SENATE COMMITTEE ON PUBLIC SAFETY

Senator Jesse Arreguín, Chair
2025 - 2026 Regular

Bill No:	AB 2405	**Hearing Date:**	June 30, 2026
Author:	Gipson		
Version:	May 18, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	AB		

Subject: ***Emergency Medical Services Act***

HISTORY

Source: Martin Luther King Jr. Community Hospital

Prior Legislation: N/A

Support (amended Assembly 5/18/26): ACLU California Action; California Hospital Association; Disability Rights California

Opposition (amended Assembly 5/18/26): California Fire Chiefs Association; California State Sheriffs' Association; Fire Districts Association of California; League of California Cities; Shasta County Board of Supervisors

Assembly Floor Vote: 47 - 18

PURPOSE

The purpose of this bill is to require a peace officer who is transporting a person subject to an involuntary psychiatric hold (of "5150 hold") to transport the person to the closest designated facility, geographically or by time, to where the peace officer took the person into custody; and to require law enforcement agencies to report such transports to the Emergency Medical Services Authority (EMSA), as specified.

Existing law establishes the EMSA, under the Emergency Medical Services (EMS) System and the Prehospital Emergency Medical Care Personnel Act, which is responsible for the coordination of various state activities concerning emergency medical services. (Health & Saf. Code, §§ 1797, et seq.)

Existing law requires, among other things, EMSA to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies. (Health & Saf. Code, §§ 1797.103 & 1797.105)

Existing law provides that regulations, standards, and guidelines adopted by the authority and by local EMS agencies shall provide for the transport and transfer of a member of a group practice prepayment health care service plan to a hospital that contracts with the plan when the base

hospital determines that the condition of the member permits the transport or when the condition of the member permits the transfer, except that when the dispatching agency determines that the transport by a transport unit would unreasonably remove the transport unit from the area, the member may be transported to the nearest hospital capable of treating the member. . (Health & Saf. Code, § 1797.106)

Existing law provides each county may develop an emergency medical services program. Each county developing such a program shall designate a local emergency medical services authority (LEMSA) which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties, as specified. (Health & Saf. Code §1797.200.)

Existing law requires local plans developed by a local EMS agency, as specified, to require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. (Health & Saf. Code, § 1797.114.)

Existing law authorizes a county, as specified, to adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the LEMSA. (Health & Saf. Code, § 1797.222.)

Existing law declares the intent of the Legislature to improve the health of individuals in their communities by authorizing licensed paramedics, working under expert medical oversight, to deliver community paramedicine or triage to alternate destination services in California utilizing existing providers, promoting continuity of care, and maximizing existing efficiencies within the first response and emergency medical services system. (Health & Saf. Code, § 1801, subd. (c).)

Existing law permits LEMSAs to develop a community paramedicine or triage to alternate destination program that is consistent with the Emergency Medical Services Authority's regulations. (Health & Saf. Code, § 1840.)

Existing law establishes the Lanterman-Petris-Short Act, which provides for the involuntary detention for treatment and evaluation of people who are gravely disabled, as defined, or are a danger to self or others. (Welf. & Inst. Code, §§ 5000 et seq.)

Existing law provides that if a person is gravely disabled, as defined, as a result of mental illness, or a danger to self or others, then a peace officer, staff of a designated treatment facility or crisis team, or other professional person designated by the county, may, upon probable cause, take that person into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement in a designated treatment facility (known as a "5150 hold"). (Welf. & Inst. Code, § 5150.)

Existing law provides that a person who has been detained for 72 hours may be further detained for up to 14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment. (Welf. & Inst. Code, § 5250.)

Existing law establishes that a person who has been taken into custody on a 5150 hold because that person is a danger to themselves or to others and admitted to a designated facility because of that danger shall not own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase, a firearm, other deadly weapon, or ammunition for a period of five years after the person is released from the facility. (Welf. & Inst. Code, § 8103, subd. (f)(1)(A).)

Existing law specifies that for each person subject to involuntary commitment, as specified, the facility shall, within 24 hours of the time of admission, submit a report to DOJ containing information that includes, but is not limited to, the identity of the person and the legal grounds upon which the person was admitted to the facility. (Welf. & Inst. Code, § 8103, subd. (f)(2)(A)(i).)

Existing law provides that no peace officer seeking to transport, or having transport or having transported, a person to a designated facility for assessment under Section 5150, shall be instructed by mental health personnel to take the person to, or keep the person at, a jail solely because of the unavailability of an acute bed, nor shall the peace officer be forbidden to transport the person directly to the designated facility. (Welf. & Inst. Code, § 5150.1.)

Existing law provides that no mental health employee from any county, state, city, or any private agency providing specified psychiatric emergency services shall interfere with a peace officer performing duties under Section 5150 by preventing the peace officer from entering a designated facility with the person to be assessed, nor shall any employee of such an agency require the peace officer to remove the person without assessment as a condition of allowing the peace officer to depart. (*Ibid*.)

Existing law provides that in each county whenever a peace officer has transported a person to a designated facility for assessment under Section 5150, that officer shall be detained no longer than the time necessary to complete documentation of the factual basis of the detention under Section 5150 and a safe and orderly transfer of physical custody of the person, as provided. (Welf. & Inst. Code, § 5150.2)

This bill requires a peace officer who is transporting a person to a designated facility for assessment under Welfare and Institutions Code 5150 to transport the person to the closest designated facility, geographically or by time, to where the peace officer took the person into custody.

This bill specifies that in cases where a designated facility is unable to accept the individual and the emergency department becomes the chosen destination, the individual shall be transported to the nearest appropriate emergency department to where the peace officer first assumed custody of the individual for purposes of transport.

This bill requires each law enforcement agency to report quarterly to EMSA, all transports to an emergency department, including, but not limited to, the following data:

- Origin location of the transported individual.
- Destination facility and the date and time of transport.
- Stated rationale for destination selection.
- Whether the destination was the nearest appropriate emergency department or an alternative destination site.

- Demographic information of the transported individual, excluding personally identifiable information.
- Reason the individual was transported to the emergency department, including whether they were being transported for purposes of assessment pursuant to a 5150 hold, or for a non-behavioral health medical emergency.

This bill requires EMSA to publish annual aggregate reports on its website.

This bill defines "law enforcement agency" for the purposes of the reporting provision above as any city or municipal police department, county sheriff's department, or other public agency that employs peace officers, as specified.

COMMENTS

1. Need for This Bill

According to the author:

> AB 2405 ensures some of the most vulnerable Californians receive timely emergency care by aligning law enforcement transport practices with established EMS standards and promoting fairness across our healthcare system. This change is in the best interest of vulnerable patients who need access to emergency care as well as resource-constrained community hospitals who are overwhelmed by drop-offs from law enforcement agents.

2. 5150 Holds and Transport of Detained Individuals

The Lanterman-Petris-Short (LPS) Act governs the involuntary detention for evaluation and treatment of mentally ill individuals in California who are gravely disabled or a danger to self or others. A key feature of the LPS Act is what is known as a "5150 hold," whereby, if a person is gravely disabled as a result of mental illness, or a danger to self or others, then a peace officer, staff of a designated treatment facility or crisis team, or other professional person designated by the county, may, upon probable cause, take that person into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement in a designated treatment facility.[1] A person who has been detained for 72 hours may be further detained for up to 14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment. After the 14 days, a person may be detained for an additional 30 days of intensive treatment if the person remains gravely disabled and is unwilling or unable to voluntarily accept treatment. A 180-day commitment requires a superior court order.[2]

Existing law generally ensures that peace officers have significant autonomy and discretion in transporting a person subject to a 5150 hold to a designated facility and returning to their law enforcement duties. Specifically, existing law provides that mental health personnel at a facility cannot force peace officers to take or keep a 5150 patient at a jail just because an acute bed is not available, nor can they stop officers from bringing a patient directly into a facility for

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[1] Welf. & Inst. Code, § 5150.
[2] Welf. & Inst. Code, §§ 5150, 5250, 5260, 5301.

assessment.[3] Furthermore, facility staff are strictly prohibited from blocking an officer's entry or requiring them to leave with the patient before an assessment is conducted.[4] In addition, when an officer drops someone off at a facility under a 5150 hold, the officer can only be kept there long enough to finish their paperwork and safely hand over custody of the person.[5]

This bill provides that a peace officer who is transporting a person to a facility for a 5150 assessment must transport the person to the closest designated facility, geographically or by time, to where the peace officer took the person into custody. Moreover, in cases where a facility is unable to accept the individual and the emergency department becomes the chosen destination, the bill requires that patient be to the nearest appropriate emergency department to where the peace officer first assumed custody of the individual for purposes of transport.

While this appears to be generally consistent with many agencies' departmental policy regarding 5150 transport, it this provision does raise various questions that the author and Committee may wish to consider.[6] First, how will officers know whether the "closest" designated facility, or even their second or third choice, is under diversion? Generally, peace officers do not have access to the same EMS information system that firefighters and other emergency medical responders do. Moreover, what enforcement mechanism does the bill contemplate if the peace officer does not comply with the bill, either intentionally or inadvertently? Is it even appropriate to penalize officers or their agencies in such circumstances? A prior version of the bill authorized EMSA to levy substantial fines against law enforcement agencies, but this penalty provision was removed in recent amendments.

3. California Emergency Medical Services Authority and Reporting Requirement

The Emergency Medical Services Authority (EMSA) was created in 1980 to provide leadership in developing EMS systems throughout California and to develop standards for training and scope of practice for EMS personnel. Prior to 1980, California did not have a central state agency responsible for ensuring the development and coordination of EMS services and programs statewide. According to the EMSA website:

> Although the many stakeholders in EMS, including local administrators, fire agencies, ambulance companies, hospitals, physicians, nurses, and other health care providers did not agree on all issues, there was a consensus that a more unified approach was needed to emergency and disaster medical services. After several years of effort by the EMS constituents to establish a state lead agency, Governor Jerry Brown signed into law the Emergency Medical Services System and Prehospital Emergency Care Personnel Act in 1980 creating the Emergency Medical Services Authority. EMSA's mission is to ensure quality patient care by

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[3] Welf. & Inst. Code, § 5150.1.
[4] *Ibid.*
[5] Welf. & Inst. Code, § 5150.2
[6] See the following policies, all of which generally require officers transporting 5150 patients to take them to the "nearest" appropriate facility. Orange County Sheriff: https://ocsheriff.gov/sites/ocsd/files/2021-03/Policy%20409%20Mental%20Illness%20Commitments.pdf ; Yolo County https://www.cityofwinters.org/DocumentCenter/View/684/MOU-Yolo-HHSA-and-5150-PDF ; Sacramento PD: https://www.cityofsacramento.gov/content/dam/portal/police/Transparency/policy/GO/Section-500/GO-52201-Handling-Mentally-Ill-Persons-31618-website.pdf

> administering an effective statewide system of coordinated emergency medical care, injury prevention and disaster medical response.[7]

The EMS Act authorizes each county to develop an EMS program and to designate a local emergency medical services authority (LEMSA; usually a single county or multi-county region) that oversees the delivery of EMS within that geographic area. EMSA and LEMSAs do not usually cover law enforcement officers such as police and sheriff deputies. EMS regulatory agencies cover firefighters, paramedics, EMTs, and other first responders, but law enforcement is not required to maintain licensure through their LEMSA, except where they chose to obtain a Public Safety First Aid Certification to provide basic emergency medical care while performing their job duties.

This bill requires each law enforcement agency to report, on a quarterly basis to EMSA, all transports to an emergency department, including specified information, such as 1) the origin location of the transported individual, 2) destination facility and the date and time of transport, 3) the stated rationale for destination selection, 4) whether the destination was the nearest appropriate emergency department or an alternative destination site, 5) demographic information of the transported individual, excluding personally identifiable information, and 6) the reason the individual was transported to the emergency department, including whether they were being transported for purposes of assessment pursuant to Section 5150 of the Welfare and Institutions, or for a non-behavioral health medical emergency. Although such information may be valuable, given that EMSA has little connection to local law enforcement agencies, and there appears to be no existing requirement that law enforcement agencies report any other types of information to EMSA, is EMSA the appropriate agency? Moreover, California law enforcement officers are already subject to a myriad of reporting requirements based on other responsibilities – should the Legislature add another such requirement?

4. Argument in Support[8]

According to ACLU California Action:

> California's emergency medical services (EMS) system operates under well-established protocols that require paramedics and EMTs to transport patients, including those experiencing behavioral health crises, to the nearest appropriate facility. However, law enforcement agencies are not subject to comparable statewide standards, resulting in inconsistent or discretionary practices. These gaps have led to inequitable patterns of care, where certain hospitals — particularly safety-net facilities — receive a disproportionate share of patients transported from outside their service areas.
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> Moreover, these inconsistent law enforcement transport practices are contributing to overcrowding, delays in care, and inequitable burdens on safety-net hospitals. For example, MLK Community Hospital in South LA experienced over 1,150 law enforcement drop-offs in 2025, including from jurisdictions far outside its service

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[7] https://www.emsa.ca.gov/caemsa?id=about_us

[8] It should be noted that letters included in this analysis were received by committee prior to the most recent amendments substantially changing the bill. They may not reflect the positions of these groups after the most recent round of amendments were taken. These letters have been included here to provide arguments in favor of and against the general approach proposed by the bill.

area. This places significant strain on the limited resources of safety net hospitals and exacerbates already high emergency department utilization This bill will improve fairness in how emergency care is distributed across hospitals and reduce unsafe delays in treatment.

5. Argument in Opposition

According to the California State Sheriffs Association:

> This sort of law enforcement practice should not be subjected to specific statutory regulation. There are many factors that might go into a decision as to where a person should be transported and local protocols should be determinative. The bill's recent inclusion of an exigent circumstances exception is far too narrow and AB 2405 still ignores a situation in which the nearest ED might be physically inaccessible.
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> In addition to this inflexible requirement, AB 2405 allows for the imposition of civil penalties "per pattern of violation," a term that is not defined in statute but rather would be defined in regulations. The bill also imposes an unfunded mandate that law enforcement agencies report quarterly on several categories of data relative to ED transport.

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