to resolve his or her problem in a less restrictive setting; and**
- **Client is capable of participating and benefitting from a residential psychiatric treatment program.**

**Mendocino County Mental Health Services Psychiatric Health Facility Operating Procedures, Admission Policy OP87-51.**

**On January 25, 1997, staff determined that Kaye L. did not need and would not benefit from being admitted voluntarily on an in-patient basis to the PHF.**

◆ **PROSECUTING PATIENTS**

**Mendocino County Mental Health Services also has a policy and procedure for prosecuting patients who commit crimes while they are hospitalized. This policy was carried out on January 25, 1997 when Kaye L. refused to leave the PHF and staff placed her under citizen’s arrest and had her transported to jail. The policy states:**

**POLICY: Circumstances exist where it is realistic and appropriate to file legal charges against an individual identified as a client/patient of the Department of Mental Health when they have clearly committed a serious offense and violated a law intended to**

**preserve and protect the safety of others and/or property and the individual is objectively assessed as responsible for their acts. Extreme care must be exercised to assure that no client/patient is held legally liable when their behavior is a direct consequence of their mental illness.**

**Mendocino County Mental Health Services Policy & Procedure, Involuntary Admissions to Psychiatric Health Facility II. F-4.**

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**C. MENDOCINO COUNTY CRISIS STABILIZATION UNIT**

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**The Crisis Stabilization Unit (CSU) shares its physical plant with the Mendocino County PHF, and is adjacent to the Mendocino County Mental Health out-patient complex. According to the 1997-98 Compendium of Programs and Services, the CSU's goal is:**

**To resolve acute mental health crises that cannot be treated with outpatient services. To prevent psychiatric hospitalization or psychi-atric decompensation. To reduce the utilization of out-of-county psychiatric hospitals for Mendocino County residents of all ages, especially for children and adolescents.**

**The program offers the following services:**

- Treatment is provided for up to 23 hours; 3 beds.**
- A quiet, low-stimulus environment with an individual focus.**
- Individual assessments and crisis counseling.**
- Planning and coordination with other treatment personnel, adminis-tration of prescribed medication.**

- **Aftercare plans developed with referrals to appropriate resources and program.**

**Recommended criteria for determining an individual's clinical appropriateness for admission to the CSU include:**

- **Individual's behavior is indicative of the need for increased intensity of services. Examples are depressed mood; increase in frequency of panic attacks; obsessions/compulsions causing marked distress interfering with normal routine; situational crisis; and/or experience of a major life event or other event causing psychological trauma.**
- **The individual is impaired to the degree that there are manifestations of disability in interpersonal, occupational, and/or educational functioning. There can also be a significant increase in drug and/or alcohol use which has led to significant impairment in daily functioning with some indication of psychiatric illness.**

**Services are provided to the following broad classifications of patients, including:**

- **Any person demonstrating the need for observation and acute, rapid stabilization who is determined to be medically stable through biological assessment/screening or medical history and physical examination.**
- **Any person who does not meet criteria for involuntary in-patient admission but exhibits potential risk of behaviors which is life threatening, destructive or disabling to self and/or others.**

**The range of services provided include crisis intervention, mental health assessment, physical health screening, evaluation and/or consultation by a psychiatrist, medication evaluation, one-to-one counseling, discharge planning, and case management services, when appropriate.**

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## **D. MENDOCINO COUNTY JAIL**

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The Mendocino County Jail is located at 951 Low Gap Road in Ukiah, California, and is operated by the Mendocino County Sheriff's Department. The jail has various kinds of cells for housing inmates. Dormitory cells are used to confine the general jail population. Inmates with psychiatric and other specific characteristics and needs are sometimes assigned specific housing, referred to as Safety Cells and Administrative Segregation Cells. While incarcerated, Kaye L. was put in a Safety Cell as well as an Administrative Segregation Cell.

### **◆ SPECIAL HOUSING ASSIGNMENTS**

Section 403.00 of the Policy and Procedure Manual for the Corrections Division (the Corrections Manual) of the Mendocino County Sheriff's Department describes a Safety Cell in the following manner:

Located at Intake/Reception, this padded cell is specifically designed and equipped for an inmate who is classified as suicidal, extremely destructive, violent, or shows violent psychiatric disorders.

Section 402.00 of the Corrections Manual defines Administrative Segregation as:

The physical separation of different types of inmates from the general population, i.e., protective custody, civil commitments, inmates prone to escape or assault on staff or other inmates, medical/mental health problems, and inmates who cannot function normally in an open wing as demonstrated by numerous write-ups for major violations of facility rules.

### **◆ INMATE CLASSIFICATION**

According to state law, each jail must have a written classification plan for assigning inmates to a housing unit. This plan must take into consideration the sex, age, criminal sophistication, seriousness of crime charged, assaultiveness, and other criteria pertinent to the safety of inmates and staff. Cal. Code Regs. tit. 15, § 1050. The Corrections Division's policies and procedures regarding classification of inmates meet the requirements set forth in Title 15. Section 410.00 of the Corrections Manual states:

- A. The objective of the Inmate Classification Plan is to systematically and continually assess and monitor the risk criteria and custody requirements for all inmates confined to the Mendocino County Corrections Facilities. A successful classification plan will provide safe and secure custodial environment, protect inmates and staff, and appropriately house inmates, ensure necessary levels of security, minimize new crimes and infractions, assist in determining inmate eligibility for participation in facility programs and activities, and facilitate the administration and management of detention facilities.
- B. The classification of inmates shall be undertaken in accordance with Federal, State, and local laws; with nationally accepted standards for Adult Detention Facilities; and with the policies, procedures and guidelines set forth in the Inmate Classification Plan. Inmate levels of classification shall be assigned, to reasonably ensure the safety and security of individuals, property, and programs within the facilities. Classification shall be administered equitably and consistently, without discrimination against any individual based on sex, race, color, cultural background, physical handicaps, or national origin.
- C. Classification assessments and housing decisions will be supported by as much information as can be reasonably gathered from an inmate, from the inmate's personal, criminal, medical, social, and detention histories; from professional staff evaluations and assessments; and from observed conduct and behavioral patterns. Classification is a distinct and separate process from discipline (see Inmate Discipline Plan) although rule infractions, misconduct, non-confirming behavior, and resultant disciplinary actions will

**be considered in classification requirements, housing assignments, and program eligibilities.**

**According to the Corrections Manual, each inmate is assigned an alphabetical classification code which serves as a framework for housing and handling inmates. The classification codes have discrete descriptions of inmate characteristics and/or conditions.**

**An "M" Classification is defined as:**

**Medium-range risk potential with no currently identifiable major risk characteristics.**

**An "S" Classification is defined as:**

**History of psychiatric hospitalization; mentally retarded or developmentally disabled; history of suicide attempts or self-mutilation; use of psychotropic medications; symptoms of mental/psychiatric/psychological conditions or problems, being maintained with or requiring frequent medication and/or mental health treatment.**

**A "Y" Classification is defined as:**

**Immediate threat to own safety; behavior symptomatic of acute, critical psychiatric/mental health problems.**

**◆ WALK-THROUGHS**

**According to George Carter, Commanding Officer at the Mendocino County Sheriff's Department, inmates are checked every hour during jail inspections (i.e., "walk-throughs"). Section 203.00 of the Corrections Manual reads, in part:**

**III. INFORMAL INSPECTIONS**

**H. CORRECTIONS STAFF will inspect every area of the facility daily, including holidays and weekends, and report their findings to the appropriate Facility Supervisor.**

- 1. Staff will continuously assess inmate morale and the quality of care and supervision inmates are receiving and report the findings on the respective Daily Activity Log and/or Shift Activity Report and the Cell/Module Security Log. These walk-throughs shall be done at least once an hour. (Emphasis added.)**

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**E. CALIFORNIA FORENSIC MEDICAL GROUP**

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Medical and mental health services at the jail are provided by the California Forensic Medical Group (CFMG), a private medical group under contract to provide on-site medical and mental health assessment and care on a 24-hour basis. CFMG employs a psychiatrist and a licensed psychiatric technician to provide mental health services at the jail. CFMG also employs licensed vocational nurses (LVNs) who are on-site at the jail at all times. According to Cynthia Jones, CFMG Program Manager, LVNs are trained to perform initial suicide assessments of inmates demonstrating a suicide risk. Referrals are made for further evaluation by CFMG mental health staff if the LVN's suicide assessment indicates a possible safety risk.

According to CFMG policies and procedures, the psychiatric technician works under the direction of the medical director or the psychiatrist and the program manager. The job responsibilities for the psychiatric technician are:

- 1. Provide on-going crisis intervention and counseling.**

- 2. Refer all 5150 and 4011.6 eligible inmates to M.D. or psychiatrist.**
- 3. Respond to psychiatric emergencies as identified.**
4. Refer inmates requiring psychotropic medications to psychiatrist for evaluation and monitoring.
5. Chart all findings in inmate's medical record.
6. Consult with the psychiatrist on a weekly basis to review psychiatric records of inmates seen.

The CFMG psychiatrist works under the direction of the medical director. The job responsibilities for the psychiatrist are:

1. Provision of all required medication prescriptions and medication monitoring.
2. Provision of ongoing individual counseling as required.
3. Referral of all 5150 eligible inmates.
4. Supervision of psychiatric technician.
5. Respond to psychiatric emergencies as identified.
6. Attend Quality Assurance meetings.

Information obtained through PAI interviews indicate that Annette Gilbert is the only licensed psychiatric technician employed by CFMG. Ms. Gilbert reportedly works part-time at the jail, but is available by pager at all times. Wayne Peters, M.D., is the psychiatrist employed to provide psychiatry services to jail inmates.

**IV.**  
**CIRCUMSTANCES SURROUNDING**  
**THE DEATH OF KAYE L.**

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**A. SEQUENCE OF EVENTS**

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On January 25, 1997, Kaye L. was taken into custody by Ukiah police officers for involuntary psychiatric evaluation following a suspected suicide attempt. She was transported to the Mendocino County Psychiatric Health Facility (PHF) where she was evaluated at the Crisis Stabilization Unit and determined not to meet the criteria for involuntary detention pursuant to California Welfare and Institutions Code Section 5150, *et seq.* She subsequently requested but was denied in-patient hospitalization on a voluntary basis. When Kaye L. was instructed to leave the facility, she refused to do so. As a result, she was escorted to the back door, where she proceeded to tear the shirt off the physician who had refused to admit her and then attempted to choke Ms. Annette Gilbert, a licensed psychiatric technician. When Kaye L. was finally removed from the building, she threw a cement ashtray through one of the windows. The Ukiah Police Department was then called and Kaye L. was transported to the Mendocino County Jail and incarcerated.

On January 30, 1997, Kaye L. was released from jail on her own recognizance.

On January 31, 1997, Kaye L. was again arrested and booked into the Mendocino County Jail — this time for an unrelated outstanding warrant.

On February 3, 1997, Kaye L. was placed into a Safety Cell at the Mendocino County Jail as a result of assaulting an inmate on that date while in a Holding Cell at the Mendocino County Courthouse, awaiting her court appearance.

On the morning of February 4, 1997, Kaye L. was released from the Safety Cell and placed into an Administrative Segregation Cell, following an evaluation conducted by Annette Gilbert, a California Forensics Medical Group (CFMG) licensed psychiatric technician — who is the same technician Kaye L. assaulted at the PHF on January 25<sup>th</sup>. Later that afternoon, at approximately 4:30 PM, Kaye L. was found dead in her cell, apparently the result of hanging herself with a piece of clothing. Jail staff observed Kaye L. lying on the floor, underneath a wall-mounted table across from the door. Her body was propped against the wall, with one end of a nightgown knotted around her neck and the other end knotted around the support post of the mounted table. There were no signs of life, and she was pronounced dead.

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**B. MENTAL HEALTH EVALUATION AND INCIDENT RESULTING IN FIRST INCARCERATION: JANUARY 25, 1997**

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In the late afternoon of January 25, 1997, Kaye L. was involuntarily detained by the Ukiah Police Department for psychiatric evaluation, pursuant to California Welfare and Institutions Code Section 5150. Police officers were summoned after Kaye L. told a friend she had taken a handful of prescription antidepressants in an attempt to kill herself.

The Application for 72-Hour Detention or Evaluation and Treatment, which was completed by Officer David Walker, states, in part:

*On 1-25-97 I was dispatched to . . . regarding a possible overdose. Upon arrival I spoke with Joann Atkins. Atkins stated that Kaye L. told her she had taken a handful of Elavil.*

*I contacted Kaye L. who was very disoriented. Kaye L. refused to believe I was a Police Officer and became combative. Kaye L. was transported to UVMC. While here she stated she took a handful of Elavil because she did not want to live anymore, since she was ‘tripping out and hearing voices.’*

**Kaye L. was then transported to Ukiah Valley Medical Center where she received medical clearance for admission to the Mendocino County PHF. Later that evening, she was evaluated for nearly two hours at the Crisis Stabilization Unit (CSU) by Crisis Worker Elaine Bennett, R.N., and Stephen Young, D.O., Medical Director of the CSU and Chief Psychiatrist for Mendocino County Mental Health Services Department.**

**According to the Crisis Intervention Contact Sheet:**

*Precipitating Event: On 1-24-97 client came home from BAR under the influence of alcohol and mistakenly at 3:00 a.m. took a handful of Elavil instead of Thorazine to treat voices and went to bed. Next day Police were called by friend, 14 hrs later. When [Crisis Worker] asked how many Elavil client took, she gave vague answer. Stressor: Client has no place to stay at this time. Client wants to be admitted because she has no place to stay. 'I called everybody I know.' Client states, 'I am tripping man . . .' but can't describe to [Crisis Worker] what tripping means.*

**Kaye L. verbally contracted with crisis staff to stay safe; signed a written contract not to harm herself; and agreed to contact Dr. Vramer, at the Mendocino County Mental Health Services Department, for out-patient counseling as soon as possible. According to Nurse Bennett, Kaye L. was not complaining of suicidal ideation, homicidal ideation, auditory hallucinations, or visual hallucinations at that time.**

**Dr. Young's evaluation described Kaye L. as:**

*Affect [labile] of late, no [signs or symptoms] active psychotic symptoms, seems to be struggling with psychosocial pressures of an unknown origin. Demanding & hostile.*

**Dr. Young told PAI investigators that it was his opinion that Kaye L. was not a danger to herself, a danger to others, or gravely disabled on January 25, 1997, and, therefore, did not meet the criteria for involuntary commitment. Dr. Young also determined that Kaye L. should not be admitted to the In-patient Unit on a voluntary basis. According**

to Dr. Young, Kaye L. did not benefit from the in-patient program during prior admissions and did not appear to need in-patient hospitalization that night.

Nurse Bennett told PAI investigators that Kaye L. changed her story once she realized that she wasn't going to be admitted for in-patient hospitalization. According to Nurse Bennett, it was at this point that Kaye L. complained of being delusional and hearing voices. The medical record states that Kaye L. *“changes her description of symptoms and states that she is delusional and hearing voices.”* Nurse Bennett consulted with Dr. Young about Kaye L.'s complaint of auditory hallucinations; and Dr. Young ordered the immediate administration of Navane 5 mgs. by mouth.<sup>4</sup>

After Kaye L.'s admission was denied, the crisis team provided her with the following discharge plan:

- Received Navane 5 mg by mouth and a two week prescription for Navane 2 mg one to two tablets at night (a total of 24 tablets);<sup>5</sup>
- Instructed to contact mental health outpatient clinic 1-27-97 for follow-up appointment;
- Offered a ride anywhere in Ukiah by Crisis Worker, which she refused.
- Instructed to contact Ford Street and 463-HELP for housing;
- Held her vial of Amitriptyline<sup>6</sup> 50 mg at the Psychiatric Health Facility to be picked up in one week if deemed suitable by the physician.

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<sup>4</sup> According to the Physicians' Desk Reference (PDR), Navane is "a psychotropic drug . . . effective in the management of manifestations of psychotic disorder."

<sup>5</sup> The prescription for Navane was never filled. According to the PDR and Poisoning & Toxicology Handbook, the recommended maximum daily dose is 60 mgs. It does not appear that the prescription, if taken in total, would have been lethal. Consequently, the prescription was not contraindicated, given KayeL's history of suicide attempts involving excessive amounts of prescription medication.

<sup>6</sup> Amitriptyline (also known as Elavil) is "an antidepressant with sedative effects." Physicians' Desk Reference.

According to the records, after being denied in-patient hospitalization to the PHF, Kaye L. became *"loud and threatening and refuse[d] any other offers made her."* She was asked to leave and was informed that if she did not do so, the police would be called. She said, *"Call the police. They will bring me right back to you. I am not going anywhere."* Dr. Young called the Ukiah police, but they declined to respond and stated they would only do so if a riot occurred. Kaye L. was then escorted to the back door of the PHF by Nurse Bennett, Dr. Young, and Annette Gilbert, a licensed psychiatric technician who was in charge of the In-patient Unit of the PHF during the afternoon shift.

At this point, Kaye L. reportedly became *"combative,"* tore Dr. Young's shirt off, and put her hands around the throat of Ms. Gilbert and attempted to choke her. When Kaye L. was eventually placed outdoors, she ran around to the side of the building and threw a cement ashtray through one of the windows. The police were once again called, and this time responded to the scene. According to the Police Report, Nurse Bennett placed Kaye L. under citizen's arrest, and police officers handcuffed Kaye L. and transported her to the Mendocino County Jail where she was incarcerated.

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**C. EVENTS AT THE MENDOCINO COUNTY JAIL: JANUARY 25 THROUGH JANUARY 30, 1997**

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According to jail records and interviews conducted by PAI investigators, the following is a synopsis of Kaye L.'s first incarceration following her evaluation at the CSU.

❖ JANUARY 25, 1997

In the late evening, when Kaye L. was booked at the Mendocino County Jail, she was asked a series of questions regarding her medical history. She reported a “*history of suicide attempts.*” According to the Inmate Medical Screening Form, dated January 25, 1997, and signed by Kaye L.:

*[Kaye L.] [t]ook a handful of pills on Friday night, but says that this wasn't a suicide attempt (only to get mentally balanced).*

*Comments/notes: Kaye L. says that she is 'healthy.' Takes Thorazine, Melatonin, Trazodone, and Elavil. Says that she attempted [sic] suicide 2 mo ago when she took 2 handfuls of medications. Friday night, she says she only took one handful and this was not a suicide attempt only a attempt to get mentally balanced. Kaye L. states she is not suicidal at this time.*

When asked if she wanted to talk to a mental health worker or a psychiatrist, Kaye L. replied: “*Yes, because I need my medications.*”

A Classification/Housing Input Report, dated January 25, 1997, which was routed to Annette Gilbert, licensed psychiatric technician, states:

*Kaye L. states that she needs her medications. She says she loses it when she doesn't get them. She has periods of time that are lost and she has no memory of where she is or what she is doing. She says she just came out of a blocked out period of time. She was hospitalized on Friday night for overdosing, but claims this was not a suicide attempt. She however states that 2 months ago she attempted suicide by taking 2 handfuls of prescription medications. She stated that she knew this was a attempt at suicide because she took 2 instead of 1 (handfuls). [Without] meds she states she will hear voices and have more problems 'losing it' (See medical questionnaire for med list).*

According to the Classification/Housing Log, despite Kaye L.’s known history of suicide attempts, her acknowledged use of psychotropic medication, and documentation that she had been evaluated for involuntary commitment earlier that day, she received an inmate classification of “M” (medium-range risk) rather than “S” (history of suicide attempts; use of psychotropic medication).

❖ JANUARY 26, 1997

A handwritten notation on the Inmate Medical Screening Form notes that Corrections Department staff consulted with Annette Gilbert regarding Kaye L. According to CFMG records, Kaye L. submitted a Sick Slip and requested mental health services, stating: *“I need a prescription of Navae [sic] I need to see mental health.”*

A handwritten notation on the Sick Slip documents Corrections Department staff having received the request at 3:30 AM. A second handwritten notation documents that Kaye L. was seen by Ms. Gilbert the following day, on January 27, 1997.

Despite Kaye L.’s repeated request for psychotropic medication and her recent reported suicide attempt, her inmate classification remained an “M.”

❖ JANUARY 27, 1997

Ms. Gilbert evaluated Kaye L. and made the following notation in the CFMG medical record.

*‘I want my meds.’ (Navane bid). They gave me 5 mg before. Sullen, subdued, does not elaborate, does not appear to be responding to abnormal internal stimuli. Conferred with Dr. Young who is going recommend she be followed at Laws Ave clinic rather than [mental health] when she is released. She was on no antipsychotic meds on her last PHF admit.  
? medical necessity for her meds [sic].  
Refer to M.D. for further [evaluation].*

Ms. Gilbert told PAI investigators that Kaye L. also requested transfer to the Mendocino County PHF. However, after assessing Kaye L., Ms. Gilbert denied Kaye L.’s request based on lack of medical necessity. There is no evidence in the

CFMG records that Ms. Gilbert consulted with Dr. Peters, the jail's psychiatrist, or that Dr. Peters evaluated Kaye L.

During a classification review, Kaye L. was again erroneously reassigned an "M" classification.

❖ JANUARY 29, 1997

According to CFMG records, Ms. Gilbert met with Kaye L. A progress note by Ms. Gilbert states:

*Informed [inmate] of further discussion of lack necessity of antipsychotic meds. There is no apparent psychosis noted or elicited. [Inmate continues to be] hostile; says we're not helping her, that she needs medicine and to be in the hospital, but gets up and leaves when asked why.*

According to CFMG policy, the psychiatric technician is to "refer inmates requiring psychotropic medications to psychiatrist for evaluation and monitoring." The psychiatrist is responsible for all required medication prescriptions and medication monitoring. There is no evidence in the CFMG records that Kaye L. was evaluated by the CFMG psychiatrist.

❖ JANUARY 30, 1997

Kaye L. was released from the Mendocino County Jail on her own recognizance.

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**D. EVENTS AT THE MENDOCINO COUNTY JAIL: JANUARY 31 THROUGH DATE OF DEATH, FEBRUARY 4, 1997**

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❖ JANUARY 31, 1997

In the late afternoon, Kaye L. was again booked into the Mendocino County, this time for an unrelated probation violation. According to the Inmate Medical Screening Form signed by Kaye L., she stated that she was “*at emergency room 2 hours ago to get Navain [sic].*” Kaye L. asked to see mental health or a psychiatrist, stating it was “*urgent.*” However, a handwritten notation on this same form states: “*denies urgent.*”

CFMG Progress Notes for this date state, in part:

*Seen @ [booking]. States 2 mg Navane @ [Emergency Room] 0500 1-31-97. . . . Health Screening this date. Request to see [mental health] - Denied to nurse, urgent. Calm, [cooperative]. Confined [sic] [with] A. Gilbert, LPT @ this time - [no] meds. Will be seen on [mental health] [sick call] if turns in [sick slip].*

Despite her mental health history and her requests to see mental health staff for psychotropic medication, Kaye L. was once again improperly given an “M” rather than an “S” classification.

❖ FEBRUARY 1, 1997

Kaye L. completed an Inmate Request Form and a CFMG Sick Slip, requesting medication. After stating that she “*need[ed] to see someone right away,*” Kaye L. was evaluated by Stephanie Dixon, a licensed vocational nurse on duty at the jail. The CFMG Progress Notes state:

*Needs to see someone right away.  
[Inmate] clenching hands into fists, states she ‘is hearing voices,’ ‘going through a tough time.’ [Inmate] applies finger tips to temples raising her eyes & says she is losing it.  
[Inmate’s] reactions appear rehearsed when asked a questions, takes a while as if appraising which answer to give.  
Monitor & do suicide [evaluation].*

Subsequently, at 12:45 PM, Nurse Dixon conducted a suicide evaluation. According to the CFMG medical record, Kaye L. *"states she is hearing voices but doesn't remember what they are saying, like being in a big storm & states she doesn't listen to them."* Kaye L. acknowledged feeling depressed, but denied suicidal ideation and intention. Nurse Dixon noted that Kaye L. appeared *"depressed, sad, fearful, crying,"* but not *"confused/disoriented."* When asked, *"[H]ow would you harm yourself?"* Kaye L. replied, *"I wouldn't."*

Following the suicide evaluation, Ms. Dixon made the following progress note:

*After Suicide [evaluation] done [inmate] seen conversing [with] other [inmate's] [sic] smiling, sitting, & watching T.V. hands open. . . . Facial expressions appeared relaxed.*

❖ FEBRUARY 2, 1997

Kaye L. filed a Sick Slip, stating: *"I need Medi-Cal [sic] for medicine."* A handwritten notation by Ms. Gilbert documents that Kaye L. was seen the following day.

Three Classification/Housing Input Reports were submitted regarding Kaye L.'s conduct. The first report states:

*Hyman, Rorke, Tillman, Ramsey, Gonzales [all inmates] told me Kaye L. was beginning to scare them. Hyman said she walks up to a person and stares without speaking to them and stands behind people making them fearful. All the above females said Kaye L. was acting very strange, that she is becoming more hyper and upset as the day goes on. I asked Kaye L. what the problem was and she told me she needed her medication. I moved Kaye L. into cell 114 away from the other females. Kaye L. told me when was very afraid to be in a cell alone during lock down and her voices would find her more easily than in the dorm. Sending a copy of this [classification report] to mental health. (Emphasis added.)*

As a result of this information, Kaye L. was then moved into an Administrative Segregation Cell.

The second Classification/Housing Input Report states:

*During tray pick up I came up missing one spoon out of Wing One. When I told the females I was missing a spoon and to check the slop bucket, while Hinkley was going thru [sic] the bucket, Kaye L. walked up to me and handed me the missing spoon. She acted as thou [sic] she had no clue as to why I found her in possession of the spoon, a possible rules violation. She is playing games with us.*

The third Classification/Housing Input Report states:

*Kaye L. was chewing on her tooth brush. When I checked it, it appeared she was trying to make a point on the end. I removed the brush from the wing and told her when she wanted to brush her teeth, to ask the [Commanding Officer] on duty and she would be allowed to use it, but it was to be returned when she finished with the brush. Also, when she removed the brush from her mouth to check the point, she walked from the yard, table, etc. to the check the point right in front of Wing I door. I feel she was attempting to intimidate me. She wanted to be sure I saw what she was doing to the brush.*

An Incident Report indicated the following:

*SYNOPSIS: Kaye L. acting bizarre all day and while Med Staff was doing med pass, Kaye L. attempted to push her way out of Wing I. (Emphasis added.)*

*NARRATIVE: On above time and date, when returning from Sally port with a booking, Kaye L. was attempting to push her way past Phyllis, the nurse. Kaye L. was saying 'I have to get out of here.' I walked Kaye L. back into Wing I and into her cell 114. I called control and told them Kaye L. was to remain in Ad Seg.*

*ACTION/TAKEN INFORMATION: I submitted two class inputs on Kaye L. today and also sent copies to mental health.*

Later in the day after the above complaints from inmates were noted, Kaye L.'s classification was changed to an "S," with a notation in the Classification/Housing Log, stating: *"bothering other females - they are afraid of her."*

❖ FEBRUARY 3, 1997

A Progress Note by Ms. Gilbert states: *"Seen. Rather hostile, uncooperative. Asking for meds. No evidence of need observed. Will [follow-up as needed]."* (Emphasis added.)

According to an Incident Report from the Mendocino County Sheriff's Department, later that afternoon, while in the Mendocino County Court holding cell awaiting a court appearance, Kaye L. assaulted another female inmate.

*On above time and date Lewis returned Kaye L. from court and told me to house her in Safety Cell. Kaye L. had gone off in court and punched inmate Ramsey. When I removed the cuffs Kaye L. said she was going to rip her veins open and there would be blood everywhere. I housed Kaye L. in Safety without incident. She gave me her clothing with out an argument. But when Wing II came out for Life Skills, Kaye L. began screaming at inmate Ingersoll, who is black, calling her a black bitch, said she was going to kill her. Ingersoll returned to her cell. Kaye L. was seen by Medical staff Stephanie. (Emphasis added.)*

Kaye L. was then moved to a Safety Cell and her classification was changed to "Y" (immediate threat to own safety; behavior symptomatic of acute, critical psychiatric/mental health problems); and the following comment was noted in the Classification/Housing Log: *"incident in courthouse in safety cell."* According to the Jail Inmate Monitoring Log, checks were conducted every 30 minutes while Kaye L. was in the Safety Cell, in compliance with Title 15 regulations and jail policy and procedure.

❖ FEBRUARY 4, 1997

In interviews with PAI investigators, Ms. Gilbert related that on February 4, 1997, the Jail Commander requested that she evaluate Kaye L. to see if she could be released from the Safety Cell. According to Ms. Gilbert, at approximately 9:00 AM, she evaluated Kaye L. in her Safety Cell, at which time Kaye L. denied being suicidal, stated that she wanted out of the cell, and requested to be transferred to the Mendocino County PHF. Ms. Gilbert also said that Kaye L. did not request medication or other health services. Although Ms. Gilbert found Kaye L. to be belligerent, it was her opinion that Kaye L. was not intimidating, threatening, or a threat to herself. Ms. Gilbert's Progress Note states:

*[Inmate] cooperative with interview. - 'Because I'm cold, I want my clothes to be able to sit down I need to take a shower.' She is more willing to listen. She denies ever being suicidal - She has been unreliable with what she says -*

*She denies being suicidal. She can be released from Safety to ad seg.*

Based on Ms. Gilbert's evaluation, Kaye L. was released from her Safety Cell and placed into Administrative Segregation Cell #114, in Wing One. The last time Kaye L. was observed alive was approximately 1:30 PM, when a walk-through was conducted. According to the Sheriff's Department's investigation, at approximately 2:00 PM, Kaye L. requested her bra via the intercom. Officers and inmates described hearing Kaye L. in her cell until approximately 3:30 PM. At approximately 4:30 PM, while dinner trays were being distributed, Kaye L.'s body was discovered. What actually occurred in Kaye L.'s cell between the 1:30 PM walk-through and the time she was found dead at approximately 4:30 PM remains uncertain.

According to Inmate Fernandez: “[T]he last time she heard the decedent yelling and screaming was just before three.” According to Inmate Sloan:

*[A]round 3:30 she heard what sounded like a ‘cup’ being thrown or falling to the ground and hear Kaye L. yell, ‘I’m going to kill you all’ . . . she heard Kaye L.’s voice say yelling and then the cup falling and then silence.*

The Mendocino County Sheriff's investigation describes the discovery of Kaye L.'s body as follows:

*At approx. 1630 hours, George Carter, Deputy Kline and inmates, Oscar Tucker and Brenda Perkins, entered Wing One to serve dinner to the inmates. George Carter said that they served cell #114 first since it was the closest cell to the front door of the wing. He said that he put the key in the lock of the tray pass to give the Decedent her dinner. As he placed the key in the lock he looked inside the cell via the small window located on the cell door, and observed the Decedent lying on the floor, underneath a wall mounted table, directly across from the door. He said that the Decedent was lying on the floor with her upper body semi propped against the wall. He could see what appeared to be her nightgown, knotted around the support post of the mounted table, and knotted around her neck. Once he observed the Decedent he told the meal runners to get back to the door of wing one. He then told Deputy Kline to call for back up and contact medical staff. Deputy Kline did not have a radio on her person so*

*George gave her his radio. George Carter said that he then opened the cell door and entered. He said that he felt that the Decedent was dead and did not observe any signs of life. He then took a pocket knife out of his pocket and cut the nightgown off the Decedent's neck. Correctional Deputy Ben Tyler arrived on scene from the men's wings which are located in the same building. A short time later nurse Vivian Schultz and Sgt. Gordon arrived on scene as well as Ukiah Ambulance employees who had been contacted by Corporal Underwood. Death was pronounced a short time later.*

**The CFMG Progress Note states:**

*Stat med. call to Bldg. II - Wing One  
[No] pulse, [no] respirations - face purple & tongue thickened and  
purple, blood from [left] nares; eyes fixed & pupils dilated - body cool  
in neck area and extremities.  
appears to have committed suicide T-shirt around neck  
[Ambulance] called by custody Code 3 - C. Jones notified*

**The Mendocino County Coroner's Office was notified and took possession of Kaye L.'s body. An investigation by the Sheriff's Department was initiated immediately.**

**V.**

**INVESTIGATIONS INTO THE DEATH OF KAYE L.**

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**A. MENDOCINO COUNTY CORONER**

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The Mendocino County Sheriff-Coroner's Office conducted an investigation into the death of Kaye L. Witnesses were interviewed and an autopsy was conducted by Henry Moon, M.D., Forensic Pathologist. The Death Investigation Report listed the cause of death as a "*Hanging*," and classified it a "*Suicide*."

The Toxicology Report prepared by the Institute of Forensic Sciences does not identify any ethanol, opiates, cocaine, phencyclidine or methamphetamine present in Kaye L.'s heart blood at the time of her death.

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**B. MENDOCINO COUNTY SHERIFF'S DEPARTMENT**

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The Mendocino County Sheriff's Department conducted an investigation into the death of Kaye L., and presented its results in a 31-page report. The Sheriff's investigation included interviews with Wing One inmates and all sheriff personnel who were on duty in Wing One on February 4, 1997, where Kaye L. was housed. Several inmates recalled a change in Kaye L.'s behavior between her two periods of incarceration: January 25-30, 1997; and from January 31, 1977 until her death on February 4, 1997.

Inmate Rita Gonzales told Sheriff's investigators:

*When she first came into jail she was alright but when she came back she was acting really weird [sic]. A few times Kaye L. would be sitting at the table and say something about snakes biting her legs.*

Sheriff's notes from an interview with Inmate Janet Tillman stated:

*Tillman has known Kaye L. for about six months and described the last seven days stating, 'She didn't need to be in here and they didn't even check on her once.' Tillman said that Kaye L. was disturbed these past seven days, I asked her in what context she was disturbed and she described Kaye L. saying that she was hearing voices and would start crying. She said that she needed medication. I asked Tillman when the last time was that she saw any of the correctional officers and she said that she barely saw them during the day. She said that this time was around 10:30. I asked Tillman if she thought that Kaye L. was suicidal and she said yes that she told them (the staff) that she was. (Emphasis added.)*

The Sheriff's interview with Inmate Megan Rhymes revealed that:

*... two nights ago before this thing happened that Kaye L. had made a verbal comment to [Rhymes] and others that she just got bitten by a snake. Rhymes went on to say that Kaye L. was okay before last Friday she was released from jail and within [sic] 12 hours Kaye L. was back in jail. Also when she came back in she was not the same person that had left. Rhymes explained that before she left she was not agitated, she'd laugh and she got along with everyone. Rhymes said she acted agitated and had her fists clenched like something was bothering her and she also wanted her medication and that she kept saying she needed her medication from her doctor. I asked if she knew what the medication was and Rhymes said it started with an N, narcopsyo something like that. Rhymes stated that when Kaye L. came back into custody on Saturday she was not the same and she was placed up stairs [sic] in a dorm. Then on Sunday she scared the other girl then on Monday she beat on Ramsey so she went to the rubber room. Rhymes said she never mentioned anything to her about suicide. While speaking with Rhymes I learned that Rita Gonzales was the decedents [sic] next door neighbor and knows something about what the decedent had said or was talking about. (Emphasis added.)*

During the Sheriff's interview with Inmate Tonya Fernandez, she stated that *"the decedent was much different after coming back into custody."*

*She stated that she'd known the decedent for about four days and she'd never said anything about committing suicide. There had been conversation about another girl over in the rubber room who'd tried to kill herself three times. Fernandez said the decedent said, 'It's really easy to kill yourself if you want to.' Fernandez said she did not pay attention to this thinking she was not suicidal, thinking that she just needed her medicine. Fernandez then told us that an officer named Yvette had came up and found her (decedent's) sheet tied to her bed and became worried about it so they moved decedent down to the rubber room.*

According to the Sheriff's interview with Inmate Loretta Hinkley:

*I asked Loretta how well she knew the Decedent and she said that she knew her well. She said that ever since the Decedent was in custody she acted strange. Loretta said that at one point the Decedent was living in the dorm with her and on one occasion, Correctional Deputy Gayle Bailey found her bed sheets tied together in knots and tied to the bed frame. When asked why she had tied the sheets together she stated that it was an easy way to hang herself. After that incident the Decedent was removed from the dorm and placed in lock down. Loretta said that she knew the Decedent was going to kill herself. (Emphasis added.)*

In response to documents requests, Protection & Advocacy, Inc. received no information from the Sheriff's Department which would corroborate statements by Inmate Fernandez that a sheriff's deputy had observed Kaye L. tie her bed sheets together several days prior to her death.

**The Sheriff's Department interview with George Carter, the Commanding Officer at the Mendocino County Sheriff's Department, states, in part:**

*I asked George Carter what the normal procedure was for checking on inmates in the county Jail. He said the minimum standard for walk through, in the wings, was once every hour. He described a walk through as entering the wing and having contact with each inmate. The lock down inmates were to be checked on by looking through the windows of their cells. I asked George Carter if there was any reason why between the hours of 1330 and 1630 there had not been a walk through of wing one. George said that because Deputy Kline could not have any physical contact with the inmates, there was quite a bit of activity.*

**The Sheriff's Department investigation concluded that Kaye L.'s death was a suicide and that no criminal acts were involved. PAI identified no evidence to suggest otherwise.**

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### **C. MENDOCINO COUNTY GRAND JURY INVESTIGATION**

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**The Mendocino County Grand Jury also investigated Kaye L.'s suicide death at the county jail, and issued its final three-page report on May 15, 1998. Most of the findings and recommendations are consistent with those set forth in this Public Report.**

**The Grand Jury made the following recommendations, which should be implemented without delay.**

- ☐ All Psychiatric Health Facility (PHF) and California Forensic Medical Group (CFMG) personnel who are responsible for patient assessment and/or care should receive further training in the assessment of suicide risk.**

- All PHF and CFMG personnel who are involved with patient assessment and/or care should receive additional training in dealing with difficult clients, with a particular emphasis on non-physical methods of behavioral restraint.
- The Mendocino County Sheriff's Department should follow its policies and procedures regarding inmate classification and walk-through checks.

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#### D. PROTECTION & ADVOCACY, INC.

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PAI first learned of Kaye L.'s death on February 26, 1997, from a newspaper article, which stated: *"Family members say their relative was fighting to stay inside the psychiatric facility because she was mentally ill and needed help."* PAI was also informed that some members of the community believed there was a direct connection between the Mendocino County PHF and Crisis Stabilization Unit (CSU) refusing to hospitalize Kaye L. on January 25, 1997 and Kaye L.'s subsequent jail suicide on February 4, 1997.

On March 21, 1997 PAI opened its own investigation, which included the following:

- Reviewing Kaye L.'s clinical and other records from the Mendocino County PHF and CSU covering the period 1994 through 1997.
- Reviewing the Mendocino County Mental Health Services' policies and procedures regarding Voluntary and Involuntary Admissions and the Legal Prosecution of Assaultive/Destructive Clients/Patients.

- Reviewing Ukiah Police Department Report #97-0244, dated January 25, 1997.**
- Reviewing Mendocino County Sheriff-Coroner's Death Investigation Report #C0R97-030.**
- Reviewing the California Department of Mental Health's Psychiatric Health Facility Review Protocols dated January 3, 1990; May 19, 1994; August 20, 1995; and May 13, 1996.**
- Reviewing Kaye L.'s Mendocino County Jail records for the period January 25 to January 30, 1997, and from January 31 to February 4, 1997.**
- Reviewing the Mendocino County Sheriff's Department's Investigative Report #1-97-000365 regarding the death of Kaye L.**
- Reviewing Mendocino County Jail policies and procedures regarding: Inmate Classification; Medical and Mental Health Services; Inmate Sick Call; Administrative/Disciplinary Segregation; Use of Safety Cell; Inmate Count; Medical/Mental Health Staff; Injury/Illness to Inmates; Inmate Death; and Medical Emergency Response.**
- Interviewing five Mendocino County PHF staff members.**
- Touring the Mendocino County PHF.**
- Touring the Mendocino County Jail, including the Administrative Segregation Cell where Kaye L. died.**

- Reviewing Kaye L.'s clinical/medical records from the California Forensic Medical Group.**

**PAI's investigation found no evidence to suggest that Kaye L.'s death was anything other than a suicide. This was also the conclusion of investigations conducted by the Mendocino County Coroner, the Mendocino County Sheriff's Department, and the Mendocino County Grand Jury.**

**PAI's investigation did not find evidence to support a causal connection between Kaye L. being denied admission to the Mendocino County PHF on January 25, 1997 and her suicide death on February 4, 1997 in the Mendocino County Jail.**

**Dr. Young, the Medical Director of the Mendocino County PHF and Chief Psychiatrist for the Mendocino County Mental Health Services Department, made a professional judgment not to voluntarily admit Kaye L. into the Mendocino County PHF on the night of January 25, 1997. In his opinion, Kaye L. would not have benefitted from in-patient hospitalization. He considered Kaye L. a low suicide risk because she had few of the risk factors associated with suicidality. She had children, a relatively stable support system, and no known plan for ending her life. Although Dr. Young's decision may, in retrospect, be questioned, it appears to have been supported by his belief that Kaye L. did not need and would not benefit from in-patient hospitalization.**

**The arrest and filing of charges against Kaye L. on January 25, 1997, as outlined earlier in this report, was within the policies and procedures of the Mendocino County PHF. However, PAI questions the necessity of forcing Kaye L. to leave the CSU after two hours of evaluation. Given Kaye L.'s agitated state, her alleged suicide attempt the previous night, and her desperate wish to be admitted for psychiatric treatment, additional crisis intervention services, including respite and counseling, could have been provided.**

**PAI's investigation revealed that both times Kaye L. was incarcerated in the Mendocino County Jail, she did not receive the housing classification required by jail policy and procedure. She was classified and reclassified as an "M" ("medium-range risk potential with no currently identifiable major risk characteristics"), rather than an "S" ("history of psychiatric hospitalization; mentally retarded or developmentally disabled; history of suicide attempts or self-mutilization; use of psychotropic medications; symptoms of mental/psychiatric/psychological conditions or problems, being maintained with or requiring frequent medication and/or mental health treatment").**

**The evidence substantiated that for a duration of approximately three hours before Kaye L.'s body was discovered, jail staff failed to check on Kaye L. and other inmates housed in Wing One, in violation of Mendocino County Jail Policy. The policy requires correctional personnel to "walk-through" and contact each inmate hourly. PAI could not determine whether hourly checks on the afternoon of February 4, 1997 would have prevented Kaye L. from taking her own life. However, the conduct of the hourly walk-throughs, as required, would have decreased the opportunity for Kaye L. to commit suicide, and/or increased the likelihood of jail staff discovering Kaye L. in time to resuscitate her.**

**PAI's investigation revealed that a conflict of interest existed with Annette Gilbert's involvement with the assessment, care and treatment of Kaye L. at the Mendocino County Jail. Ms. Gilbert was the victim of an assault and battery by Kaye L. at the Mendocino County PHF on January 25, 1997 — the event which precipitated Kaye L.'s initial incarceration. The conflict of interest was particularly significant because Ms. Gilbert was the primary gatekeeper to the jail's psychiatrist and, hence, to psychotropic medications. Under these circumstances, PAI seriously questions whether Ms. Gilbert was capable of maintaining clinical objectivity in her evaluation of Kaye L.**

## **VI.**

### **FINDINGS AND CONCLUSIONS**

- ◆ **THERE IS NO EVIDENCE THAT KAYE L.'S DEATH WAS ANYTHING OTHER THAN A SUICIDE.**

Investigations conducted by the Mendocino County Coroner's Office, the Mendocino County Sheriff's Department, the Mendocino Grand Jury, and Protection & Advocacy, Inc. (PAI) revealed nothing criminal in nature about the death of Kaye L. The evidence overwhelmingly indicates that Kaye L. died by her own hands, without assistance from anyone.

- ◆ **THE DECISION OF STAFF TO DENY KAYE L. IN-PATIENT HOSPITALIZATION AT THE PHF DID NOT APPEAR TO VIOLATE PROFESSIONAL STANDARDS; HOWEVER, THE CRISIS EVALUATION SERVICES PROVIDED KAYE L. ON JANUARY 25, 1997 DID NOT APPEAR TO SUFFICIENTLY PROBE THE UNDERLYING REASONS FOR HER CRISIS ADMISSION OR CONSIDER THE THERAPEUTIC VALUE OF RESPITE AND SANCTUARY.**

Kaye L. was evaluated on a crisis basis for two hours. Appropriate clinical professionals determined that she was not a threat to herself or others, nor gravely disabled, and therefore did not meet the requirements for involuntary commitment pursuant to Welfare and Institutions Code Section 5150. Although the decision by Dr. Young not to voluntarily admit Kaye L. to the In-patient Unit may, in retrospect, be questioned, the evidence indicates that Dr. Young's decision was based on his belief that Kaye L. did not require and would not benefit from in-patient hospitalization.

During her two-hour crisis evaluation, staff noted that Kaye L. was experiencing psychosocial stressors of an unknown origin and that she desperately wanted to be hospitalized. No documentation or statements were provided to PAI which indicated that the underlying reasons for this distress were sufficiently probed. Had staff further

evaluated the stressors underlying Kaye L.'s condition and weighed the therapeutic value of providing Kaye L. additional respite and sanctuary, the altercation which resulted in staff being assaulted and Kaye L.'s being arrested and jailed may have been avoided.

◆ **JAIL STAFF GAVE KAYE L. THE WRONG HOUSING CLASSIFICATION BOTH TIMES SHE WAS INCARCERATED.**

State law requires each jail to have a written classification plan for assigning inmates to housing units. Mendocino County procedure requires each inmate to be assigned an alphabetical classification code which serves as a framework for housing inmates.

Kaye L. received an "M" classification, which is reserved for inmates who have a medium-range risk potential and no currently identifiable risk characteristics. This was clearly erroneous given her known history of psychiatric hospitalizations, suicide attempts, and use of psychotropic medications — which required that Kaye L. should have received an "S" classification. PAI could not determine what effect, if any, the correct classification would have had on the circumstances surrounding Kaye L.'s death.

◆ **THE EVIDENCE IS IN CONFLICT AS TO WHETHER CORRECTIONAL OR MENTAL HEALTH STAFF AT THE JAIL KNEW OR SHOULD HAVE KNOWN THAT KAYE L. WAS AT RISK OF SUICIDE.**

The evidence did not substantiate that Kaye L. expressed any suicidal ideation to the mental health nursing or correctional staff at the jail. Kaye L. had swallowed a handful of Elavil ten days before her death — and this was known to mental health staff at the jail. She was evaluated twice for her potential to commit suicide, and on both occasions denied that she would harm herself in any way. There is a conflict in the evidence as to whether other inmates informed correctional staff of behavior or statements on Kaye L.'s part which indicated she was at risk for suicide during her second incarceration, which ended in her death.

◆ **THE LICENSED PSYCHIATRIC TECHNICIAN RESPONSIBLE FOR EVALUATING KAYE L.'S MENTAL HEALTH NEEDS AT THE JAIL HAD A CONFLICT OF INTEREST.**

Licensed Psychiatric Technician Annette Gilbert was the crisis worker on duty at the Mendocino County PHF on January 25, 1997, and is the individual Kaye L. attempted to choke while being escorted out of the facility. This raises serious questions as to whether Ms. Gilbert could be objective regarding Kaye L.'s assessment, care and treatment during her incarceration at the jail. This conflict of interest was particularly crucial given Ms. Gilbert's role as the gatekeeper to the jail psychiatrist, and hence to psychotropic medications.

◆ **KAYE L. WAS DENIED REASONABLE ACCESS TO APPROPRIATE PSYCHIATRIC SERVICES.**

It is not appropriate for a licensed psychiatric technician to determine whether a request for psychiatric medications should be honored. Such a determination must be made on the basis of medical necessity, which requires a timely evaluation by a qualified physician.

◆ **MENDOCINO COUNTY SHERIFF'S PERSONNEL FAILED TO COMPLETE THE REQUIRED "HOURLY WALK-THROUGHS" THE AFTERNOON OF KAYE L.'S SUICIDE DEATH, IN VIOLATION OF MENDOCINO COUNTY SHERIFF'S DEPARTMENT POLICIES AND PROCEDURES.**

According to the Mendocino County Sheriff's investigative report, the required hourly "walk-through" checks of inmates, including Kaye L., were not made between 1:30 PM and 4:30 PM on the afternoon of February 4, 1997. This violated Mendocino County Sheriff's Department policy and procedure. It is unknown if completion of the required checks would have prevented Kaye L.'s suicide death.

## **VII.**

### **RECOMMENDATIONS**

Based on its findings and conclusions, Protection & Advocacy, Inc. (PAI) recommends a number of actions be taken by staff at the Mendocino County Crisis Stabilization Unit (CSU), Psychiatric Health Facility (PHF), and County Jail.

◆ **EVALUATING THE THERAPEUTIC VALUE OF RESPITE AND SANCTUARY IN PROVIDING CRISIS SERVICES**

PAI questions staff's judgment in forcing Kaye L. to leave the CSU after two hours of evaluation. The CSU is authorized to keep patients for 23 hours. Kaye L. had swallowed a handful of prescription antidepressants the previous night, was experiencing underlying stressors of an unknown origin, and was desperate to stay. Further evaluation of the stressors underlying Kaye L.'s condition, and additional respite and sanctuary, may have prevented the altercation which resulted in staff being assaulted and Kaye L. being arrested and jailed. Providing a person rest and a safe place to stay can be an invaluable mental health service. County CSU and PHF staff should receive training about the therapeutic value of respite and sanctuary and how to recognize situations in which it will be an effective intervention. Admission policies and procedures should be amended so that proper attention is given to the benefits of respite and sanctuary when staff is deciding whether to admit a patient to the CSU or PHF.

◆ **DEVELOPING A RELIABLE INMATE HOUSING CLASSIFICATION SYSTEM**

**The Mendocino County Jail should develop an effective quality assurance mechanism to ensure that its policies and procedures regarding inmate housing classification are followed. For example, developing a classification form that makes an “S” classification (history of suicide attempts; use of psychotropic medication) automatic when the box for psychiatric treatment is checked, training on the jail’s classification system and use of survey instruments, and regular quality assurance reviews would help ensure accurate housing classifications. In addition, all jail staff responsible for inmate care or supervision should receive thorough training on suicide risk assessment. Such training should occur during orientation and be repeated at least annually thereafter.**

**◆ ENSURING ACCESS TO PSYCHIATRIC MEDICATIONS**

**The Mendocino County Jail’s gatekeeping system for access to medications interferes with inmates’ rights to adequate mental health services. Inmates requesting psychiatric medications should have access to the jail’s psychiatrist within eight (8) hours of making the request. Such access to a physician should not depend on the judgment of a licensed psychiatric technician. The procedure in place at the time of Kaye L.’s death directed the licensed psychiatric technician to refer inmates “requiring” medication to the staff psychiatrist. This is inappropriate. Only physicians are licensed to determine if an inmate with a psychiatric disability needs medication. The procedure should be amended to ensure that all inmates requesting psychiatric medications, whose requests are not immediately honored, will be seen promptly by a physician.**

◆ **AVOIDING CONFLICT OF INTEREST**

**If there is any indication or reason to believe that jail staff may have a conflict of interest, that person should not be allowed to work with affected inmates. Although particularly important for mental health staff, this requirement should apply to all jail personnel. Jail policy should specify that mental health and other care staff who have been assaulted by an inmate are not responsible for the care, treatment or assessment of that inmate. It is unreasonable to expect a treating professional to maintain clinical objectivity under such circumstances, particularly where, as here, the assault was recent.**

◆ **ENSURING COMPLIANCE WITH INTERNAL WALK-THROUGH POLICY**

**Jail management should adopt a quality assurance system that ensures walk-throughs are performed by staff on an hourly basis. This policy provides an important safety net for all inmates, especially those who may be suicidal. If necessary, additional staff should be hired.**

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**PAI welcomes your comments and questions. You can reach us at the address and phone number on the cover of this report.**

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