**UNITED STATES DISTRICT COURT**
**WESTERN DISTRICT OF MICHIGAN**

EVERETT HADIX, et. al.,

Plaintiffs, No. 4:92-cv-110

v. HONORABLE ROBERT J JONKER

PATRICIA CARUSO, JOHN OCWIEJA and NICK LUDWICK,

Defendants.

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**DEFENDANTS' SECOND AMENDED POST-HEARING PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW RELATED TO THE APRIL 28-30 AND JUNE 11-12, 2008 HEARING REGARDING MENTAL HEALTH**

Defendants, through counsel, submit the following findings of fact and conclusions of law. These are being submitted following the evidentiary hearing held on April 28-30 and June 11-12, 2008. This five-day hearing reviewed testimony of eleven witnesses on behalf of the parties. The Court also received testimony from Dr. Cohen, the Associate Monitor for Medical Issues and Mr. Henry Dlugarz who works with Dr. Cohen on mental health issues. Ms. Childers, testified by video de benne esse deposition. One of Defendants' witnesses, Mr. Roy Cally

testified live and through his transcribed deposition testimony given between the April and June 2008 hearing dates.

The parties submitted approximately 160 exhibits including excerpts from deposition taken in late summer and early fall of 2007. These exhibits also included Plaintiffs' expert reports from early summer 2007 based on information from 2006 and late spring early summer 2007. Plaintiffs submitted some portions of medical records, mostly from 2007. However, the primary documentary focus of the parties were Michigan Department of Corrections (MDOC) and Department of Community Health (DCH)/Corrections Mental Health Program (CMHP) documents. Of these latter exhibits, the Special Management Housing Unit (SMHU) logs (Defendants' Exhibit D), the drafts of new mental health screening forms (Defendants' Exhibit K and L), the CMHP caseload (Defendants' Exhibit RR), and CMHP utilization information (Defendants' Exhibit RR and SS), PSU referral information and testimony regarding the Defendants Bridge Order (Defendants' Exhibit A) process was the focus of substance.

This hearing was required by the Court's November 13, 2006 Opinion and Preliminary Injunction (hereafter 11/13/06 Order).

**Proposed Findings of Fact**

1. The 1985 *Hadix* Consent Decree contained provisions regarding mental health care (section II.B.).

2. The *Hadix* Consent Decree mental health provisions were dismissed (terminated) in January 2001.

3. More than 5-1/2 years later, the Court entered its November 13, 2006 Opinion and Preliminary Injunction. That Opinion and Preliminary Injunction stated, in paragraph 1, "IT IS HEREBY ORDERED that Plaintiffs' Motion to Reopen Judgment Regarding Mental Health

Care and Issue a Preliminary Injunction (dkt #2102) is granted and section II.B. of the Consent Decree is reopened **limited**[1] to the provisions of this Order and Preliminary Injunction."

4. The reopening of section II.B. of the Consent Decree was limited to the following four issues:

a. Mandatory cessation of using any form of punitive mechanical restraints within *Hadix* facilities and the development of practices, protocols and policies to enforce the limitation.

b. Defendants were required to work to develop a staffing plan for adequate psychiatric and psychological staffing at *Hadix* facilities to ensure that routine and emergent psychiatric and psychological services are provided in a timely way.

c. Defendants were to immediately work to provide daily psychologist or psychiatrist rounds in the segregation unit at the *Hadix* facilities.

d. Defendants were to work to develop protocols for the coordination of mental health and medical staff, and were to require weekly conferences of the two disciplines which would include, but not be limited to, the treatment of prisoners in the segregation unit and would include necessary training to prevent staff and administrative indifference to the provision of care.

5. No other aspect of section II.B. of the *Hadix* Consent Decree provisions regarding mental health, that had been completely terminated in January 2001, were reopened by the Court's November 13, 2006 Order and Preliminary Injunction.

6. The Court's November 13, 2006 Order and Preliminary Injunction allowed Plaintiffs discovery as to mental health care in advance of a final injunctive hearing. That final injunctive hearing was held on the five days of April 28-30 and June 11-12, 2008.

[1] Emphasis added.

7. At the time of the November 13, 2006 Order and Preliminary Injunction, the *Hadix* facilities included the following: a) Reception and Guidance Center (RGC) cell blocks 1, 2, 3 and 7, the Duane Waters Health Center (DWH) and C-Unit, an extended care or nursing home facility; b) Southern Michigan Correctional Facility (JMF) (cell blocks 4, 5 and 6). Part of 6-block of JMF was an administrative segregation unit; and c) Parnall Correctional Facility's (SMT) 8-block.

8. On April 2, 2007, the Defendants permanently closed SMT's 8-block in accord with the Court-approved Defendants' Alternative Fire Safety Plan (DAP). That DAP has been completed and is fully operational in cell blocks 1-3 of RGC.

9. On or about July 13, 2007, Defendants permanently closed RGC's cell block 7, leaving only cell blocks 1, 2 and 3 still in use.

10. On November 2, 2007, the Defendants permanently closed JMF, including all of cell blocks 4, 5 and 6. This action closed JMF's administrative segregation unit. As a result of this closure and the previous closures of the old segregation cell blocks in the early 1990s, the closure of 11 and 12 blocks in 2001, the closure of 8-blockin April 2007, the July 13, 2007 closure of 7-blockand the November 2, 2007 closure of 4, 5, and 6 blocks, SPSM-CC described in 1985 *Hadix* Consent Decree does not exist.

11. In 1985, 3 blocks of prisoners could only exit the block into the yard of "central complex" and was considered central complex because of the mingling of its population with the populations of 4, 5, 6, 7 and 8 blocks. Considering the former SPSM to be shaped, when viewed from above, like home plate on a baseball diamond, 4, 5, 6 and 7 blocks formed the long side of the home plate nearest the catcher. 3-blockand 8-blockwere the first of three cell blocks that made up the sides of the plate. Of the original 1, 2 and 3 blocks, only 3-block prisoners exited their block into the common central yard inside home plate. 1 and 2-blockprisoners exited their

blocks, i.e. were "turned out" outside of the central yard and so were not part of central complex or SPSM-CC. Similarly, 9 and 10 blocks were "turned out" to yards outside the cell block and were not and still are not part of SPSM-CC.

12. 7-block, part of the line of cell blocks along the base of home plate, was the original reception center. In 2001, 3-block was a general population block, as were cell blocks 1 and 2. That summer, all three cell blocks ceased being general population and became reception cell blocks. This meant they no longer contained permanent or long term residents. Rather, prisoners are usually transferred out in under 30-45 days. That number is steadily getting shorter on its way to an average of just 21 days.

13. Therefore, the 11/13/06 order requiring the re-opening of the *Hadix* Consent Decree's mental health provisions limited to the issues enumerated in the 11/13/06 order, must now be understood to be without any of the SPSM-CC in the 1985 Consent Decree still existing. SPSM-CC, the sole facility subject to the provisions of the 1985 *Hadix* Consent Decree ceased to exist on November 2, 2007 when JMF closed. Duane Waters Health Center, contemplated as a hospital to be built as a support facility to SPSM-CC, is no longer a hospital and has no SPSM-CC to support.

14. C-unit, built outside of the RGC perimeter was never part of SPSM-CC, never dedicated as a nursing home level of care for SMSP-CC prisoners primarily and, as of November 2, 2007, cannot possibly receive on transfer a SMSP-CC prisoner because there are none.

15. Attached to RGC is DWH. DWH serves as placement for short or long-term health care prisoner patients and is also a step-down unit for prisoner patients returned from outside hospitals prior to those prisoner patients' transfer back to the sending facilities.

16. C-Unit is an extended care/nursing home type facility under the administrative control of RGC.

17. Even 3 block, which as not been part of SMSP-CC since it was "turned out" in the 1990s, ceased being a general population cell block in July 2001. After 7-blockclosed on July 12, 2007, there was no longer any SMSP-CC reception function. After November 2, 2007, there was no longer and SMSP-CC at all.

18. It is not just a literary construction to say that SMSP-CC no longer exists. It is a fact. Sine SMSP-CC no longer exists, the 1985 *Hadix* Consent Decree should be terminated in its entirety.

19. Since November 2, 2007 there have been no general population prison facilities subject to the *Hadix* Consent Decree. RGC is the location at which new commitment prisoners and parole violation prisoners are returned to the Michigan Department of Corrections (MDOC). There, the prisoners undergo intake processing and health care and security classification screening. On average, within 21 days, these reception prisoners are then transferred to general population prisons throughout the State.

**Specific Requirements of the 11/13/06 Order**

20. Defendants, having formerly used observation cells in their administrative segregation unit in JMF for placement of prisoners who were on a suicide watch, ended that practice in the summer of 2007. Defendants have established four suicide observation cells in DWH so that prisoners on suicide watch would not be moved to a segregation unit for observation. Defendants established a procedure requiring prompt mental health consultation and/or assessment of a prisoner on suicide watch to determine that prisoner's suicide risk and also to determine whether the prisoner needed to be transferred to a more formal mental health setting.

21. As required by the November 13, 2006 Order, the Defendants have ceased any form of mechanical in-cell restraints within the *Hadix* facilities. There was no dispute from the

parties on this point. Dr. Cohen agreed that no mechanical in-cell restraints were being used in a *Hadix* facility. (Cohen Tr. V, p. 786) For the purpose of this discussion, Defendants are using *Hadix* facility as shorthand for RGC, DWHC and C-Unit.

22. Defendants did develop and submit a staffing plan for adequate psychiatric and psychological staffing at *Hadix* facilities to ensure that routine and emergent psychiatric and psychological services are provided in a timely way. Defendants have added at least three psychologist positions at RGC. Defendants have also implemented an on-call psychiatrist process so that at least one psychiatrist will be available to RGC, DWH and C-Unit within an hour on an on-call basis after business hours, and on holidays, 24/7. Defendants maintain psychiatrist on-call logs to record the times in which the on-call psychiatrists are called to consult on or assess a patient. (Defendants' Exhibit F) There was no dispute that Defendants' on-call psychiatrist process has been implemented and is working. (Cohen Tr. V, p. 804).

23. Defendants had provided daily psychologist rounds in the "segregation" unit of the *Hadix* facilities until the only true segregation unit, the one in JMF, closed November 2, 2007. The only remaining unit that remotely qualifies or compares to a segregation unit are the 23 Special Management Housing Unit (SMHU) cells in cell block 1 of RGC. In addition to the case manager's office in the unit, which uses up one of those 23 cells, Defendants have established the psychologist's office, who makes the daily rounds in this unit, in another of the 23 cells. Daily, PSU rounds have been made in RGC's SMHU for the last 17 months. After the rounds are made, a daily report is prepared and distributed. A copy of those reports for the month of March 2008 have been filed as Defendants' Exhibit D. There is no dispute that Defendants have met this requirement of the November 13, 2006 order.

24. Prisoners newly placed in the SMHU are called out by the psychologist for an out of cell evaluation. Those out of cell evaluations are noted on the daily rounding reports.

(Defendants' Exhibit D) Prisoners are placed in SMHU cells for a variety of reasons (Defendants' Exhibits MM-PP) with mental status review or observation being a very infrequent reason. (Baker, Tr. III, pp. 465-472, 473; Metzner, Tr. I, pp. 44-50, 51-52; Rome, Tr. VI, pp. 968-972).

25. Defendants have worked to develop protocols for the coordination of mental health and medical staff and have required weekly conferences of the two disciplines which have included, but are not limited to, the treatment of prisoners in the "segregation unit" (SMHU). A sample of the case management meeting minutes from January 1, 2008 to April 15, 2008 have been submitted as Defendants' Exhibit E. During these case management meetings, staff from the different disciplines, including medical, custody, psychological services unit (PSU) and psychiatry Outpatient Mental Health Team (OPMHT) meet to discuss cases that are of interest to any of the individual disciplines represented. (Crawford, Tr. VI, p. 927; Cohen, Tr. V, p. 788).

26. Defendants have also undertaken and provided training to prevent staff and administrative indifference to the provision of care. This training was called "Offenders in our Care" (identifying prisoners in distress) training and was provided to all staff who would have contact with prisoners in the JMF administrative segregation unit and also to those staff in RGC who would have contact with the prisoners in the SMHU. (Metzner, Tr. I, pp. 30-31; Rome, Tr. VI, pp. 964-965).

27. RGC received 12,273 prisoners in 2005, RGC received 13,260 prisoners in 2006. RGC received 12,039 prisoners in 2007. For the three months including January through March 2008, RGC received 2,775 prisoners. While the total number of prisoners who will be sent to RGC in 2008 is unknowable until it has happened, the present trend makes it reasonable to believe that RGC will receive between 11,100 and 12,000 prisoners in 2008. If this projection holds, this represents an approximate 10% decline in prisoners arriving at RGC in 2008 than

arrived at RGC in 2006, while the PSU unit has three more psychologists than at the end of 2006. (Defendants Exhibit RR).

28. At present, the RGC intake process begins with the arriving prisoner's identification and the filling out of the initial health intake screen. The initial screen is done by a registered nurse in a face to face interview with the prisoner, with the information collected being entered into the Electronic Medical Record (EMR) known as SERAPIS. This initial intake health screen includes a screen that has been used at RGC for several years and is designed to determine present suicide risk, along with identifying current physical health status. As of June 30, 2008, a new intake screen was implemented by adding the last page of Defendants Exhibit K on to the existing screen. This adds a mental status assessment in that first contact with the new prisoner. This addition to the screen has been normed for jail inmates as a mental status screen. (Defendants Exhibit M).

29. Following the prisoner's initial health care screen, prisoners who are identified as having a suicide risk are referred to the OPMHT, and they move six feet from the nurse's office and along a narrow hallway, into a glass-fronted observation room.

30. Other RGC prisoners who have an acute/emergent health care need are referred to a medical practitioner (MP) right there in the "bubble" as it is known. The bubble is the term used to describe the whole intake area including the several holding rooms and the smaller rooms that branch out from those holding rooms where this initial screening process takes place.

31. Following the initial intake health screening, and assuming no acute problems are identified, the prisoner goes to dress-in and formal identification including issuance of the ID card. If a prisoner arrives at RGC with psychotropic medications that the prisoner brings with him from the jail, or reports that he has a current prescription for psychotropic medication, and these medication orders can be confirmed, the prisoner is referred to an MP so that those

medications may be immediately continued. This continuation of medication process had not been consistent in 2006 or 2007 because the practice had been to refer such a prisoner to an OPMHT psychiatrist who would then make a decision whether a medication should be issued, discontinued or changed based on an initial face to face interview. (Calley, Tr. I, pp. 128-129).

32. During the second half of 2007 and the first two months of 2008, this practice had been under review by Defendants. As a result, the Defendants made a determination that a reasonable risk management practice should include the automatic continuation of any confirmed psychotropic medication orders for prisoners, for at least ten days after the prisoner arrived at RGC. This process of automatic continuing of psychotropic medication(s) is known as a "bridge" medication order. The most recent iteration of the memorandum mandating automatic bridge orders is found at Defendants' Exhibit A.

33. Plaintiffs' lay witness, Mrs. Childress, has acknowledged in her *de bene esse* deposition testimony, that if the bridge order process as set forth in Defendants' Exhibit A, had been in place when her son Chad Childress arrived at RGC in late March 2007, his experience of being taken off certain of his psychotropic medications, subsequently decompensating and then proceeding through a long period of recovery would not have occurred. (Childers deposition, pp. 64-65).

34. Prisoners arriving at RGC who have a confirmed psychotropic medication prescription or who have a history of being prescribed psychotropic medications are automatically put on the OPMHT case load. March 2008 is the first full month in which the mandatory bridge order was in effect. In that month the admissions to the OPMHT case load in RGC went from 141 in February to 163 in March. (Defendants' Exhibit SS; Calley Tr. I, pp. 155-175, 188-194).

35. For the most recent three-month period for which data was available (January-March 2008) there were 515 referrals to the OPMHT representing 18.7% of the reception population. Of those 515 referrals, 428 were admitted to the OPMHT case load. That admission rate equals 83% of the referrals and 15.5% of all of the reception prisoners arriving in RGC in that three-month period. (Defendants' Exhibit SS).

36. During that same period there were 442 prisoners who arrived at RGC with combined psychotropic medications. The average response time for individuals coming into RGC with medications to be seen by a psychiatrist to have their medications renewed was less than one day. Also, it took less than an average of one day for prisoners coming into RGC with psychotropic medication prescriptions to receive those medications. (Defendants' Exhibit SS).

37. In the January-March 2008 period there were 81 prisoners who arrived with psychotropic prescriptions who have had those medications since discontinued after review by a psychiatrist. (Defendants' Exhibit RR and SS) These medication discontinuations are expected to happen by a) titrating the dosage; and b) by at least one follow-up assessment with the psychiatrist.

38. Defendants use a quality assurance technique for determining that they are adequately identifying those prisoners with a major mental disorder. This quality assurance technique is called a Treatment Not Required (TNR) study. The most recent complete study (data and analysis) covered the time period March 31-July 31, 2007. Since then, other TNR data has been collected but has not been reported in analyzed form. (Defendants' Exhibit QQ).

39. From the data for the first quarter of this current year, there were 416 TNRs. That means that 416 prisoners were determined by either the PSU staff or the Corrections Mental Health Program staff (CMHP) to not require further treatment. Review of the TNR decisions out of RGC and DWH for that same quarter showed that a very low percentage of prisoners referred

to the OPMHT for evaluation and then determined to not need further treatment, were found within the next 60 days to have a major mental disorder. This low rate could, at most, be called the "omission rate" representing those prisoners who got through the screening process with a major mental disorder without detection. However, that would be an excessive characterization since not all major mental disorders have constant symptoms that manifest themselves. Therefore, these examples of subsequent admissions of prisoners who were found at one point to be TNR may actually merely be an example of those prisoners' mental disorder subsequently manifesting itself and then being discovered or recognized rather than "missed" or disregarded earlier. (Metzner, Tr. I, pp. 33-39; Calley, Tr. I, pp. 138-142 and 156-159).

40. The low post-TNR admission rate when compared to the entire TNR population represents a small proportion of those prisoners screened. The prisoners who receive a TNR evaluation compared to all prisoners referred to the OPMHT case load was itself a small number. Currently, approximately 18% of the RGC intake population is referred to the OPMHT. Therefore, the number of prisoners who after being referred to the OPMHT and evaluated and determined to be TNR and then subsequently to be found to be expressing a major mental disorder is substantially less than 0.1% of the entire intake population at RGC. (Defendants' Exhibit QQ; Calley , Tr. I, p. 135-136).

41. While not directly relating to the identification of a major mental disorder or the treatment of that disorder on its own, Defendants have removed the prohibition against placing a prisoner on the OPMHT case load in C-Unit, MDOC's long-term or nursing home care facility. This will have the effect of allowing prisoners on the OPMHT case load who were housed in DWH but who would have been, based on their physical ailments, able to be placed in C-Unit, but who had been excluded from C-Unit based on their OPMHT case load, to move to C-Unit. A primary benefit of a move from DWH to C-Unit is that the prisoner moves from a Level V level

of custody in DWH to a Level II level of custody in C-Unit. Defendants have officially recognized and given notice of the removal of the bar to placing prisoners on the OPMHT case load by noting that prisoners on the OPMHT case load may be placed in C-Unit in the MDOC's transfer grid. (Defendants' Exhibit AA).

41. Defendants have decided to implant an additional mental health screening appraisal screen. (Defendants' Exhibit L). This screen is being used some time between day 2 and 4 of a prisoner's arrival in RGC. This mental health/functionality appraisal is being used to identify those prisoners who require further follow-up through either psychological, personality or some other psychometric testing, and/or could benefit from referral to a medical specialist or to a psychiatrist or psychologist for a full mental status and functionality assessment. Another benefit of this mental health appraisal allows Defendants to identify those prisoners who do not need further intensive psychological or psychiatric or other mental function-related medical testing, so that the resources Defendants have available for such things are focused on those prisoners who may actually benefit from them and not spent on prisoners who do not have any particular need for such detailed or specific testing, only to confirm again that they are of "normal" mental status and functionality.

42. Defendants have added these screens to the existing EMR and will add them to the new EMR that they will use to replace the current SERAPIS EMR. Defendants have also created document templates that are now being filled out and then copied directly into the SERAPIS EMR.

**Conclusions of Law**

1. The Court's November 13, 2006 order specifically limited the reopening of the *Hadix* Consent Decree section II.B. to the provisions of the [November 13, 2006] Order and Preliminary Injunction. (Dkt #2187) There is nothing in the November 13, 2006 order that allows Plaintiffs to ask for further relief beyond the five issues "reopened" by the November 13, 2006 order that reopens any other provision or issue related to mental health in section II.B. of the *Hadix* Consent Decree, all such provisions and issues having been terminated in January 2001.

2. Since November 13, 2006, Defendants have been operating under preliminary injunctive relief ordered by this Court on that date. The applicable provision of the Prison Litigation Reform Act, 18 USC § 3626(a)(2), deals with preliminary injunctive relief. That section states: "In any civil action with respect to prison conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief. Preliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires the preliminary relief, and be the least intrusive means necessary to correct that harm…."

3. Defendants have argued that the mental health portion of the Consent Decree should never have been reopened and that Plaintiffs' claim should have been required to be filed as new litigation since they were not based on either the terms of the Consent Decree, or the original allegations in Plaintiffs' complaint but were brand new allegations based on facts and circumstances that did not exist at the time of the filing of the complaint or at the time of the entry into the Consent Decree. For that argument, Defendants rely on their motion to dismiss mental health issues from this litigation, filed on November 20, 2007. (dkt #2684)

4. To the extent that it was allowable for the district court to have entered its November 13, 2006 Order and "reopen" portions of section II.B. of the Consent Decree, 18 USC § 3626(a)(2) required that the preliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court found, requires preliminary relief and be the least intrusive means necessary to correct that harm. In light of the requirements of this section, the Court's opening paragraph in its November 13, 2006 Order and Preliminary Injunction recognizes that it is operating within the limited scope of preliminary injunctive relief allowable. The Court's statement that: "IT IS HEREBY ORDERED that Plaintiff's Motion to Reopen Judgment Regarding Mental Health Care and Issue a Preliminary Injunction (dkt #2102) is granted and section II.B. of the Consent Decree is reopened limited to the provisions of this order and preliminary injunction." Therefore, to the extent that any issues could be reopened at all in this litigation, as opposed to being required to be brought in a new lawsuit filed in the proper venue, the scope of the issues that were reopened are limited to the remedies mandated in the November 13, 2006 order.

5. PLRA, 18 USC § 3626(b)(3) states: "Prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the federal right, extends no further than necessary to correct the violation of the federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation."

6. This Court should now find as a fact that:

a) Defendants' experts Dr. Jeffrey Metzner's and Dr. Tony Rome's testimony and their expert reports submitted as Defendants' Exhibits C and J have demonstrated that Defendants have in fact complied with the mandates of the November 13, 2006 order ; and

b) That the testimony of psychologist Baker, CMHP Director Calley, psychologists Crawford and Rushbrook and Associate Monitor Cohen demonstrates, consistent with expert opinion of Drs. Metzner and Rome, that Defendants have met all mandatory requirements of the November 13, 2006 order; and that

c) There is no current or on going constitutional violation concerning these issues. Therefore, the prospective relief required by the November 13,2006 order should be terminated.

7. In the Court's November 13, 2006 decision, the Court, on several occasions, cited to 18 USC § 3626(a)(2), the section requiring that preliminary injunctive relief be narrowly drawn and that it extend no further than necessary to correct the harm and that it be the least intrusive means necessary to correct that harm. (Dkt #2186, p 20) The November 13, 2006 decision refers to the PLRA's provision for limited injunctive relief even when it banned use of "punitive in cell restraints" (Dkt #2186, p 34) in the *Hadix* facilities, described the requirement that a plan for necessary psychological and psychiatric staffing be provided, (Dkt #2186, p 36) with regard to the psychological/psychiatric segregation rounds (Dkt #2186, p 37) and when describing the requirement of the mental/medical interdisciplinary weekly meetings (what the parties call "case management meetings"). (Dkt #2186, p 38).

8. The Court's remedies were designed to alleviate what the Court had found were constitutional violations at JMF and, arguably with regard to a single prisoner's resistance to being forced to accept invasive medical care and subsequent return to an upper peninsula prison, to DWH. Therefore, if the Court's required remedies under the Preliminary Injunction have been accomplished and are in place then the constitutional violations that gave rise to the Preliminary Injunction have been remedied. That fact alone requires termination of the preliminary

injunctive relief and recognition that the mental health provisions of the *Hadix* Consent Decree should be declared closed and all prospective relief terminated.

9. To the extent Plaintiffs have asked to explore other issues that were not subject to the Court's November 13, 2006 order, Plaintiffs should have to file the appropriate new case. With JMF closed on November 2, 2007 and 7- and 8-blocks having also been closed (since last July and April 2007 respectively), the class of *Hadix* facility prisoners (at RGC, DWHC and C-Unit) consists of less than 1,300 at any given time, compared to the November 2006 population in 4, 5, 6, 7 and 8-blocks plus those in RGC, DWHC and C-Unit of more than 3,200. The Plaintiffs are required to show that there is a class-wide injury before they can seek a class-wide remedy.[2]

10. Plaintiffs tried to show this class wide injury as a risk of being denied adequate mental health services. Plaintiffs offered the testimony of Dr. Kupers but he admitted he could not put any number on the risk of harm to the current population. (Kuper Tr. II, pp. 409-424). Plaintiffs then relied on Dr. Walsh for an assertion that there will be harm in the present system because Defendants do not routinely request and receive mental health treatment records for the RGC prisoners. However, Dr. Walsh admitted during his 20 plus years as Director of Psychological Services at the former SPSM-CC he requested and asked that they be requested these same records but rarely got them. (Walsh, Tr. V, p. 730).

11. Dr. Walsh then testified that even as a highly skilled clinical diagnostician with more than 30 years of clinical experience, he could do no better than a provisional diagnosis of a person when he was evaluating face to face, without that person's pre-incarceration mental health records. Dr. Kupers said he could reach a diagnosis of a person during a personal evaluation without their pre-incarceration mental health record. (Kuper Tr. II, pp. 374-376). So did

[2] *Lewis v Casey*, 518 US 343; 116 S Ct 2174; 135 L Ed 2d 604 (1996).

Metzner, Dr. Rome and psychologist Crawford. (Metzner Tr. I, pp. 96-97; Rome Tr. VI, pp. 956-957; Crawford Tr. VI, pp. 904-905).

12. Plaintiffs then tried to distinguish between the different clinical judgments of Defendants' Dr. Thai (the hesitant clinician) and other psychiatrists (the bold clinicians), but by presenting Dr. Walsh (the hesitant clinician) and Dr. Kuper (the bold clinician) they demonstrated their own acceptance of differences in professional judgment. These differences in professional judgment are obviously a far cry from the "deliberate indifference" necessary to show a current and on-going violation.

13. In regard to individual prisoners being able to refuse medical care that Plaintiffs, Plaintiffs' experts or any person other than the prisoner patients themselves determines would be in that prisoner's best interest, this Court should look to Michigan's law covering the right of a prisoner to refuse medical care. MCL 700.1105(a) defines an incapacitated individual as an individual who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication or other cause, not including minority, to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions. Michigan has long held to the principle that a competent adult patient has the right to decline any and all forms of medical intervention, including life-saving or life-prolonging treatment.[3] Also, in Michigan, if a physician treats or operates on a patient without consent, he has committed an assault and battery and may be required to respond in damages.[4] If there is a question about whether or not the person is incapacitated to the extent that they lack sufficient understanding or capacity to make or communicate informed decisions, Michigan law has

[3] *Worth, et al v Taylor, et al,* 190 Mich App 141 (1991) citing *Cruzan v Director, Missouri Department of Health*, 497 US 261; 110 S Ct 2841; 111 L Ed 2d 224 (1990).
[4] *Banks v Wittenberg*, 82 Mich App 274, 279 (1978).

provided a means to seek a determination through the filing of a petition for the appointment of guardian for incapacitated individual under MCL 700.5303.

14. This is important to recognize because many of Plaintiffs' allegations of mental health shortcomings are in reality allegations that Defendants' staff either did not or could not overcome a patient's resistance or refusal of medical care and that the Defendants' staff did not act sufficiently vigorously to persuade the prisoner patient to grant that consent or did not act sufficiently vigorously to take the necessary steps to file a petition in a Michigan probate court seeking to have a judge determine that the person was incapacitated. Plaintiffs preface this argument upon what appears to be the assumption that if the patient does not agree with the physician's recommendation for their treatment and there is any limitation in that prisoner's mental or emotional or cognitive capacity, that it is Defendants' staffs' constitutional obligation to overcome that resistance in order to accomplish the care Plaintiffs or Plaintiffs' experts or the Associate Monitor believe was appropriate. Defendants do not agree that this is their constitutional obligation or even the proper course of action under Michigan law.

15. Much of Plaintiffs' medical expert Dr. Walden's testimony was directed at the point. He said he reviewed all of the death cases he cited in his 2006 report. (Walden Tr. VI, p. 1015) from 2005 and part of his 2006 medical care report. Most prisoner deaths in the Michigan prison system occur at DWHC or at area hospitals because DWHC serves as the location where prisoners with severe or near-death health conditions are sent. All death case files occurring at these *Hadix* facilities are provided to Plaintiffs.

16. Dr. Walden's review of these case led him to conclude that he, as a family practice physician, would have preferred more palliative and counseling type social worker or psychologist care in about one half of those cases. (Dr. Pandya and psychologist Crawford

disagreed with Dr. Walden's assertion of the need for more intervention by psychologists in these cases or that it would have made a difference in the medical outcome of the cases).

17. The avoidance of deliberate indifference, which is the acknowledged obligation of the Defendants when considering providing medical care to prisoners who have been remanded to MDOC custody, requires that they not be deliberately indifferent to a prisoner's medical need.[5] If a serious medical need exists and the Defendants identify that serious medical need and offer the treatment and the prisoner rejects the treatment or does not give his consent, that is the end of it. It is not a constitutional obligation for Defendants' staff to browbeat the prisoner into submission in order to obtain their consent in order to provide treatment that the prisoner has indicated they did not want. This conclusion of course presumes that the prisoner is not incapacitated. However, it is not even essential for the physician offering care to the patient to inquire into their particular rationale for rejecting the care. However, if the physician believes that the prisoner is incapacitated, Defendants admit that steps could and should be taken in accord with Michigan's guardianship status to secure a determination of that incapacity. However, Defendants contend that the failure to accomplish an intervention guardianship in sufficient time to overcome a prisoner's refusal for medical care, that can legitimately only be begun once the physician concludes that the prisoner really is incapacitated, is hardly the infliction of cruel and unusual punishment in violation of the Eighth Amendment on that prisoner.

18. Absent the requirement that the physicians, psychologists and psychiatrists always have a constitutional obligation to secure their version of appropriate treatment towards a prisoner patient, the issue of whether there is a current and ongoing constitutional violation in the

[5] *Estelle v Gamble*, 429 US 97 (1976).

form of a deliberate indifference to the class of *Hadix* prisoners' serious medical need as represented by the mental health needs of that class, must surely be concluded in the negative.

**Relief**

Wherefore, for the above stated reasons, Defendants respectfully request that this Court find first that the reopening of mental health, even as limited by the November 13, 2006 order, was inappropriate and order that the dismissal/termination of the Consent Decree provisions regarding mental health entered by this Court in January 2001 be again the status quo.

In the alternative, the Court should find that the Defendants have fully complied with the requirements of the November 13, 2006 order and that said compliance has remedied and eliminated any current and ongoing class-wide constitutional violation that those injunctive remedies were designed to remedy. Therefore, the preliminary injunctive relief of November 13, 2006 is hereby terminated and mental health issues in the *Hadix* litigation are closed.

This Court should deny Plaintiffs any further relief regarding a mental health remedy or mental health issues, as such a class-wide current and on-going constitutional violation does not exist. Plaintiffs should be required to institute litigation regarding mental health issues that they believe are sufficient to warrant relief.

Finally, Defendants request that this Court take note of the reality that SPSM-CC does not exist anymore. No portion of SPSM-CC still exists. Any application of the *Hadix* consent decree to any current facility or activity is to a new entity not contemplated by the parties in the 1985 Consent Decree. Therefore, in addition to the above requests, Defendants request that the *Hadix* Consent Decree be terminated in it entirety as neither the prisoner class nor the Defendants' enterprise any longer exist.

Respectfully submitted,

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**PROOF OF SERVICE**

I hereby certify that on July 25, 2008, the foregoing paper was presented and uploaded to the United States District Court ECF System which will send notification of such filing to the attorneys of record listed herein and I hereby certify that a copy of this same document(s) was mailed by US Postal Service to any involved non-ECF participant.

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