Circuit Court for Howard County
Case No. 13-C-17-111538

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 1663

September Term, 2017

IN THE MATTER OF GERALD DAVIES

Fader, C.J.,
Beachley,
Kenney, James A., III
(Senior Judge, Specially Assigned),

JJ.

Opinion by Kenney, J.

Filed: June 25, 2019

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Maryland's procedures for involuntary admission to an impatient mental health facility require balancing the liberty interest of a patient against the State's interest in protecting the patient and other members of society from harm caused by failure to provide appropriate treatment and care. One such provision, colloquially known as the "Thirty-hour Rule," provides that "[a]n emergency evaluee may not be kept at an emergency facility for more than 30 hours." Md. Code. Ann., Health - General § 10-624(b)(4) (effective October 1, 2013 to September 30, 2018).[1]

Mr. Gerald Davies, appellant[2], argues that his involuntary admission to Howard County General Hospital by an administrative law judge ("ALJ") was improper because he was kept in its emergency room for 141 hours prior to his admission. The Circuit Court for Howard County affirmed the ALJ's decision. In his timely appeal, appellant presents the following question:

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[1] Subsequent to the trial proceeding in this case, the General Assembly enacted Health - General §10-632(g), which provides:

> The hearing officer may not order the release of an individual who meets the requirements for involuntary admission under subsection (e)(2) of this section on the grounds that the individual was kept at an emergency facility for more than 30 hours in violation of § 10-624(b)(4) of this subtitle.

(effective October 1, 2018). We have not considered this legislation in this opinion.

[2] On August 31, 2017, the circuit court granted Mr. Davies's motion to consolidate his case with the case of Portia N., who had been involuntarily committed by the same ALJ to the same hospital on the same day. After the circuit court's October 2, 2017 opinion, Portia N. also noted an appeal. Both Mr. Davies's case and Portia N.'s case were docketed to this Court as No. 1663 of the September 2017 Term, and the case was captioned under Portia N.'s name. On September 6, 2018, Portia N. filed a line dismissing her appeal. As Mr. Davies is the only appellant in this case, we re-captioned the appeal as "In the Matter of Gerald Davies."

Did the ALJ err when she ordered that Mr. Davies be involuntarily admitted to the Hospital?

For reasons that follow, we answer this question in the negative and affirm the judgment of the circuit court.

FACTUAL AND PROCEDURAL BACKGROUND[3]

Mr. Davies was brought to the emergency room of Howard County General Hospital at 8:25 p.m. on April 21, 2017 by a police officer (Officer Robinson; no first name given). At 4:26 p.m. on April 22, 2017, the hospital had completed a psychiatric evaluation and determined the need to find a bed for Mr. Davies in a psychiatric unit. A bed search of area hospitals was performed but a bed was not available until one became available at Howard County General Hospital. That Mr. Davies remained in the emergency room for 141 hours is not disputed.

On May 2, 2017, an administrative hearing was held at the hospital on the hospital's application for Mr. Davies's involuntary admission. An assistant public defender appeared on behalf of Mr. Davies, and Ms. Celeste Renninger, a clinical social worker at the hospital, represented the hospital. Ms. Renninger stated that, according to Officer Robinson, Mr. Davies had stepped onto the street in front of a car, endangering himself and the occupants of the vehicle. Officer Robinson had to restrain Mr. Davies to transport him to the hospital safely.

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[3] The transcript of Mr. Davies's administrative hearing is incomplete with gaps and missing words. As noted by the transcriber on the first page of the transcript: "There are many portions in this transcript that were inaudible or unintelligible due to a mechanical noise present through the entire recording."

Mr. Davies requested his release, arguing that the hospital violated Health - General § 10-624(b)(4)—the Thirty-hour Rule—by keeping him in the emergency room for 141 hours. Acknowledging that that was "a violation of the law," the ALJ proceeded to hear "further evidence regarding the merits of whether Mr. Davies needs to remain in the hospital."

Dr. Anisa Cott, the first medical professional to sign the certificate of Mr. Davies' involuntary admission, testified that Mr. Davies was diagnosed with chronic paranoid schizophrenia. In characterizing Mr. Davies's condition, Dr. Cott stated that he was "delusional"[4] and behaved "loud[ly] and offensive[ly]."

The hospital's representative, Ms. Renninger, inquired of Dr. Cott whether there were standing orders for emergency medications; whether Mr. Davies agreed with his own diagnosis or need for treatment; whether Mr. Davies had been accepting medications; and why she thought that Mr. Davies could not have been effectively treated with other care. Although the transcript has gaps, we are able to summarize Dr. Cott's responses to those questions:

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[4] According to the transcript, Dr. Cott said, "I heard him explaining to the employees and a peer in the hallway, and said that he (unintelligible) from MIT, that he needed to leave the hospital…."

Mr. Davies was able to "get Ativan[5] as needed for agitation," and was receiving a medication named "Haldol."[6] Dr. Cott had spoken with Mr. Davies's former outpatient psychiatrist on the day of the hearing and received advice on prescribing "Risperdal,"[7] a medication to which Mr. Davies previously responded well.[8] She had "started him on Risperdal," and had "issued a standing order" for it.

While Mr. Davies was visiting his children in Howard County, police had been called when he had become "very loud and intrusive around other peoples [sic] homes." Dr. Cott believed that this behavior would be repeated if Mr. Davies were released from the hospital because his behavior in the psychiatric unit continued to be "disorganized," "confused," and "repetitive."

Even though he reluctantly accepted medication at the hospital, Mr. Davies did not think that he had a mental illness, or that he needed to be on any medication or in the

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[5] Ativan is a brand name for Lorazepam, which is a "benzodiazepine" drug used to "treat anxiety." See Lorazepam, WebMD, https://www.webmd.com/drugs/2/drug-8892-5244/lorazepam-oral/lorazepam-oral/details (last visited June 24, 2019).

[6] Haldol is a brand name for Haloperidol, which is a "psychiatric mediation (antipsychotic-type)" used to "treat certain mental/mood disorders (e.g., schizophrenia)." *See* Haloperidol, WebMD, https://www.webmd.com/drugs/2/drug-8661/haloperidol-oral/details (last visited June 24, 2019).

[7] Risperdal is a brand name for Risperidone, which is an "atypical antipsychotic" drug used to "treat certain mental/mood disorders," including schizophrenia. *See* Risperidone, WebMD, https://www.webmd.com/drugs/2/drug-6283-2034/risperidone-oral/risperidone-oral/details (last visited June 24, 2019).

[8] Mr. Davies had made progress from the treatment prescribed by his previous psychiatrist for a few years, but he began refusing treatment in the summer of 2016. The outpatient psychiatrist closed Mr. Davies's case in March 2017.

hospital. The night before the hearing, Mr. Davies was "pounding his fists on the table," screaming in the middle of the night and had had "zero hours of sleep." In Dr. Cott's view, Mr. Davies was "in the same psychotic agitated disorganized state" that led him to the hospital. She and the hospital staff strongly felt that Mr. Davies's commitment was necessary.

When the ALJ asked if Mr. Davies wanted to cross-examine Dr. Cott, his counsel declined. Although the transcript of Mr. Davies's testimony was, as noted, incomplete, the record is clear that Mr. Davies requested to leave the hospital on the day of the hearing. When his counsel asked Mr. Davies if he had a mental illness, he answered, "Not really."

At close of the hearing, the ALJ ordered Mr. Davies involuntarily committed to the hospital:

> After considering all of the evidence presented, I find that such evidence is clear and convincing that Mr. Gerald Davies has a mental disorder diagnosed as chronic paranoid schizophrenia, that he is in need of institutional care or treatment at this time. He presents a danger to his own life or safety predominantly, as well as the life and safety of others, in that he's engaging in dangerous behavior in the community . . . . Stepping out into the street in front of a car, certainly he could have been injured, the people in the vehicle could have been injured. His behaviors are such that he is at risk for being harmed in the community . . . . [H]e was getting medical care in the institution in the emergency room[.] . . . [W]e have to weigh the factors . . . does the evidence showing his required admission outweigh his deprivation of liberty, and in this instance I find that it does, because he continues to present a danger to himself even within the very supervised and structured environment of a hospital . . . Further, he is unwilling or unable to be voluntarily admitted to a facility at this time . . . . Therefore, I find that all of the above has been proven by clear and convincing evidence, and Mr. Davies shall be retained as an involuntary patient in this facility.

Mr. Davies sought judicial review in the circuit court, which held a hearing on September 6, 2017. After noting that there was no law mandating how an ALJ should proceed when a violation of § 10-624(b)(4) occurs, that court affirmed the ALJ's decision on October 2, 2017. An appeal to this court followed.

STANDARD OF REVIEW

In judicial review, we look through the circuit court's judgment and review the ALJ's decision. *See J.H. v. Prince George's Hospital Center,* 233 Md. App. 549, 578 (2017); *Sturdivant v. Md. Dep't of Health & Mental Hygiene*, 436 Md. 584, 587 (2014). We give deference to the ALJ's findings of fact "if there is substantial evidence in the record as a whole to support the agency's findings." *J.H.*, 233 Md. App. at 578; *see also Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 67-68 (1999). We review the ALJ's legal conclusions de novo without the deference that might ordinarily be extended to an agency adjudicating a statute it administers or a regulation it has promulgated because the ALJ is independent of the Maryland Department of Health, and is without its "subject matter expertise." 233 Md. App. at 581.

DISCUSSION

I. Involuntary Admission

Contention

Mr. Davies does not argue in this appeal that his mental condition did not warrant an involuntary admission. His sole contention is that, when he was brought in on a petition for emergency evaluation, he was kept in the emergency room for 141 hours, which was,

in his view, a substantial violation of Health - General § 10-624(b)(4). Therefore, he posits that the only remedy consistent with due process was his release from the hospital.

Analysis

The ALJ found:

> Mr. Gerald Davies has a mental disorder diagnosed as chronic paranoid schizophrenia, that he is in need of institutional care or treatment at this time. He presents a danger to his own life or safety predominantly, as well as the life and safety of others, in that he's engaging in dangerous behavior in the community . . . . Stepping out into the street in front of a car, certainly he could have been injured, the people in the vehicle could have been injured. His behaviors are such that he is at risk for being harmed in the community . . . . [H]e was getting medical care in the institution in the emergency room[.] . . . [W]e have to weigh the factors . . . does the evidence showing his required admission outweigh his deprivation of liberty, and in this instance I find that it does, because he continues to present a danger to himself even within the very supervised and structured environment of a hospital . . . .

To determine whether Mr. Davies met the requirements for involuntary admission, we turn to Maryland's mental health law and regulations governing admission hearings.

Health - General § 10-632 provides:

> (e) The hearing officer shall:
> (1) Consider all the evidence and testimony of record; and
> (2) Order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought:
> (i) The individual has a mental disorder;
> (ii) The individual needs in-patient care or treatment;
> (iii) The individual presents a danger to the life or safety of the individual or of others;
> (iv) The individual is unable or unwilling to be voluntarily admitted to the facility; [and]
> (v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual.

We interpret a statute by looking first and foremost to the plain meaning of its words. *See, e.g.*, *Md. Econ. Dev. Corp. v. Montgomery County*, 431 Md. 189, 194 (2013). The plain language of the statute mandates release "unless the record demonstrates by clear and convincing evidence" that all five elements of § 10-632(e)(i)-(v) existed at the time of the hearing.

The regulations promulgated by the Maryland Department of Health mirror the requirements of § 10-632(e)(2) and place the burden of proving elements (i) - (v) on the inpatient facilities:

> The burden of proof is on the inpatient facility to demonstrate by clear and convincing evidence that:
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> (1) The individual has a mental disorder;
> (2) The individual needs inpatient care or treatment;
> (3) The individual presents a danger to the life or safety of the individual or of others;
> (4) The individual is unable or unwilling to be admitted voluntarily; [and]
> (5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

COMAR 10.21.01.09(F).

The evidence presented at the hearing indicates that Mr. Davies was diagnosed to have a mental disorder on two occasions. Once a few years earlier by an outpatient psychiatrist, and then by Dr. Cott at the hospital prior to the hearing in this case. The ALJ relied on Dr. Cott's testimony to find that Mr. Davies had chronic paranoid schizophrenia. *See J.H.*, 233 Md. App. at 555, 599 (affirming involuntary admission decision where ALJ relied on the treating physician's testimony that the patient had been diagnosed with chronic schizophrenia).

Mr. Davies had rejected treatment in 2016, which led to the close of his case by his outpatient psychiatrist in March 2017. Without treatment, his mental disorder persisted and his behaviors impacted himself and others. He was reported to have stepped in front of a vehicle on the street and acted intrusively around other people's homes sometime in April 2017. Dr. Cott testified that Mr. Davies was in denial of his mental state at the hospital. In clear contradiction to his health records, Mr. Davies testified that he did not have a mental illness.

The ALJ considered the testimony that Mr. Davies had been found "stepping out into the street in front of a car," which could have caused injury to himself or the people in the car. In *J.H.*, one of the patients did not eat or bathe regularly, another patient "appeared confused and almost was hit by a car." 233 Md. App. at 557, 561. Both patients were found to have posed danger to themselves and others. *Id.* at 599. In this case, the potential danger to himself and others reflected in Mr. Davies's behavior was more pronounced than the first *J.H.* patient and analogous to the second. As the ALJ found: "He presents a danger to his own life or safety predominantly, as well as the life and safety of others, in that he's engaging in dangerous behavior in the community." And, Mr. Davies's testimony indicated his unwillingness to be voluntarily admitted.

Dr. Cott testified that she believed that no alternative care was effective to treat Mr. Davies. The night before the hearing, Mr. Davies was screaming in the middle of the night and had "zero hours of sleep." She reasoned that, because Mr. Davies's behavior at the hospital's psychiatric unit continued to be a concern, admission was the only proper care.

See In re J.C.N., 460 Md. 371, 381, 395 (2018) (affirming ALJ decision for involuntary admission where psychiatrist testified that there was no safe alternative for a patient).

We hold that the ALJ's factual findings as to the statutory elements for involuntary commitment were supported by substantial evidence.

II. Violation of the Thirty-hour Rule

Contention

Mr. Davies contends that his extended detention in the emergency room was a substantial error in the pre-admission process, and that no remedy other than his release from the hospital was consistent with due process and the protection of his rights. The ALJ agreed that an error had occurred, but that involuntary admission was still necessary.

Analysis

To support his argument that the violation of the Thirty-hour Rule was substantial, Mr. Davies refers us to the Maryland Department of Health regulation governing conduct of involuntary admission hearings. COMAR 10.21.01.09(G) provides:

> After the evidence and testimony are presented, and following summation and argument by the parties, the ALJ shall:
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> * * *
>
> (3) Order the release of the individual from the inpatient facility if:
> (a) An error in the process occurred;
> (b) The error in the process is substantial; and
> (c) No other available remedy is consistent with due process and the protection of the individual's rights[.]

We held in *J.H.*, when a patient raise a procedural violation:

> [T]he burden shifts to the hospital to establish, *by a preponderance of the evidence*, either its compliance with respect to the alleged procedural violation, or that the violation was not substantial or that "[n]o other remedy

> [wa]s consistent with due process and the protection of the individual's rights[.]"

233 Md. App. at 590-91 (emphasis added). "To prove by a preponderance of the evidence means to prove that something is more likely so than not so . . . such evidence, when considered and compared with the evidence opposed to it, has more convincing force[.]" *Coleman v. Anne Arundel County Police Dep't*, 369 Md. 108, 125 n.16 (2002).

The ALJ did not err in proceeding with the hearing when Mr. Davies raised the Thirty-hour Rule violation. The plain language of COMAR 10.21.01.09(G)(3) indicates that release was not an automatic remedy for a violation of the Thirty-hour Rule. An order of release is only necessary if the error in the process is substantial and there is no other available remedy that is consistent with due process and the protection of his rights.

To sustain the argument that the 141-hour delay, which was 111 hours beyond the thirty-hour threshold, was substantial, Mr. Davies mounts a three prong attack. He cites *J.H.*, 233 Md. App. at 599, where we upheld the ALJ decisions to admit four patients. First, he distinguishes the facts of this case from those of two of the *J.H.* patients: "One individual, M.G., alleged that she was kept in the emergency room for forty-one hours . . . another individual, B.N., alleged, and proved, that she was kept in the emergency room for seventy-six hours before being admitted. . . . the lengths were relatively minor[.]" Second, Mr. Davies contends that the bed search did not justify his extended stay in the emergency room: "the thirty-hour requirement is rendered meaningless if it can be evaded simply by performing a bed search." He also questions the geographic range, frequency, and timing of the bed search, arguing the absence of such information in the record renders it unknown

whether his extended stay at the emergency room was "undertaken out of necessity or convenience of the hospital staff." Third, Mr. Davies asserts that "there is no proof in the record that [he] received any psychiatric treatment during the 111 hours he was illegally confined."

In *J.H.*, we upheld an ALJ's involuntary admission decisions notwithstanding evaluees' stay in the emergency room longer than thirty hours, after considering the following: the unavailability of beds in the inpatient unit, the initial psychiatric evaluations that supported admission, and the nature of psychiatric treatment provided in the emergency room. *See* 233 Md. App. at 597-99. In other words, "substantial" in the context of the involuntary commitment process is not a simple calculation of hours, but a commonsense calculus involving time, the patient's psychiatric evaluation, and the treatment provided during that time.

In holding that patient M.G.'s stay in the emergency room was not a substantial error, the *J.H.* Court noted that, although M.G. was not transferred to an inpatient psychiatric unit within thirty hours, "the emergency room physicians performed their initial evaluation and concluded that M.G. required inpatient treatment." *Id.* at 597. And, "[t]he emergency room physicians began administering that treatment in the ASC prior to her transfer to an available bed in the inpatient unit." *Id.* at 597. As for B.N., we also held that the violation was not substantial because an initial evaluation was completed, and beds were unavailable in the inpatient unit, but, like for M.G., there was access to psychiatric care in the emergency room. *Id.* at 598-99.

After Mr. Davies reported to the hospital at 8:25 p.m. on April 21, 2017, the emergency room completed Mr. Davies's initial psychiatric evaluation the following day at 4:26 p.m. Here, as in *J.H.*, the ALJ properly considered the emergency room evaluation and the unavailability of beds in the inpatient unit in rendering her decision. The ALJ also concluded that "he was getting medical care in the institution in the emergency room."

Alleging that he did not receive specialized care, Mr. Davies asserts that: "[Dr. Cott] did not testify [that Mr. Davies] was receiving . . . medication during his extended confinement in the emergency room[.]" At the hearing, Dr. Cott responded to a question: "And do you have standing orders[9] for *emergency* medications?" (Emphasis added). Although Dr. Cott's answer was partially unintelligible in the transcript, she testified to three medications mentioned earlier and to one standing order. In deference to the ALJ, it is not unreasonable to infer that Dr. Cott's testimony was the basis for the ALJ's finding that Mr. Davies received appropriate treatment for his condition in the emergency room. In short, we are not persuaded to disturb the ALJ's finding that Mr. Davies received appropriate medical treatment before his transfer to the hospital as an inpatient. *See J.H.*, 233 Md. App. at 578.

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[9] "Standing orders" are what nurses use to provide medications to patients without a direct physician's order. Standing orders spell out what nurses can do under a specific set of circumstances with a particular patient population. Nurses Service Organization, *Administer meds without a doctor's order? Proceed with caution*, https://www.nso.com/Learning/Artifacts/Articles/Administer-meds-without-a-doctor-s-order-Proceed (last visited June 24, 2019).

We accordingly hold that 111 hours beyond the Thirty-hour Rule is not substantial in light of the psychiatric diagnosis, the unavailability of a psychiatric unit bed, and the medical care and treatment being provided to Mr. Davies in this case. And, because the need for inpatient treatment was clear, there was really "no other available remedy" consistent with due process and the protection of Mr. Davies's rights. As the ALJ recognized, "we have to weigh the factors . . . does the evidence showing his required admission outweigh his deprivation of liberty[?]" She determined that it did. In sum, we are persuaded that the ALJ's decision to involuntarily admit Mr. Davies was legally correct and supported by substantial evidence.

JUDGMENT OF THE CIRCUIT COURT FOR HOWARD COUNTY AFFIRMED; COSTS TO BE PAID BY APPELLANT.