AN ANALYSIS OF DEATH CERTIFICATES OBTAINED FROM CALIFORNIA DEPARTMENT OF STATE HOSPITALS (DSH): PRISONERS WHO DIED IN CUSTODY AT STATE MENTAL HOSPITALS BETWEEN JANUARY 1, 2005 and AUGUST 1, 2015

A Study by

FAMILIES FOR THE ETHICAL PSYCHIATRIC TREATMENT OF PATIENTS AND PRISONERS

(FEPTOPP)

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INTRODUCTION

Patients in California state mental hospitals have historically been subjected to criminal abuse **(1)**. As a result of the recognition of that abuse, the California Legislature has enacted laws designed to protect these patients from further abuse by constructing a system of administrative checks on the treatment of this vulnerable population **(2)**. This Study is an examination of how well that system of protection is working for both mental hospital patients as well as for the general public.

The current primary treatment of mental disorders is characterized by intensive drug therapy **(3)**, based upon the still unproven theory that mental illness is caused by an imbalance of biochemicals in the brain. The extensive use of psychotropic drugs on the captive population in state mental hospitals has important public health ramifications for the general public because of the widespread use of these same drugs by the public at large. It has been shown that persons with severe mental illnesses confined to public institutions have shortened life spans by an average of 25 years **(4)**. Similar results have been found in all persons who suffer from serious mental illness **(5)**. Therefore, a study of the deaths of mental hospital inmates holds important information for the general public health, and the results of such studies should be made available to the public as a guiding principal of sound public health policy. It follows that for both the inmates of state hospitals and public health welfare, the Department of State Hospitals should be collecting and disseminating all information relevant to the effects of drug treatment on state mental patients. Due to their prolonged treatment with these drugs, these involuntary patients provide valuable information regarding the effects of this class of drugs on the human body. Current laws in California mandate that such information should be collected by the Department of State Hospitals (DSH).

This Study into Death Certificates provided by the Department of State Hospitals of patients who died at state hospital facilities after long periods of incarceration confirms the fact that this important information is not being collected for availability to public health agencies and disseminated to the public. This failure to document important medical information as required by law denies public citizenry the information they need to make informed health decisions.

STUDY METHODOLOGY

FEPTOPP submitted a request to the Department of State Hospitals asking for copies of all Death Certificates of patients who died while incarcerated at state hospitals for the period January 1, 2005 to August, 2015. DSH responded by transmitting seventy five (75) documents comprising sixty three (63) death records of patients who died at DSH facilities during that time period **(6)**. DSH claims that these are the only records available, and admits that the records are incomplete due to non-compliance by several of the state hospitals with the law. The Death Certificates submitted were severely redacted beyond the removal of personal identification, and included the redaction of information such as the age at death and length of time in the county (which would indicate how long the person had been a patient) -- information necessary to perform any kind of meaningful differentiation between natural causes and drug-related causes. DSH was unresponsive to a request for further information **(7)**.

Each document was examined for information related to cause of death, manner of death, medical examination, and Coroner certification. Each Death Certificate was then rated on whether or not it met the legal requirements required and deficiencies were noted. From this body of evidence, a Conclusion was drawn regarding the compliance of DSH with state law in regards to the death of inmates kept in their care during this ten plus years of the Study.

DATA COMPILATION

Each Document is numbered, 1 through 75. Each document was studied for information and comments were made regarding the quality of the document; i.e., whether it was complete, whether an autopsy was performed, whether the Coroner or a Deputy signed it, etc. Deficiencies of the document were noted and briefly explained. Copies of the documents received from DSH are included in Appendix A.

TABULATION OF RESULTS

Doc. #	Year of Death	State Hospital	Comments (see Page 7)
1	2005	ASH	1,2,3
2	2005	ASH	1,2,3
3	2005	UNKNOWN	County of Record is Stanislaus County. Modesto State Hospital closed in 1972. Comment 4.
4	2005	UNKNOWN	Amendment to Document #3
5	2005	ASH	1,5
6	2005	ASH	1,4,6
7	2005	ASH	1,2,3
8	2005	ASH	1,4,6
9	2005	ASH	1,2,3,4
10	2005	ASH	1,2,3,4
11	2005	ASH	1,2,3,4
12	2005	ASH	Amendment to Doc. # 11
13	2006	ASH	1,2,3
14	2006	ASH	1,2,3
15	2006	ASH	1,4
16	2006	ASH	Amendment to Doc. #15
17	2007	ASH	1,7
18	2007	ASH	1,7,8. Different version of Doc. #17
19	2007	ASH	1,5
20	2007	ASH	1,2,3,4
21	2007	ASH	1,2,3,4
22	2007	ASH	1
23	2007	ASH	1,2,3,4
24	2007	ASH	1,2,3,4
25	2007	ASH	9. Exact copy of Doc. #24
26	2007	ASH	1,2,3,4
27	2007	ASH	9. Exact copy of Doc. #26
28	2007	ASH	1,2,3,4
29	2007	ASH	Amendment to Doc. #28
30	2008	ASH	1,2,3,4,10
31	2008	ASH	1,2,3
32	2008	ASH	1,4
33	2008	ASH	1,11
34	2008	ASH	1,2,3,4
35	2008	BOB WILEY DET. FACILITY TULARE CO.	1
36	2008	ASH	1,12
37	2008	ASH	Amendment to Doc. #36

Doc. #	Year of Death	State Hospital	Comments (see Page 7)
38	2009	ASH	1,4
39	2009	ASH	1,4
40	2009	ASH	1,2,3,4
41	2009	ASH	1,2,3,4
42	2010	ASH	1,2,3,4
43	2010	ASH	1,2,3,4
44	2010	ASH	1,2,3
45	2011	ASH	1,4
46	2011	PSH	1,5
47	2012	ASH	1,2,3,4
48	2014	ASH	1,2,3
49	2014	ASH	1,4,11
50	2015	ASH	1,2,3,4
51	2015	ASH	1,2,3,4
52	2015	ASH	1,2,3,4
53	2013	MSH	1,2,3,4. This is page 2 of Death Certificate. Page 1 is missing.
54	2014	MSH	1,2,3,4
55	2014	MSH	1,2,3,4
56	2014	MSC	1,2,3,4
57	2010	NSH	1,2,3,4
58	2014	PSH	1,4
59	2014	PSH	Amendment to Doc. #58
60	2014	PSH	1,2,3,4
61	2015	PSH	1,2,3,4
62	2015	PSH	1,4
63	2014	PSH	1,2,3,4
64	2014	PSH	1,2,3,4
65	2014	PSH	1,4
66	2014	PSH	Amendment to Doc. #65
67	2014	PSH	1,4
68	2014	PSH	Amendment to Doc. #67
69	2014	PSH	1,2,3,4
70	2014	PSH	1,5
71	2014	PSH	1,4
72	2014	PSH	1,2,3,4
73	2014	PSH	1,2,3,4
74	2014	PSH	1,2,3,4
75	2014	PSH	1,2,3,4

COMMENTS

1. No birth date/age of patient redacted. Length of stay in county redacted.
2. No Manner of Death listed.
3. No Coroner signature or information from Deputy Coroner.
4. No drug screen or medical record investigation.
5. Coroner's Amendment to Death Certificate missing.
6. Illegible.
7. Suicide. No drug screen or medical records investigation.
8. Different version of another document.
9. Exact copy of another document.
10. "Medication non-compliance". No medical records examination.
11. Homicide. No drug screen or medical records examination.
12. Death due to prescribed drug overdose.

STATE HOSPITAL ABBREVIATIONS

ASH -- Atascadero State Hospital, San Luis Obispo County

CSH -- Coalinga State Hospital, Fresno County

MSH -- Metropolitan State Hospital, Los Angeles County

NSH -- Napa State Hospital, Sonoma County

PSH -- Patton State Hospital, Riverside County

SVSH -- Salinas Valley State Hospital, Monterey County

SSH -- Stockton State Hospital, San Joaquin County

VSH -- Vacaville State Hospital, Solano County

ANALYSIS AND DISCUSSION

1. Skewed data. Sixty five per cent (65%) of the data originated at Atascadero State Hospital; 25% originated at Patton State Hospital; 5% originated at Metropolitan State Hospital; and approximately 1 1/2% originated at Napa State Hospital. The remaining 3 1/2% originated at facilities not presently within the state hospital system. There was no data from Coalinga State Hospital, Salinas Valley State Hospital, Stockton State Hospital, or Vacaville State Hospital. Other than the fact that Stockton State Hospital has only recently opened, DSH has no valid reason for the missing data from the other hospitals, indicating that there is no administrative effort to comply with the law requiring DSH to keep records on the deaths of inmates occurring at their facilities. This refusal to follow the law is puzzling, and DSH makes no attempt to explain their flouting of both the intent and the letter of the law. DSH is simply unresponsive to the fact that they are violating the law, an attitude that bespeaks arrogance toward the public welfare that they are supposed to be serving as well as a belief that they are somehow above the law and not subject to legal consequences.

2. Hidden data. We can only speculate as to how much of the historical data is missing, but it is not unreasonable to estimate that more than half of the relevant data has not been provided as requested. As noted above, DSH gives no reason for this omission, other than to promise that data from Coalinga State Hospital will be produced "within the next 30 days (from 9/11/15)", a promise that has not been fulfilled **(6)**. Since DSH is unresponsive as to the reason for the missing data, it is impossible to know why it is not forthcoming. Possible motives might be incompetence; deliberate obfuscation; or bureaucratic manipulation. We are left to analyze the data that was received, understanding that it is incomplete and possibly deliberately misrepresentative.

3. Altered data. Document 18 and Document 17 are different official versions of the same document, proof that falsification of a Death Certificate occurred in this instance. This raises questions about the authenticity of all the documents supplied by DSH.

4. Avoidance of the law. Given that the reason for the existence of the law requiring DSH to keep records on the examinations of deaths of inmates at DSH facilities is to prevent abuse and make a record for public health purposes, the data presented to FEPTOPP for this study clearly shows that DSH is breaking the law both by refusal to collect and analyze the relevant data and by redacting information necessary for other agencies to conduct a complete evaluation. We were struck by the fact that it appears that no one has asked for this data in the past, and therefore there has been no attempt to find out why and how inmates in state hospitals are dying, despite clear legislative direction that it is imperative to report on this specific

information. Again, given the history of abuse of mental health patients in state institutions, this avoidance of the facts is extremely suspicious and warrants close public scrutiny. This suspicion is heightened by the fact that DSH has redacted the death certificates that they did provide in such a way as to prevent significant meaningful analysis of the possible role that excessive drug prescription could have played in the deaths, e.g., redacting the age at death. For example, if an inmate died of renal failure at age 85, that might be due to natural causes, but if he died of renal failure at age 40, that would indicate that Metabolic Syndrome due to long term drug use might have been the cause.

5. What the existing data reveals. County Coroners have not followed the law requiring them to investigate all deaths of inmates in state mental hospitals, sign the Death Certificates, and forward the documents to the DSH. There has been virtually no attempt on the part of county Coroners to link the causes of inmate deaths with any medical treatment they have been receiving in the hospitals **(8)**. In particular, there has been no attempt to examine the cases where the cause of death clearly indicates that prior medications could have played a significant role in the death of the inmate. Psychotropic drugs cause Metabolic Syndrome, a well established fact **(9)**. Metabolic syndrome is marked by obesity, elevated lipids, diabetes, fatty liver disease, heart disease, liver failure, and kidney failure, among other conditions. Of the 63 Death Certificates examined, 45 (71%) listed conditions under "Cause of Death" that could be linked to Metabolic Syndrome, yet no investigation into the drug history of the patient was performed. Furthermore, there is no signature by the Coroner or the Coroner's Deputy in 70% of the Death Certificates, a direct violation of the law.

CONCLUSIONS

1. This study clearly shows that DSH officials and county Coroners are in violation of the laws that were specifically enacted to stop further abuse of inmates entrusted to the care of the state for treatment of their mental disorders. After more than 160 years of attempts, the state of California is still failing to prevent this public health tragedy, and continues to be complicit in the cover up of these crimes, as recorded in these official documents provided by the DSH.

2. With the advent of powerful neuroleptic drugs first brought to the market 70 years ago which have now been established as the first line of psychiatric treatment, valuable public health information regarding the effects of these drugs on the human body has been systematically and illegally withheld from the public. Given the fact that prescription drugs are now the third leading cause of death in the U.S.(10), the illegal cover up by public officials of the causal relationship between these drugs and the mortality of these patients rises to a level of criminality that demands investigation and prosecution of the authorities responsible for the suppression of the data and analysis.

FOOTNOTES

(1) See, e.g., Edwin Black (2012). *"War against the weak": Eugenics and America's campaign to create a Master Race*.

(2) e.g., **California Welfare & Institutions Code** 4137. "Whenever a patient dies in a state mental hospital and the coroner finds that the death was by accident or at the hands of another person other than by accident, the State Department of State Hospitals shall determine upon review of the coroner's investigation if the death resulted from the negligence, recklessness, or intentional act of a state employee. ***If it is determined that the death directly resulted from the negligence***, recklessness, or intentional act ***of a state employee***, the department shall immediately notify the State Personnel Board and any appropriate licensing agency and shall terminate the employment of the employee as provided by law. In addition, if the state employee is a licensed mental health professional, the appropriate licensing board shall inquire into the circumstances of the death, examine the findings of the coroner's investigation, and make a determination of whether the mental health professional should have his or her license revoked or suspended or be subject to other disciplinary action. "Licensed mental health professional," as used in this section, means a person licensed by any board, bureau, department, or agency pursuant to a state law and employed in a state mental hospital."

See also: California Government Code 27491 which states, inter alia, "... coroner must investigate ... all deaths of patients in mental hospitals" and "the coroner or a deputy shall personally sign the certificate of death".... "the coroner shall forward a copy of his or her report to the state agency responsible for the state hospital."

(3) See, e.g., website of the National Institute of Mental Health, www.nimh.nih.gov.

(4) Colton, C. (2006). Congruencies in increased mortality rates, years of life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease 3 (April).

(5) Joukmaa, M.; Heliovaara, M.: Knekt, P.; Aromaa, A.; Raitasalo, R.; & Lehtinen, V.(2006). Schizophrenia, neuroleptic medication and mortality. The British Journal of Psychiatry 188: 122-127 http://bip.rcpsych.o.../188/2/122.full.

(6) email from Brandon Nishimura, AGPA, Public Records Act Coordinator at Department of State Hospitals to Roland Angle, 9/11/15.

(7) email from Roland Angle to Brian Nishimura at DSH, 9/11/15.

(8) The one exception is Document Number 36, which describes the death of an inmate due to an "accidental" prescription drug overdose.

(9) See, e.g., "The Metabolic Syndrome in Patients with Severe Mental Illnesses" by Toalson, Ahmed, Hardy & Kabinoff, Journal of Clinical Psychiatry, 2004.

(10) Dr. Barbara Starfield, *"Is the U.S. Health Really the Best in the World?",* Journal of the American Medical Association, 7/26/2000.

APPENDIX A

REDACTED DEATH CERTIFICATES

SUBMITTED BY THE CALIFORNIA DEPARTMENT OF STATE HOSPITALS