Office of Ombudsman for Mental Health and Developmental Disabilities

Provisional Discharge/Stay of Commitment Revocation Alert

This Medical Alert is based on the work of the Medical Review Subcommittee and should be posted prominently. The Office of Ombudsman for Mental Health and Developmental Disabilities works to improve the services provided to people with disabilities by communicating important information found in the Medical Review Subcommittee's reviews of deaths and serious injuries. Thank you for promptly reporting deaths and serious injuries. You are helping us to meet our mission.

To Minnesota's 87 County Sheriffs, Human/Social Services Departments, and Probate Courts:

This alert is intended to inform your departments and courts of the circumstances surrounding deaths reviewed by the Medical Review Subcommittee (MRS) of the Office of Ombudsman for Mental Health and Developmental Disabilities. As an increasing number of counties rely on contracted case management services for clients with mental health issues, it is critically important to keep current records of contact for all case managers and for probate court staff to provide adequate information to the Sheriff's Department when it is required under Minn. Stat. 253B.15 Subd. 5. to act upon a judicial order. The Office of Ombudsman for Mental Health and Developmental Disabilities recommends that all county sheriffs' departments consult with their probate court and social service department contacts to review and update their policies and procedures in view of the tragic cases outlined below.

Could this Happen in Your County?

Case Study: A 44-year-old woman, with major depressive disorder with psychotic features, borderline personality disorder, a sleep disorder, and other medical conditions, was found dead in May 2004 in her home. Her death was reported to the medical examiner. No autopsy was performed. Her manner of death was suicide, and her immediate cause of death was attributed to hanging. The client had a long history of suicidal ideation and attempts. Prior to her death, she had been receiving intensive community support services, therapy, and psychiatric care. She was under a provisional discharge from a commitment as a person with mental illness. In the week before her death, her treatment team took steps to have her provisional discharge revoked due to concerns about her safety.

On the Friday before her death, the probate court judge signed an order "to immediately apprehend, transport, and hold" the client at a hospital. However, the order from the court did not include a physical description, address, or phone number for the client or contact information for the client's contracted case manager. The order was not acted upon before the client's suicide.

After the suicide of this client, a meeting was held between probate court staff and the sheriff's department. A new form was developed that includes detailed contact information for the client's case manager, as well as detailed information about the client's address and/or expected whereabouts for those clients who are homeless. The sheriff's department had in place, at the time of the "immediate apprehension, transport, and hold" order for this client, a practice whereby, in urgent cases, the local police department would be notified of the court order when the Sheriff's Department was unable to respond immediately. In this case, due to a lack of contact information for the client and her case manager, the local police department was not notified of the court order.

Recommendation: The Medical Review Subcommittee of the Office of Ombudsman for Mental Health and Developmental Disabilities recommends that all county sheriffs' departments consult with their probate court and social service department contacts to review and update their policies and procedures to ensure that the Sheriff's Department is provided with all of the information it needs when it is required under Minn. Stat. 253B.15 Subd. 5. to act upon a judicial order.

Case Study: Suicide of a client, who was on a revoked stay of commitment with an "apprehend and hold" order issued by the District Court to the County Sheriff's Department. This 46-year-old man, with alcohol dependence, bipolar disorder, attention deficit disorder, hypertension, past alcohol-related myocardial infarction, cardiomyopathy, and other medical conditions, died in May 2009. His death was reported to the medical examiner, and an autopsy was done. His manner of death was suicide, and his immediate cause of death was attributed to a gunshot wound to the chest, with chronic alcoholism and bipolar disorder noted on his death certificate as other significant conditions contributing to his death.

The client had been hospitalized in January 2009 for pneumonia and cardiac arrest. During this hospitalization, he underwent a protracted alcohol withdrawal and delirium. He nearly died during this episode. He was discharged to a cardiac rehabilitation facility. Despite being instructed that continued alcohol use could be fatal, he resumed drinking. In early February, he presented to a hospital and was placed on a 72-hour hold. A petition for civil commitment as a chemically dependent person was supported by a psychiatrist, and the court issued an order for a stay of commitment. Following his hospitalization, the client was discharged to a residential chemical dependency treatment program. He remained there until early April 2009 and then entered the low intensity outpatient program.

In early May 2009, it was confirmed that he had relapsed. The client's case manager initiated a revocation of his stay of commitment. An order for apprehension was entered by the court. County Sheriff's staff reportedly attempted once to pick up the client, but he was not at home. One week after the order for apprehension, the case manager learned that the client had not been picked up. After checking with the Sheriff's Office, she called one of the client's family members, who informed her that the client was staying with his parents. The case manager informed the Sheriff's Office of the new address. Later the same day, the case manager was informed of the client's death.

Recommendation: The MRS recommends that, when a stay of commitment is revoked by the court and an order for apprehension is issued by the court, both the individual case manager and the Sheriff's Office maintain close contact to ensure that the client is apprehended on a timely basis.

Under Minnesota Statutes Chapter 253B, in order to issue a stay of commitment, the court must find that the person meets the standards for commitment – the person must be a danger to self or others as a chemically dependent person or a person who is mentally ill. When the court revokes a stay of commitment, the Sheriff should consider that the court has determined that the client is a danger to self or others and apprehend the client.