UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

EVERETT HADIX, et al.,	)	
	)	
Plaintiffs,	)	
	)	**Case No. 4:92-CV-110**
v.	)	
	)	**HONORABLE ROBERT J. JONKER**
PATRICIA CARUSO, et al.,	)	
	)	
Defendants.	)	
	)	

PLAINTIFFS' TRIAL BRIEF REPLY

I. THE SCOPE OF THE FACILITIES COVERED BY THE CONSENT DECREE

Defendants argue that no facilities covered by the Consent Decree are still in existence. *See* Defs' Proposed Findings of Fact & Conclusions of Law, July 18, 2008 (Dkt. No. 2824) ("Defs.' Br.") at 5. This argument cannot be sustained based on the Consent Decree provisions and Orders of the Eastern District Court that are now binding law of the case. The Consent Decree itself indicates that the Reception and Guidance Center ("RGC") and the Central Complex of the State Prison of Southern Michigan will be referred to as the SPSM-CC. The Plaintiffs are then defined as the class of all prisoners who are now or will be confined within the SPSM-CC. Consent Decree, Feb. 13, 1985 (E.D. Dkt. No. 199) at 1; *see also id.* at 8 (setting forth requirements for health screening upon entry into the Department of Corrections).

As the wording of the Consent Decree suggests, at the time RGC was a separate facility consisting of Cellblock 7 operating within the Jackson Complex. *See* Defs.' Br. at 5. If the parties had intended to limit membership in the *Hadix* class to Central Complex and Cellblock 7,

they could have easily done so. Instead, and significantly, the parties defined the class by physical location in Central Complex or by RGC function.

Given this definition, settled law in the Sixth Circuit requires that the class be defined to include all prisoners in the Jackson complex devoted to an RGC function. In *Glover v. Johnson,* 855 F.2d 277 (6th Cir. 1988),[1] the court of appeals characterized a challenge by defendant prison officials to a similar definition of the class as "without merit". *Id.* at 281. In that case, the judgment referred only to female prisoners incarcerated in one Michigan prison. The district court, however, had earlier certified a class on behalf of all women prisoners in Michigan. The court of appeals therefore determined that the judgment covered women prisoners in a facility that did not exist until after the judgment. *A fortiori,* prisoners in Cellblocks 1 and 2, as well as Cellblock 3,[2] are part of the class here under the Consent Decree definition of SPSM-CC, since the Consent Decree defines RGC prisoners as part of the class.

Further, these cellblocks also qualify as "support facilities" under the Order Accepting Consent Judgment because they support the RGC function. That Order provides in relevant part as follows:

> Due to anticipated structural changes which may result in renaming of certain portions of the facility at issue in this lawsuit, State Prison of Southern Michigan Central Complex, shall be defined as "all areas within the walls of the State Prison of Southern Michigan at the time this cause commenced and all areas which will supply support services under the provisions of this Consent Judgment, e.g., food service and Boiler Plant Operations[.]"

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[1] *See also Glover v. Johnson*, 934 F.2d 703, 709 (6th Cir. 1991) (again rejecting argument that new facility for women was not covered by judgment).

[2] Cellblock 3 was an original part of the Central Complex itself. *Hadix v. Johnson,* 367 F.3d 513, 518 (6th Cir. 2004). Thus, Cellblock 3 is also a *Hadix* facility by virtue of its location.

Order Accepting Consent Judgment, May 13, 1985 (E.D. Dkt. No. 213) at 2. The court of appeals upheld the district court's decision that these cellblocks were covered by the Consent Decree and further orders of the district court. *Hadix,* 367 F.3d at 518.[3]

Duane Waters Health Care ("DWH") and C Unit are also "support facilities" under the May 1985 Order, since these facilities similarly provide medical services to prisoners in the RGC process. *See* Order Regarding Jurisdiction over the Egeler Facility, Oct. 5, 1989 (E.D. Dkt. No. 656) (noting May 1985 Order regarding definition of "support services" and finding that DWH, as well as Cellblock 3 and other facilities specifically listed, were *Hadix* facilities). For the same reasons that DWH is a *Hadix* facility because it supplies support services, C Unit, which is a step-down medical unit, is also a *Hadix* facility.[4]

II. THIS COURT'S ABILITY TO GRANT INJUNCTIVE RELIEF REGARDING MENTAL HEALTH IS NOT LIMITED TO THE SPECIFIC ITEMS OF RELIEF GRANTED IN THE NOVEMBER 2006 ORDER.

Defendants argue that Plaintiffs are precluded from requesting any mental health relief that goes beyond the requirements of the Order of November 13, 2006. Defs.' Br. at 13-14. This claim is incorrect. To understand the Court's Order, it is important to consider exactly what Plaintiffs requested in their motion. Plaintiffs' motion requested, among other relief, that the "Court set a separate discovery and hearing schedule for Plaintiffs' remaining mental health claims." Pls.' Mot. to Reopen Judgment, Sept. 8, 2006 (Dkt. No. 2102) at 2. The accompanying

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[3] The court noted that the functions of these cellblocks might change in the future. *Id.* This notation is consistent with both of Plaintiffs' arguments. If these two cellblocks were to no longer house an RGC function, the cellblocks' membership in the *Hadix* class would have to be reconsidered.

[4] C Unit, like DWH and all three *Hadix* cellblocks, is located in the Egeler Correctional Facility. Defendants note that C Unit is administratively part of RGC. Defs.' Br. at 5.

brief explained this request more fully:

> Plaintiffs also request that this motion be considered at the forthcoming October 11 hearing, and that the Court further issue a discovery and hearing schedule, with the goal of determining whether additional or different relief is appropriate with regard to the remaining mental health problems.

Pls.' Br. in Support of Mot. to Reopen, Sept. 8, 2006 (Dkt. No. 2103) at 2.

The Court recites in the Order that it is granting Plaintiffs' motion to reopen, not some part of Plaintiffs' motion. Order & Prelim. Inj., Nov. 13, 2006 (Dkt. No. 2187) at 1. Aside from specifically stating that the Court was granting Plaintiffs' motion, the Court said the following:

> Plaintiffs shall be permitted discovery as to mental health care in advance of a final injunctive hearing. The parties shall contact Magistrate Judge Ellen S. Carmody . . . . The final injunctive hearing will be later scheduled for a three-day evidentiary hearing at an appropriate interval after the motion filing deadline is established.

Id. at 2-3.

In short, the scope of the discovery permitted Plaintiffs was not limited to whether Defendants had addressed the four items of relief in the November 2006 Order; Plaintiffs were permitted open-ended discovery on the subject of mental health care, consistent with the request in their motion. While the Court's goal was to reopen the mental health issue only to the extent necessary to cure the constitutional violation, the evidentiary hearing was necessary to determine the scope of that violation. Further, Defendants apparently understood the Order in the same way. Although Plaintiffs' first discovery regarding mental health care was filed more than a year ago, Defendants did not object to any of that discovery on the ground that it exceeded the scope of the Order until they raised this issue in opposition to Plaintiffs' motion to compel, filed after

Defendants' unilaterally canceled scheduled depositions without cause. *See* Defs.' Mem. in Opp'n, March 14, 2008 (Dkt. No. 2746) at 2.[5]

Thus, the Court contemplated in the November 2006 Order that, if Plaintiffs proved at the evidentiary hearing that Defendants' plan was insufficient to address the failures of constitutional dimension in the provision of mental health care, further relief would be forthcoming. This further relief to eliminate the constitutional violation is appropriate under Fed. R. Civ. P. 60(b)(6) for the same reasons that the original reopening of the mental health issues was warranted.

Indeed, the law has become much clearer than it was at the time that the Sixth Circuit remanded but did not vacate the November 2006 Order. In *Jenkins v. Kansas City Mo. Sch. Dist.*, 516 F.3d 1074 (8th Cir. 2008), a unanimous panel of the Eighth Circuit decided that the

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[5] All the relief sought in Plaintiffs' motion for further relief is within the scope of the Consent Decree. The mental health provisions of the Consent Decree include the following: "Professional staff are responsible for provision of adequate mental health care to meet each inmate's serious mental health needs." Consent Decree, Feb. 13, 1985 (E.D. Dkt. No. 199) at 15 (§ II.B.3.a); *see also id.* at 14 (§II.B.1.a.) (requiring mental health care for serious mental illness or injury if the illness is treatable and there is substantial potential for harm if treatment is delayed or denied). All of the relief afforded by the preliminary injunction meets this standard, as does the relief sought by Plaintiffs' motion for further relief. Similarly, it is clear as a matter of general law that, if a consent decree provision proves insufficient to remove the violation of law that it was intended to address, a federal court has the power and indeed the duty to issue further relief to achieve the object of the Consent Decree provision. *See, e.g., United States v. United Shoe Machinery Corp.,* 391 U.S. 244, 248, 250-52 (1968) (reversing district court and holding that if consent decree provisions had not eliminated violations of anti-trust laws that the consent decree was intended to address, district court had duty to issue further relief); *see also Rufo v. Inmates of Suffolk Co. Jail,* 502 U.S. 367, 378, 383-84 (1992) (holding that consent decrees may be modified pursuant to Rule 60(b) when a party shows that a change in the injunction is warranted by changes in the law or facts, as long as the modification is suitably tailored); *United States v. Michigan,* 940 F.2d 143, 155 (6th Cir. 1991) (noting that any modification of consent decree in favor of plaintiff had to be tailored to address conditions giving rise to a constitutional violation).

district court correctly reopened an injunctive case regarding racial segregation following termination of relief, and issued a new injunctive order, when the state defendants took actions inconsistent with previous orders and a settlement incorporated into the district court's orders. *Id.* at 1076. Of note, *Jenkins* is a much weaker case for exercise of the power to reopen injunctive relief because, unlike the instant case, *Jenkins* had been entirely closed. Thus in *Jenkins* there could be no argument, as there is in this case, that reopening was necessary to produce compliance with current injunctive orders. Nonetheless, the court of appeals determined that, in light of *Kokkonen v. Guardian Life Insurance Co.*, 511 U.S. 375 (1994), the district court had ancillary jurisdiction to reopen the dismissal and issue new relief, based on the inherent power of a court to enforce its previous judgment. *Jenkins,* 516 F.3d at 1080-81.[6]

Indeed, both prongs of the Court's ancillary jurisdiction support reopening as necessary to cure the constitutional violation regarding mental health. *See Kokkonen*, 511 U.S. at 379-80 (ancillary jurisdiction permits a court to adjudicate related claims that are factually interdependent and also permits a court to manage its proceedings, vindicate its authority, and effectuate its decrees); *see also id.* at 380-81 (stating that if there had been had been an order incorporating the settlement of the diversity case into a court order, ancillary jurisdiction to enforce the settlement would have existed). Here, the party's settlement had been incorporated into a Consent Decree, and the termination of the injunction did not vacate that Consent Decree.

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[6] There is nothing in the Prison Litigation Reform Act ("PLRA") that serves to distinguish this Court's relevant powers from those of the district court in *Jenkins*. *See* 18 U.S.C. § 3626(b)(4) (expressly reserving parties' existing abilities to seek modifications of injunctions under circumstances not covered by PLRA); *see also HUD v. Rucker,* 535 U.S. 125, 133 n.4 (2002) (Congress is presumed to legislate against the backdrop of existing law, and when it legislates in an area but does not change a particular subject, it indicates its intention to leave the law on that subject undisturbed).

See Benjamin v. Jacobson, 172 F.3d 144, 159 (2d Cir. 1999) (*en banc*) (holding that injunctions are terminated, not vacated, when ended pursuant to a PLRA motion); *Inmates of Suffolk Co. Jail v. Rouse,* 129 F.3d 649, 662 (1st Cir. 1997) (same). Further, since a court always has jurisdiction to amend its orders prior to final dismissal, *see Jaynes v. Austin,* 20 Fed. Appx. 421, 2001 WL 1176424 at *2 (6th Cir. Sept. 25, 2001), this Court necessarily had the power to revisit the termination of injunctive relief regarding mental health.[7]

Aside from the arguments above, reopening the mental health issues is necessary because, absent such reopening, the Court cannot fully eliminate the current constitutional violation regarding medical care. The evidence is overwhelming that prisoners who have serious mental health needs routinely have those needs unmet, with the result that any serious medical needs they have cannot be addressed. *See* Pls.' Trial Br., July 14, 2008 (Dkt. No. 2819) ("Pls.' Br.") at 33-44 (numerous examples of prisoners whose medical care was adversely affected by failure to provide necessary mental health care). Because, as discussed above in note 5, a federal court has unquestioned power to issue enforcement orders as necessary to produce compliance with its previous orders, the Court's inability to cure the unchallenged constitutional violations without addressing the constitutional violations in mental health independently supports the Court's authority to address the mental health issues.

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[7] Defendants' argument is primarily that the relief Plaintiffs seek goes beyond the scope of the reopening of the mental health issues accomplished by the November 2006 Order. The very same arguments that demonstrate the correctness of the original reopening of the mental health issues necessarily support the further reopening required to cure the constitutional violations.

III. DEFENDANTS HAVE FAILED TO COMPLY WITH THE COURT'S PREVIOUS MENTAL HEALTH ORDERS.

Defendants' Brief covers mainly the November 2006 Order; it discuss the Court's Order of May 4, 2007 only in passing. *See* Order, May 4, 2007 (Dkt. No. 2408) ("May 2007 Order"). Defendants' brief also fails to argue that Defendants' August 2007 plan to comply with the previous orders should be approved; Defendants have apparently abandoned any attempt to have this plan approved. *See* Defs.' Revised Mental Health Care Plan, Aug. 20, 2007 (Dkt. No. 2601) ("Defs.' 2nd Revised Plan"). As set forth below, Defendants have failed to comply with the November 2006 Order, as explicated in the subsequent May 2007 Order, and Defendants have also failed to implement key portions of their own Second Revised Plan.

A. Mechanical Restraints

The first substantive provision of the November 2006 Order requires Defendants to "immediately **cease and desist** from the practice of using any form of punitive mechanical restraints within *Hadix* facilities[.]" Nov. 2006 Order at 1 (bolding in original). It further requires the development of appropriate practices, protocols and policies to enforce this limitation. *Id.* The evidence at the recent hearing demonstrated a continuing problem with the inappropriate use of mechanical restraints that should be addressed by policy. *See* Fourth Report of the Office of the Independent Medical Monitor ("OIMM"), Apr. 24, 2008 (Dkt. No. 2773) ("4th Rpt.") at 3. The OIMM found that deficiencies in the restraint policies led to serious harm, and could easily have led to the death of a prisoner. *Id.* at 8, 14-17 (prisoner was repeatedly placed and continued in four-point restraints for a prolonged period at DWH; medical staff did not examine the patient or determine whether there was a continued need for restraints, but

simply ordered the restraints continued; like TS, the prisoner was restrained to his bed naked, and defecated and urinated on the floor; he was kept in restraints at DWH although there is no indication that he threatened staff there; he was allowed to become extremely dehydrated (also like TS) and hyperatremic (suffering from an excessive concentration of salt, a state associated with his dehydration); he developed sepsis and extensive pneumonia; there was no consideration of the major health risks of the use of restraints in the medical record; the patient almost died). Given Defendants' repeated insistence that the mental health reopening order was entirely based on the suffering and death of TS, it is telling that another patient came close to dying related to the improper use of restraints. Defendants made no challenge to the facts of this case, or to the OIMM's conclusions. Accordingly, it is critical to revise the restraints policies to include these issues before the next death, or near-death, occurs.

In addition, the Court's May 2007 Order identified as one of the deficiencies in Defendants' initial mental health plan that the plan failed to provide sufficient safe restraint facilities and services to prevent violations of the Eighth Amendment. Defendants were ordered to submit a further plan. May 2007 Order at 1-3. Neither of Defendants' subsequent amended plans addresses this issue. *See* Defs.' Revised Mental Heath Care Plan, June 7, 2007 (Dkt. No. 2474) ("Defs.' Revised Plan"); Defs.' 2nd Revised Plan.

Defendants' brief claims that "Dr. Cohen agreed that no mechanical in-cell restraints were being used in a *Hadix* facility", citing the testimony of Robert Cohen, M.D. Defs.' Br. at 6-7. In the cited testimony, Dr. Cohen said that he had not seen any use of mechanical in-cell restraints *in the housing units.* T., June 11, 2008 (Cohen) at 786. On the previous page, Dr. Cohen specifically disagreed with Defendants' claim:

Q. – have you found that the defendants have ceased using mechanical restraints in the Hadix facilities?
A. No.

Id. at 785. Defendants offered absolutely no testimony contradicting the findings of the Fourth Report, or the testimony of Dr. Cohen. Based on the OIMM's findings, Defendants have not satisfied the requirements of November 2006 Order regarding the use of mechanical restraints.

B. Staffing Plan

The second substantive provision of the November 2006 Order requires Defendants to develop a plan for providing psychiatric and psychological staff to ensure that routine and emergent psychiatric and psychological services are provided in a timely way. Based on the evidence summarized in Plaintiffs' trial brief, current staffing is not sufficient to meet the requirements of the November 2006 Order. *See* Pls.' Br. at 32-33. Of note, these staffing calculations are based on the most current data at the time of trial, so there is an urgent need right now for more staff.[8]

C. Daily Rounds in the Special Management Housing Unit

The third substantive requirement of the November 2006 Order is the requirement that

[8] Defendants' brief asserts that they have added "at least three psychologist positions to RGC", Defs.' Br. at 7, but they provide no citation to the record to support that statement, and Plaintiffs know of no evidence in the record supporting that claim as of the time of trial. (Plaintiffs do not claim to have reviewed the entire record searching for support for this claim). Defendants further claim to have implemented an on-call psychiatrist system for evening, weekend, and holiday services for RGC, DWH, and C Unit. *Id*. This claim is disingenuous. In fact, DWH and C Unit never have anything but on-call coverage. *See* Pls.' Br. at 33. Further, Defendants cite the testimony of Dr. Cohen in support of a claim that there is "no dispute" that the on-call psychiatrist system is working. In fact, at the point cited, Dr. Cohen starts to agree, but then makes two points: for an approximately eight-day period in December 2007 RGC had no psychiatrist on-site at all, which was a "management failure of the most extreme magnitude" and some psychiatrists come in more than others, so that a review of cases to see if psychiatrists are coming in on-call at DWH as needed should be undertaken. T., 6/11/08 (Cohen) at 804.

Defendants provide daily psychologist or psychiatrist rounds in segregation. Defendants have partially complied with this requirement by establishing appropriate weekday rounds. In contrast, however, the weekend rounds are not meaningful. Jared Baker performed the regular weekday rounds in the Special Management Housing Unit ("SMHU") during the months just before trial; he testified that, at a minimum, these rounds took him 35 minutes. T., 4/30/08 (Baker) at 492. Given Mr. Baker's experience, it is hard to argue that other limited-license psychologist would be able to perform the rounds appropriately in a shorter time period. The only evidence about these rounds indicated that, on nine out of ten days when someone other than Mr. Baker rounded, the rounds took less than the 35 minutes that Mr. Baker testified was the minimum necessary time. *See* Defs.' Exh. D, rounds for 3/1; 3/2, 3/8, 3/9, 3/15, 3/16, 3/22, 3/23, 3/30; *compare to* rounds for 3/29 (Baker rounds taking 44 minutes). In fact, as noted in the trial brief, rounds by persons other than Mr. Baker were as brief as five minutes. *See id.* (rounds for 3/8). By Defendants' own testimony, these weekend rounds are not meaningful.

D. Coordination of Mental Health and Medical Staff

The next substantive provision of the Order requires coordination of medical and mental health staff, as well as additional staff training. Nov. 2006 Order at 2. The coordination requirements were further specified in the May 2007 Order, which requires steps to produce integration of the Psychological Services Unit ("PSU") and the Out-patient Mental Health Team ("OPT"). May 2007 Order at 1-2. Defendants responded by stating in their Second Revised Plan that they "are committed to functionally merging the mental health identification and treatment activities of [PSU] and [OPT] at JMF and RGC until JMF closes." 2nd Revised Plan at 9. In fact, this promise has yet to be redeemed; at the time of trial, there was no functional integration, and

as a result class members continued to suffer harm and be threatened with harm. Pls.' Br. at 14-23. Indeed, Defendants' failures on this score illustrate why the Court should view with great scepticism any assertion by Defendants that is not backed by actual evidence. At the time Defendants filed their motion to terminate injunctive relief on mental health, Defendants asserted that they had "integrated the operational activities of the PSU, composed of limited licensed and full licensed psychologists and the [OPT], led by psychiatrists." Br. in Support of Mot. to Terminate Mental Health Relief, Nov. 20, 2007 (Dkt. No. 2684) at 4-5. As the most casual review of the later monthly PSU meeting minutes reveals, this claim is laughable. *See, e.g.* Defs.' Exh. BB (Minutes for 3/26/08 Meeting) at 2-3 (head of PSU explaining how to make complaints about failures of OPT staff; also explaining that PSU should continue to refer to OPT even if few of the referrals are successful).

E. The Need for Additional Training

The same paragraph of the November 2006 Order that requires coordination among medical and mental health staff also requires additional training for staff. Nov. 2006 Order at 2. Defendants represent, however, that only a small segment of current *Hadix* staff, those who deal with prisoners in the SMHU, have actually been given that training. Defs.' Br. at 8. There is no basis in the text of the November 2006 for limiting the training to segregation staff:

> Defendants **shall immediately** work to develop protocols for the coordination of mental health and medical staff, and shall require weekly conferences of the two disciplines which shall include, but not be limited to the treatment of prisoners in the segregation unit, and which shall include training to prevent staff and administrative indifference to the provision of care, consistent with the Court's instructions at section V.3 of its opinion.

Nov. 2006 Order at 2 (bolding in original); *see also* Op., Nov. 13, 2006 at 38 (requiring training

for staff "based on widespread provider indifference to patient care"; the Court further mandated that "[p]art of this training should include instruction about the care providers' role in insuring that patients are treated humanely by custody staff and insuring that patients' medical and mental health care is timely provided to them and is not delayed by administrators [or] the Director and/or administrators and staff of CMS.").

There is thus no arguable basis for asserting that this training requirement was limited to SMHU staff. Defendants' first citation in support of the claim that they have met the training requirement is to the testimony of their expert Jeffrey Metzner, M.D. Dr. Metzner's actual testimony at the pages cited[9] is not specific to the training issue; it is a general statement that the plan if implemented will meet the November 2006 Order. T, 4/28/08 (Metzner) at 31. The Second Revised Plan has never been approved by the Court, and Defendants offer no testimony attempting to explain why Dr. Metzner thought that a plan that did not address a specific part of the Order could be sufficient compliance. Defendants' other citation in support of compliance with this provision is to the testimony of Lee Rome, M.D., who states only his "clear impression" that Defendants have complied, when asked a question that assumes that Defendants' training obligation is limited to training "to help staff identify *in segregation units* prisoners in distress." T., 6/12/08 (Rome) at 965 (emphasis added).

F. Additional Failures to Comply with the May 2007 Order

Defendants have also failed to comply with a number of additional requirements of the May 2007 Order. In particular, Defendants have failed to comply with the requirement to provide an emergency mental health unit for RGC. May 2007 Order at 2. This unit is sorely

[9] T., 4/28/08 (Metzner) at 30-31.

needed to cure the existing constitutional violation, particularly because of the lack of anything but on-call psychiatric coverage at DWH, in addition to the lack of *any* mental health beds in the entire system available to *Hadix* prisoners that can provide the full range of medical and mental health services. *See* Pls.' Br. at 28, 31-33, 39-40.

The May 2007 Order also requires proper adequate supervision of staff,[10] another issue that Defendants fail to address in their brief despite the obvious lack of minimally adequate supervision. *See* Pls.' Br. at 23-27. In addition, the Order requires accounting for the use of mental health beds at Huron Valley ("HVM") "to ensure delivery of necessary mental health services to *Hadix* prisoners." May 2007 Order at 2. The record overwhelmingly shows that more beds are needed at HVM. *See* Pls.' Br. at 29-31. Further, the May 2007 Order requires the plan to assure mandatory referrals to psychiatry for suicidality and significant deteriorations of mental health. May 2007 Order at 2. Nothing in Defendants' Second Revised Plan or in Defendants' brief addresses this requirement and it is apparent that this critical problem remains. *See* Pls.' Br. at 11-12, 15-16, 18-22, 33-41.

Defendants claim that, if the Court finds that Defendants have complied with the November 2006 Order, PLRA requires that all relief be terminated. *See* Defs.' Br. at 15-17. This gets the PLRA requirements exactly backwards. PLRA requires termination if, following the filing of a PLRA termination motion, the Court concludes that injunctive relief is no longer required to correct a current and ongoing violation of federal law. 18 U.S.C. § 3626(b)(3). Under that standard, obviously, Defendants are not entitled to termination even if they have fully complied with a court's orders designed to address the violation but the constitutional violation

[10] May 2007 Order at 2.

remains.[11] In such circumstances, a court would have to consider further or modified relief, but relief cannot terminate when the constitutional violation remains.

Of course, a further problem with Defendants' motion is that Defendants are not eligible to file a PLRA termination motion, because such a motion may not be filed until two years after a court grants or approves such relief. 18 U.S.C. § 3626(b)(1)(A)(i). Accordingly, no PLRA motion may be filed until November 2008. In addition, even if Defendants were to have shown that they have complied with the November 2006 and May 2007 Orders, they have made no attempt to show the other requirement for relief from these Orders. Defendants have failed to follow the Supreme Court standard under the general law for determining that injunctive relief may be terminated, a standard that requires the court to determine whether the defendants have complied with the decree since it was entered, and whether the past vestiges of violations of law have been eliminated to the extent practical. *Board of Educ. v. Dowell,* 498 U.S. 237, 249-50 (1991).[12]

Defendants also make the claim that Plaintiffs have failed to demonstrate a class-wide injury because Terry Kupers, M.D., could not "place a number on the risk of harm to the current

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[11] Although PLRA requires a court to find that the relief is the narrowest and least intrusive that will serve to eliminate the constitutional violation, it does not similarly require a court to find that its relief will definitely eliminate the violation. *See* 18 U.S.C. § 3626(a)(1)(A). It comes as no surprise that some relief will prove too narrow. Were that not the case, there would be no occasion for PLRA's further provision that, if the constitutional violation does persist despite the injunction, that relief is not to be terminated. 18 U.S.C. § 3626(b)(3).

[12] Although *Dowell* is a school desegregation case, its standard also applies to prison and jail conditions of confinement cases. *See Heath v. DeCourcy,* 992 F.2d 630, 633 (6th Cir. 1993) (vacating and remanding partial termination of jail conditions of confinement consent decree; applying standard based on *Dowell*); *Cody v. Hillard,* 139 F.3d 1197, 1199 (8th Cir. 1998) (remanding termination of prison conditions consent decree because district court failed to demonstrate compliance with standard for termination consistent with *Dowell*).

population." Defs.' Br. at 17. Defendants appear to be referring to questions raised by the Court. T., 4/29/08 (Kupers) at 422-424. The Court asked if Dr. Kupers could quantify the percentage risk of harm from the failures of the mental health system. Dr. Kupers testified that while he could not provide a specific percentage for that risk, the "more common scenario" for a person whose serious mental health needs are not addressed is that the prisoner suffers increased symptoms of mental illness. If the prisoner's sentence is short, he or she survives and may either leave prison and get treatment, or the prisoner may recidivate. The prisoner may also end up in segregation. *Id*. at 424. Dr. Kupers also testified that, while he could not identify a particular person who would be foreordained to suffer a particular harm, if the constitutional deficiencies are not addressed, to a virtual certainty there would be deaths in the class, and that there will be persons who suffer severely because of these deficiencies. *Id*. at 435.

IV. DEFENDANTS' ASSERTIONS THAT MENTAL HEALTH CARE MEETS THE REQUIREMENTS OF THE EIGHTH AMENDMENT ARE UNPERSUASIVE.

A. Defendants' Assertions Are Unsupported.

As shown by the examples provided above, the Court should not rely on any of Defendants' citations to the record without close examination of the accuracy of those citations. One particularly egregious allegation by Defendants is the claim that it took less than a day for prisoners coming in to RGC with prescriptions for psychotropic medications to see a psychiatrist and receive their medications. Defs.' Br. at 11. Defendants cite their Exhibit SS, even though they know full well that Royal Calley withdrew the claim in Exhibit SS that he had any records showing that it took less than a day to provide even verified medications after the revised bridge order was put in place. *See* Pls.' Br. at 16-17. Defendants were given an extension of time, so

that they had more than five weeks to file their trial brief, and they even filed two subsequent corrected briefs, so they had more than enough time to eliminate this demonstrably false claim.

In addition, Defendants make a number of claims for which they cite nothing in the record and, Plaintiffs believe, they could not cite anything in the record. For example, Defendants claim that the initial screening for mental health issues is performed by a Registered Nurse. Defs.' Br. at 9. The only citation to the record in the entire paragraph in which this statement appears is to Defendants' Exhibit M. That exhibit, which is a National Institute of Justice Report, obviously provides no support for Defendants' statement. In fact, Defendants' policy and practice allows a correctional officer to perform this function when a Registered Nurse is not available. Pls.' Exh. 46 (Gartland Dep.) at 56.

Similarly, Defendants claim, without any citation to the record, that prisoners who are identified in the initial mental health screening as having a suicide risk are referred to the OPT. Defs.' Br. at 9. While some prisoners are referred on this ground, Plaintiffs strongly disagree that substantially all such prisoners are so referred. *See* Pls.' Br. at 11-12; *see also* 4th Rpt. at 17-19 (prisoner who had been on suicide watch at county jail did not see psychiatrist for 17 days after admission to RGC despite increasing signs that he needed to a psychiatric evaluation); *see also id.* at 19-22 (prisoner screened to have numerous suicide risk factors and well as current symptoms of psychosis was placed in SMHU; not seen by psychiatrist for six days from entry, at which point the psychiatrist decided he did not need treatment; shortly after leaving RGC the prisoner was found to need in-patient mental health treatment in the Crisis Stabilization Program at HVM); *id.* at 26-28 (prisoner who had spent most of the previous year in Kalamazoo State Hospital and acknowledged three risk factors for suicide was not referred to OPT, nor were

suicide precautions initiated; prisoner had numerous indications of mental illness but his psychotropic medications were interrupted for at least two weeks; about three weeks after admission he was referred to an observation cell at DWH for 1:1 suicide observation; one day later transferred to HVM). Similarly, Defendants' assertion that prisoners identified as having a suicide risk are referred to the OPT and held in an observation room fails to identify any record support, and the allegation is inconsistent with the evidence Plaintiffs cite above in this paragraph. *See* Defs.' Br. at 10.[13]

Defendants' only apparent support for their claim that the bridge order will prevent future disasters of the sort that led to Chad Childers' psychotic break was an unfair question to Diane Childers. *See* Defs.' Br. at 10. In fact, later in the deposition, Ms. Childers expressed misgivings about whether the new policy would actually prevent such problems in the future. She noted that at the time her son entered the system, there were policies that were supposed to provide medication continuity, and those systems did not work. Pls.' Exh. 34 (Childers Dep.) at 73. As discussed in Plaintiffs' previous brief, Defendants' expert Dr. Metzner could not endorse the bridge order as a solution to the problem of under-diagnosing (and the associated problem of discontinuing prescribed medications). *See* Pls.' Br. at 3-6.

Defendants cite nothing in support of their claim that medication discontinuations are expected to happen by titrating the dosage and having at least one follow-up assessment by a psychiatrist. Defs.' Br. at 11. In any event, the practice has been that any prisoner whose psychiatric medications are discontinued by the psychiatrist is simply refused entry to the OPT

[13] Defendants also provide no support for their assertions regarding the benefits of their claimed post-trial change in the RGC mental health screening process. Certainly the only thing Defendants cite, their Exhibit L, does not support these assertions. *See* Defs.' Br. at 13.

caseload after being characterized as not in need of treatment (TNR). *See* Pls.' Br. at 27.

Defendants' statistics regarding their TNR studies[14] are unpersuasive in that all of their studies substantially undercount their omission of persons in need of treatment. *See* Pls.' Br. at 12-14. In fact, large numbers of prisoners must be admitted to the caseload after the RGC screening process. *See* Pls.' Br. at 2-3. Plaintiffs' experts and the OIMM have also repeatedly identified numerous prisoners wrongfully TNRed in the RGC screening process, yet Mr. Calley has done nothing to instruct the psychiatrists on the need to address this problem. *See* Pls.' Br. at 5, 8-11.

Defendants cite a portion of Dr. Metzner's testimony in support of the claim that subsequent admissions to the caseload after RGC may simply be an example of the prisoner's mental illness manifesting itself rather than a missed diagnosis. Defs.' Br. at 12. Nothing in the portion of the transcript cited by Defendants supports this claim. *See* T., 4/28/08 (Metzner) at 33-39. Further, the claim that mental illness may not manifest itself until later in a prisoner's sentence inadvertently underlines one of Plaintiffs' major concerns: Defendants make no attempt to seek records of previous mental illness to assist in determining whether the prisoner needs treatment. *See* Pls.' Br. at 26. Further, as Dr. Kupers noted, when treatment is discontinued for arriving prisoners (as has happened with 23% of the persons arriving on verified medications),[15] their prognosis tends to get worse and they suffer both physical and emotional harm. T., 4/29/08 (Kupers) at 292.

Defendants claimed that Robert Walsh, Ph.D., testified that he rarely received mental

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[14] *See* Defs.' Br. at 12.

[15] *See* Pls.' Br. at 4-5.

health records when he worked at the prison. Defs.' Br. at 17, citing T., 6/11/08 (Walsh) at 730. In fact, Dr. Walsh testified that he did not know how many records were actually received, but it was not 100%, and that by the time the records came in, often the prisoner had left RGC for another facility, so staff forwarded the records there. *Id.* This testimony actually shows that at the time staff made attempts to obtain the records — something that essentially never happens now.

B. Defendants' Claims of Constitutionality Are Unpersuasive.

As set forth in Section IV.A, above, most of Defendants' relevant allegations are not supported or do not fairly summarize the record. Many of their other allegations, while they may have some support in the record, are ultimately not persuasive in light of Plaintiffs' contrary evidence. For example, at noted above, Defendants at various points present inaccurate summaries of testimony from Dr. Metzner. When carefully read, however, it is apparent that at a minimum, Dr. Metzner's testimony provides more support for Plaintiffs than Defendants on substantive issues, as he was clear that he was not endorsing a claim that current conditions met constitutional standards, and on various points, such as the efficacy of the bridge order policy, his testimony was consistent with Plaintiffs' claims. *See* Pls.' Br. at 4-6, 8, 14, 23-26, 30, 33.

Thus, the only expert testimony actually supporting Defendants came from Lee Rome, M.D. While Plaintiffs do not challenge that Dr. Rome meets the minimum standards under the Federal Rules of Evidence to be qualified as an expert, his qualifications are undistinguished compared to the other psychiatrists who testified. Both Dr. Metzner and Dr. Kupers have enormous experience in evaluating mental health care in diverse prison settings. *See* Pls.' Exh. 1C (Kupers CV); Defs.' Exh. B (Metzner CV). Both have served as a neutral court-appointed

expert. T., 4/29/08 (Kupers) at 244; Defs.' Exh. B (Metzner CV) at unnumbered 5-6. In contrast, this is the first class action prison case in which Dr. Rome has ever been qualified as an expert. T., 6/30/08 (Rome) at 986.

Further, and strikingly, he is evaluating the very system that he "played a significant role" in establishing. *Id.* at 985. Indeed, he was clinical director of the Correctional Mental Health Program in 2002-2003. *Id.* at 960-961. Finally, according to Defendants' counsel, Dr. Rome worked for the Wayne County Jail, and Dr. Rome would be impressed if that facility ever sent the right record to the RGC. T., 4/29/08 (Kupers) at 397. Accordingly, there is no showing that Dr. Rome had a reliable basis to distinguish acceptable mental health care from unacceptable mental health care.

Even more surprisingly, although Dr. Rome's original report is very similar to Dr. Metzner's report,[16] he failed to follow Dr. Metzner's example of limiting the scope of his opinion. Despite not having read a single patient's full record in over a year,[17]and not reading critical depositions such as that of Vinh Thai, M.D.,[18] Dr. Rome expressed opinions on the adequacy of the care provided. In contrast, Dr. Metzner was not comfortable assessing the actual state of mental health care without looking at the actual delivery of care. T., 4/28/08 (Metzner) at 65 (in general he made no attempt to assess the performance of the system; in particular he did not assess claims of under-diagnosis or delays in mental health treatment). Dr. Kupers, the other psychiatrist expressing general opinions about the quality of actual health care (as contrasted to

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[16] Dr. Rome used Dr. Metzner's report as a model. T., 6/30/08 (Rome) at 986.

[17] *Id.* at 1009; *see also id.* at 991-992.

[18] *Id.* at 991.

the theoretical value of Defendants' Second Revised Plan), read a large number of actual patient records, as well as the depositions of critical staff and other documents, prior to formulating his opinion. T., 4/29/08 (Kupers) at 256-257; *see also id.* at 252-255, 375-377 (describing the scope of his review). This is an accepted methodology. *Id*. at 251. Accordingly, the Court should not rely on any conclusions of systemic adequacy when Dr. Rome's testimony was not supported by Dr. Metzner. Dr. Rome's testimony, like that of Dr. Metzner, thus does not provide any meaningful support to Defendants.[19]

Defendants do not cite any specific part of Dr. Walsh's testimony when they claim that he

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[19] Defendants' internal medical director was no better. Haresh Pandya, M.D., a pediatrician by training, performed an extraordinarily superficial review of the medical files at issue. He did not have the full files for these prisoners, and he spent only four or five hours reviewing the ten files he testified about and two or three other records. T., 6/12/08 (Pandya) at 807-808, 857-858. Further, Dr. Pandya appeared to view the issue through a narrow lens. As Dr. Pandya said of Prisoner AM (*see id.* at 825), "[Y]es, he had an illness and he was being treated. Now, that treatment wouldn't make his medical condition any better and prevent his death." *Id.* at 834. It appears that Dr. Pandya simply ignored the unnecessary mental and emotional suffering to which these terminal patients were exposed. For example, Dr. Pandya was not of the opinion that a patient had a mental health issue even though he admitted that policy required a psychiatrist to see the patient because the patient was refusing medication. *Id.* at 836-837. At times his testimony was essentially unintelligible. *See, e.g., id.* at 845 (testifies that patient got "adequate mental health care as I see it," but also that the patient's mental illness had an interactive quality with his medical problems, "but I don't see it that way."). He also testified that "it's not routine" to treat mood swings in a patient suffering from Hepatitis C, end-stage liver disease, and liver cancer. *Id.* at 847-848. Indeed, Dr. Pandya found nothing to criticize in the health care of any of these patients. In contrast, Dr. Walden's review of these same cases found an essential absence of necessary psychiatric care, including failures to be involved in the prescription and monitoring of psychotropic medications; failure to consider the interactions of such medications with the patient's other medications; failures to be involved in behavioral issues for which psychiatrists have special expertise; improper use of PSU limited-license staff to erroneously decide that a patient was competent; TNRing of patients who were taking psychotropic medications and had an appointed guardian; failures to share critical medical information with other medical staff; and failures to provide counseling to patients who were struggling with life crises such as terminal illness or the aftermath of rape in prison. *See* Pls.' Br. at 35-38. From Dr. Pandya's testimony, it is hard to imagine how extreme a departure from expected medical or mental health practice would be required for him to find it inappropriate.

could make "only a provisional diagnosis" without previous mental health records,[20] but presumably they were referring to his testimony at the June 11 hearing at page 732. In fact, Dr. Walsh stated that he has an obligation to attempt to obtain previous mental health records if he knows that such records are available. T., 6/11/08 (Walsh) at 732-734. This testimony is completely consistent with that of Dr. Kupers. *See* T., 4/29/08 (Kupers) at 271-272, 350, 395-399 (it is essential to seek previous mental health records when available).[21] Further, Dr. Metzner volunteered that he tells prison systems that they need to get records. *See* T., 4/28/08 (Metzner) at 97.

Defendants attempt to argue that the stark discrepancies among the various psychiatrists are simply differences of opinion, and cannot be deliberate indifference. Defs.' Br. at 18. Dr. Thai's failures do not amount to simple "differences of opinion" with other psychiatrists. Dr. Thai discourages prisoners from continuing their medications,[22] fails to order same-day medications when prisoners are allowed to continue their medications,[23] fails to distinguish between a prisoner refusing admission to the OPT caseload and refusing medications,[24] is

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[20] Defs.' Br. at 17.

[21] Defendants suggest that Dr. Kupers was being inconsistent because he performed assessments of the patients he saw on the inspections without pre-incarceration records. In point of fact, he read those records available to him in reaching his assessments. *See id.* at 249, 251.

[22] T., 4/29/08 (Kupers) at 275; Pls.' Exh. 1A (Kupers Rpt.) at 11-12; *see also* Pls.' Exh. 1B (Kupers Decl.) at 6.

[23] Pls.' Exh. 48 (Thai Dep.) at 71-76.

[24] *Id.* at 63.

confident that his accent is not a problem in communicating with patients,[25] and fails to seek outside records. Pls.' Exh. 48 (Thai Dep.) at 79-80. Dr. Thai also rarely diagnoses any Axis I disorder except substance abuse. *See* 4th Rpt. at 10-11; *see also id.* at 24-25 (Dr. Thai TNRing patient described by another psychiatrist as delirious, disoriented, psychotic, and in need of a guardianship). The evidence, in the aggregate, raises serious questions as to whether Dr. Thai's "judgment" is so egregiously bad that it fails to qualify as a medical judgment. *See LeMarbe v. Wisneski,* 266 F.3d 429, 436 & n.4, 437 & n.6 (6th Cir. 2001) (plaintiff's evidence from affidavit of general surgeon that any general surgeon would have known that bile leak had to be stopped, but defendant surgeon failed to attempt to stop bile leak, if credited by the finder of fact, was sufficient to show deliberate indifference; rejecting claim that Michigan Department of Corrections surgeon was under those circumstances simply exercising medical judgment); *Greeno v. Daley,* 414 F.3d 645, 654 (7th Cir. 2005) (finding deliberate indifference in treatment "so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate [plaintiff's] condition"); *Adams v. Poag,* 61 F.3d 1537, 1543-44 (11th Cir. 1995) (medical treatment that is "so grossly incompetent, inadequate, or excessive as to shock the conscience" constitutes deliberate indifference).

In fact, however, Dr. Thai's deliberate indifference is beside the point. The real issue is his supervisors' deliberate indifference, and this is a fact that Plaintiffs are not required to show by separate proof. Given that Plaintiffs have shown a substantial danger of serious harm that continued up to the time of trial, they have shown a violation of the Eighth Amendment in this case seeking injunctive relief because the "same information that would lead to the court's

[25] *Id.* at 11, 13-14.

conclusion [of a substantial risk of serious harm] was available to the prison officials." *Hadix v. Johnson,* 367 F.3d 513, 526 (6th Cir. 2004). The wisdom of this approach is apparent in this case because the expert testimony from both sides expressed the opinion that supervisors had to examine the discrepancies between Dr. Thai's work and the work of other psychiatrists. T., 4/28/08 (Metzner) at 89-91, 96; T., 6/12/08 (Rome) at 988-989; T., 4/29/08 (Kupers) at 274-275; T., 6/11/08 (Walsh) at 654-657. Even though the supervisors had long known of those discrepancies,[26] supervisors did not raise the problem with Dr. Thai. Pls.' Exh. 48 (Thai Dep.) at 32-33, 79-80, 83-84, 96; Pls.' Exh. 104 (Calley Dep.), 6/3/08 at 128-129.

Defendants similarly raise a red herring when they discuss the issue of Michigan guardianship law. *See* Defs.' Br. at 18-20. The issue is not Michigan guardianship law but Defendants' failure to use that law or take other appropriate actions when prisoners in need of treatment display symptoms of severe mental illness and refuse medical treatment. *See* Pls.' Br. at 33-35 (prolonged failure to initiate guardianship for prisoner refusing biopsy of highly suspicious pelvic mass); *see also* 4th Rpt. at 11. Ironically, a failure to initiate guardianship led to the death of a prisoner, PH, extensively discussed in the 2006 hearing. *See* Op., Nov. 13, 2006 (Dkt. No. 2186) at 11-13. Despite Defendants' knowledge of this significant problem, nothing regarding this deficiency has improved, quite possibly because of the virtual lack of psychiatric coverage of DWH. *See* Pls.' Br. at 33. Similarly, Defendants serious mischaracterize Dr. Walden's testimony when they imply that it was limited to criticizing Defendants for failure to provide mental health counseling. Defs.' Br. at 19-20. While counseling can make a difference

[26] Pls.' Exh. 103 (memoranda from staff expressing concerns about Dr. Thai's behavior); T., 4/28/08 (Calley) at 181, 186.

of life and death in certain circumstances, Dr. Walden's testimony covered many additional issues. Pls.' Br. at 35-41.

V. PROOF OF DELIBERATE INDIFFERENCE DOES NOT REQUIRE PROOF THAT THE RISK IS MORE LIKELY THAN NOT TO OCCUR.

Farmer v. Brennan, which establishes the "substantial risk of serious harm" standard, does not require that the harm be more likely than not to occur. *See* 511 U.S. at 842. In fact, *Farmer* necessarily rejects such a standard. The Court uses synonyms for "substantial" several times, making clear that it is not talking about a particular percentage. *See, e.g., id.* at 836 ("unjustifiably high risk of harm" and "excessive risk to inmate health and safety"); at 843 ("sufficiently substantial 'risk'", "excessive risk" and "sufficiently serious risk"); at 844 ("sufficiently substantial danger"); at 846 ("objectively intolerable risk of harm"). Thus, the large number of formulations used in the opinion defeat any contention that some specific, quantitative level of risk was intended. Nor has any decision subsequent to *Farmer* known to Plaintiffs attempted to define the necessary level of risk quantitatively.

At the same time, the level of risk required to be shown has to be substantially less than a near-certainty. In *Farmer,* the Court rejected the Seventh Circuit's standard for deliberate indifference, a standard that required "actual knowledge of impending harm easily preventable, so that a conscious, culpable refusal to prevent the harm can be inferred from the defendant's failure to prevent it." *See McGill v. Duckworth,* 944 F.2d 344, 348-49 (7th Cir. 1991) (adopting the standard from *Duckworth v. Franzen,* 780 F.2d 645, 653 (7th Cir. 1985)).[27] Under *Farmer* and *Helling v. McKinney,* 509 U.S. 25, 33 (1993), there is no requirement that the harm be

[27] *McGill* was cited in *Farmer. See Farmer,* 511 U.S. at 836.

"impending."[28] Nor is there a requirement that the harm be "easily preventable"; under *Farmer,* when prison officials know of a substantial risk, their affirmative duty is to take reasonable measures to reduce the risk. *Farmer,* 511 U.S. at 844.

Further, a risk can apply to a group of prisoners, even though not all prisoners exposed to the risk will be affected. *Heller,* 509 U.S. at 33*; see also Farmer,* 511 U.S. at 844 (citing *Heller*). Indeed, *Farmer* also cites with approval *Commonwealth v. Welansky,* 316 Mass. 383 (1944), affirming a criminal conviction for reckless conduct when a nightclub owner created a fire hazard but did not know how or when the risk would materialize, or how many people would be affected by the risk. *Farmer,* 511 U.S. at 844. Thus the Court in *Farmer* endorsed an interpretation of "substantial risk" as a risk that might result in harm to only a small percentage of those exposed to it (given the large number of nightclub patrons who could have been exposed to the risk prior to the fatal fire).

Similarly here, there was uncontradicted evidence that, to a reasonable degree of medical certainty, future prisoners will die if mental health care is not improved. T., 4/29/08 (Kupers) at 425. This testimony was supported by the fact that there have already been a number of deaths, as well as near deaths and specific likely future deaths, caused by the failures in mental health. *See* Pls.' Br. at 33-35 (likely future death of specific prisoner); at 37-38 (deaths); at 39-40 (near death); 40-41 (likely future death of specific prisoner); *see also* Op., Nov. 13, 2006 (Dkt. No.

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[28] A harm that is "impending" is a harm that is about the happen, thus implying a very high degree of likelihood that the event will actually occur. *Helling* holds that a prisoner stated an Eighth Amendment claim by alleging an unreasonable risk of serious damage to his future health from the effects of environmental tobacco smoke, *id.,* a formulation suggesting a significantly lower degree of certainty, because health effects that are years or decades away are intrinsically harder to predict than exposures that cause immediate health harm.

2186) at 2-9, 11-15 (discussing a number of deaths occurring in the absence of necessary mental health care). Further, the deaths are only the tip of the iceberg of the harm done to the class. Many more prisoners suffered emotional harm, or lesser degrees of physical injury, like Mr. Childers. *Cf. Talal v. White,* 404 F.3d 423, 427 (6th Cir. 2005) (proof of allergy to tobacco smoke, causing sinus problems and dizziness sufficient to demonstrate objective component of Eighth Amendment violation). Accordingly, Plaintiffs have satisfied the "substantial risk" standard of *Farmer.*

CONCLUSION

For the above reasons, Plaintiffs request that Defendants' motion for termination of mental health relief be denied and that Plaintiffs' motion for further relief be granted.

Respectfully submitted,

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