Case No. 09-1424

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

EVERETT HADIX, et al.,

Plaintiffs-Appellants,

v.

PATRICIA CARUSO, et al.,

Defendants-Appellees.

PLAINTIFFS-APPELLANTS' REPLY BRIEF

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I. INTRODUCTION

The number of issues in which Defendants-Appellees ("Defendants") waive any opposition by failing to address them in their brief is quite remarkable. The points that Defendants fail to address, entirely or in any meaningful way, include the first four argument headings, out of a total of five, that Plaintiffs-Appellants ("Plaintiffs") pose in their opening brief, as follows:

1. In their first argument, Plaintiffs point out that, at a hearing on the merits, there is no subjective intent requirement in a prison conditions of confinement case seeking injunctive relief. *See* Pls.' Br. at 33-36. Defendants do not address this argument that the district court committed legal error in denying Plaintiffs relief based on a finding that Defendants did not violate the subjective component element of an Eighth Amendment violation.

2. Similarly, Defendants do not address Plaintiffs' second argument, that the district court failed to make a finding of whether an objectively unreasonable risk of harm under the Eighth Amendment existed. *See id.* at 36-44. While Defendants argue generally that prisoners were not subjected to deliberately indifferent medical care, *see* Defs.' Br. at 30-31, they do not attempt to argue, nor could they, that the district court addressed the objective component of the Eighth

Amendment.[1]

3. Defendants implicitly admit that Plaintiffs' third argument, that the district court had the unquestioned power to modify the Consent Decree to remedy a constitutional violation, is correct. *See* Defs.' Br. at 35 (arguing that there is no basis to modify the Consent Decree if no constitutional violation has been proven). In contrast, the district court concluded that it had the power to grant further relief only if the court found both a constitutional violation and a violation of the original Consent Decree. R. 2903 at 14.

4. There is nary a word in Defendants' brief attempting to rebut Plaintiffs' argument that the district court failed to comply with Fed. R. Civ. P. 52(a) by failing to find necessary facts. *See* Pls.' Br. at 49-54.

II. DEFENDANTS' ARGUMENT THAT THE *HADIX* CLASS NO LONGER EXISTS IS UNAVAILING.

Defendants assert that the *Hadix* class no longer exists, but this argument is

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[1] The closest Defendants come to addressing this issue is to say that "the trial court did not base its decision on a finding that the mental health workers of the Defendant were unaware that prisoners may have a mental illness or may need mental health care." Defs.' Br. at 31. While technically true, the statement does not encompass anything similar to Plaintiffs' actual argument. In Plaintiffs' opening brief, they argued that the district court committed legal error by basing its decision, in this injunctive case, on a determination that Plaintiffs failed to prove a violation of the subjective component of deliberate indifference (a component that does not apply to injunctive cases at the trial on the merits), while it failed to make a specific finding on the objective component of deliberate indifference. *See* Pls.' Br. at 33-44.

demonstrably incorrect. As noted in Plaintiffs' opening brief, the Consent Decree in this case states that the *Hadix* class action was undertaken

> . . . seeking declaratory and equitable relief with respect to the conditions of confinement at the Central Complex of the State Prison of Southern Michigan, including the Reception and Guidance Center (hereinafter referred to as SPSM-CC).[2]

Consent Decree, E.D. R. 199 at 1 (App. 392) (quoted in Pls.' Br. at 3).

At the time that the district court approved the Consent Decree, it issued the following order that resolves the issue of whether a class still exists:

> 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, including the Reception and Guidance Center, 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 the Consent Judgment, e.g., food service and Boiler Plant operations[.]"

Order Accepting Court Judgment, May 13, 1985, E.D. R. 213 at 1-2 (App. 446-447).

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[2] At the time that the parties entered into the Consent Decree, the Reception and Guidance Center was located in Cellblock 7, which was not part of the Central Complex. *See Hadix v. Johnson,* 367 F.3d 513, 517-18 (6th Cir. 2004) (listing the Cellblocks included in the Central Complex at the time the Consent Decree was adopted as 3-6, 8, 11, and 12, and noting that Cellblock 7 was part of the Reception Complex). Defendants cite absolutely nothing for their claim that Cellblock 7 was part of Central Complex and Plaintiffs know of nothing that they could cite.

Even in their current brief, Defendants implicitly admit, as they must, that Cellblock 3 of the Egeler Correctional Facility, at the time of entry of the Consent Decree was part of SPSM-CC. *See* Defs.' Br. at 6 (quoting *Hadix v. Johnson,* 367 F.3d 513, 518 (6th Cir. 2004). Defendants then argue that "[a]t present, however, 3 block has been completely changed and is merged with the support units of Egeler's 1 and 2 blocks. 3 block does not house any general population prisoners as it did in 1980." Defs.' Br. at 7.[3] Of course, by reason of the Order Accepting Consent Judgment, changes in usage of a cellblock that post-date acceptance of the Consent Decree are not to affect a cellblock's status as an original *Hadix* facility, although of course such changes could affect the status of whether a cellblock qualified as a *Hadix* support facility under the Order.

This Court has twice applied the Order Accepting Consent Judgment to determine whether a particular facility is subject to the Consent Decree. *See Hadix v. Caruso,* 297 F. App'x 504, 506 (6th Cir. 2008) ("Consistent with [the Order Accepting Consent Judgment], the SPSM facility consists of the areas within the walls of the original complex plus any areas that supply support services under the Decree's provisions") (internal quotation marks, brackets and

[3] Defendants are not arguing that there has been any physical change in the structure of Cellblock 3 to merge it with the other cellblocks, as any such claim has no possible support in the record and is demonstrably false.

citation omitted); *Hadix v. Johnson,* 367 F.3d at 518 (applying the standards of the Order Accepting Consent Judgment to determine whether a particular facility is covered by the *Hadix* Consent Decree). Because it is uncontested that Cellblock 3 was inside the walls of the original SPSM-CC, it is necessarily a *Hadix* facility.

The other facilities at issue in this appeal – Cellblocks 1 and 2, Duane Waters Health Center ("DWH"), and C Unit – constitute "support facilities" under the definition in the Order Accepting Consent Judgment. *See Hadix v. Caruso,* 297 F. App'x at 507 (noting that DWH is a *Hadix* support facility);[4] *Hadix v. Johnson,* 367 F.3d at 518 (upholding district court order declaring that Cellblocks 1 and 2 qualify as *Hadix* support facilities). Accordingly, there is no remotely plausible argument that the *Hadix* class no longer exists.[5]

III. DEFENDANTS' ARGUMENTS ABOUT PLAINTIFFS' FACTUAL AND LEGAL ASSERTIONS ARE NOT PERSUASIVE.

A. Degree of Risk

Defendants argue that it was a defect in the testimony of Plaintiffs'

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[4] C Unit, like DWH, is a specialized health care unit that is administratively part of the Egeler Correctional Facility, the same facility that includes Cellblocks 1-3.

[5] Regardless of the outcome of this appeal, there will still be medical orders in effect that apply to the class. *See, e.g.,* Permanent Inj., R. 2234, *remanded, Hadix v. Caruso,* 248 F. App'x 678 (6th Cir. 2007). Of note, the permanent injunction was remanded but not vacated.

psychiatric expert, Terry Kupers, M.D., that he did not attempt to quantify the degree of risk from the failures of mental health care that he described. Defs.' Br. at 24-25. First, one might view with some scepticism the testimony of a psychiatrist who would purport to calculate to a specific percentage the risk from depriving a particularly prisoner of necessary mental health care. Second, and not surprisingly, Defendants fail to cite a single case for their claim that proof of an Eighth Amendment violation regarding a substantial risk of serious harm requires that the degree of risk be quantified. In fact, in *Farmer v. Brennan,* 511 U.S. 825 (1994), the leading case about the application of the Eighth Amendment to prison conditions of confinement, the Court uses a variety of synonyms for "substantial" to describe the decree of risk that violates the Constitution, making clear that the assessment of risk is qualitative not quantitative.[6]

Equally significant, in *Farmer*, the Court explicitly 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

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[6] *See, e.g., id.* at 836-37 ("unjustifiably high risk of harm" and "excessive risk to inmate health and safety"); at 844 ("sufficiently substantial danger"); at 846 ("objectively intolerable risk of harm").

standard from *Duckworth v. Franzen*, 780 F.2d 645, 653 (7th Cir. 1985)). Under *Farmer* and *Helling v. McKinney,* 509 U.S. 25, 35 (1993) (holding that a claim that a prisoner had been subjected to the threat of future harm by exposure to an unreasonable level of secondary tobacco smoke stated an Eighth Amendment claim) , there is no requirement that the harm be "impending" (a term implying not simply that something is on the verge of happening, but also that an event that is very likely to happen).

Further, a risk can apply to a group of prisoners, even though not all prisoners exposed to the risk will be affected. *Helling,* 509 U.S. at 33; *see also Farmer,* 511 U.S. at 844 (citing *Helling*). Indeed, *Farmer* 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" 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).

Plaintiffs offered uncontradicted evidence that, to a reasonable degree of medical certainty, future prisoners will die if mental health care is not improved.

T. 425 (Supp. App. 1292) (Kupers). This testimony was supported by the fact that there have already been a number of deaths, near-deaths and similar events caused by failures of mental health treatment. *See* Pls.' Br. at 12 (near-death), 23-24 (possible future death); 25-26 (deaths); 31 (near-death); *see also id.* at 41-42 (other examples of somewhat less serious harm suffered by prisoners as a result of lack of health care); *see also* R. 2773 at 24-26 (discussing a second patient in DWH with a suspicious mass who was refusing treatment and needed a guardian); *see also infra* at 8-9, 16, 18, 21-22.

B. The Systemic Failures of the Intake Screening Process

Defendants attempt to characterize the failures of Vinh Thai, M.D., as simple "differences in professional judgment" that cannot constitute a constitutional violation. Defs.' Br. at 25-26. Dr. Thai's repeated denials of care do not amount to mere differences in professional judgment.[7] Rather, the

[7] Similarly, a second psychiatrist, Dr. Khan, repeatedly designated prisoners as both "seriously mentally ill" and not in need of treatment, contrary to policy. One patient, who had been diagnosed by another Departmental psychiatrist as suffering from severe bipolar disorder with psychotic features, and who had been diagnosed with depression in RGC, was transferred to DWH for treatment. At DWH, the patient was placed in an observation cell, and given repeated anti-psychotic injections. The patient was not eating or drinking and was reported by the nurse to be engaging in psychotic behavior. Dr. Khan found him to be merely a "malingerer". Subsequently, Defendants started guardianship proceedings for this patient, who had very serious medical problems and almost died from forced feeding at DWH. R. 2773 at 15-17.

statistical records of Defendants, demonstrate that Dr. Thai consistently failed to diagnose mental illness at a remotely comparable rate to any other psychiatrist who assessed patients in the RGC. Pls.' Br. at 10-14. The evidence from individual examples underlines how egregious Dr. Thai's practice has been. *See, e.g.,* R. 2773 at 24-25 (another psychiatrist in the prison system found a patient to be delirious, delusional, psychotic, and in need of a guardian; Dr. Thai decided to remove him from the treatment caseload). Dr. Thai also discouraged prisoners from continuing their medications;[8] failed to order same-day medications even though policy requires it; [9] failed to distinguish between a prisoner refusing admission to the mental health caseload and refusing medications, with the result that prisoners with serious mental health needs were dropped from the caseload;[10] and failed to seek outside medical records.[11] Experts from both sides freely expressed the opinion that supervisors had to examine the discrepancies between

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[8] T. 275 (App. 889) (Kupers); R. 2609-02 at 11-12; R. 2609-03 at 6.

[9] Pls.' Exh. 48 at 71-76 (App. 1079-1084); *compare to* Exh. SS at 1 (App. 1275).

[10] Pls.' Exh. 48 at 63 (App. 1078).

[11] *Id.* at 77-80 (Supp. App. 1311-1314).

Dr. Thai's work and the work of the other psychiatrists.[12] Nonetheless, despite years of complaints by other staff about his practices, the supervisors did nothing.[13]

In short, the record demonstrates that the supervisors were blind to clinical judgment so egregiously bad that it fails to qualify legally as a medical judgment. Even in an individual damages action, the lack of appropriate care proven in this case would demonstrate subjective as well as objective deliberate indifference on the part of the individual psychiatrist. *See LeMarbe v. Wisneski,* 266 F.3d 429, 436 & n.4 , 437 & n.6 (6th Cir. 2001) (plaintiffs' evidence from affidavit of general surgeon that any general surgeon would have know that bile leak had to be stopped, but defendant surgeon failed to stop bile leak, if credited by finder of fact, was sufficient to show deliberate indifference; rejecting claim that Michigan Department of Corrections surgeon was simply exercising medical judgment);

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[12] T. 89-91, 96 (App. 854-857) (Metzner); T. 988-989 (App. 988-989) (Tony Rome, M.D., another one of Defendants' psychiatric experts); T., 274-275 (App. 889, Supp. App. 1284) (Kupers); T., 654-657 (Supp. App. 1297-1300) (Walsh).

[13] Pls.' Exh. 48 at 32-33, 79-80, 83-84 (Supp. App. 1309-1310, 1313-1316); Pls.' Exh. 104 at 127-128 (Supp. App. 1319-1320); Pls.' Exh. 104 at 95 (App. 1127); *compare to* Defs.' Exh. Z at 6 (App. 1188). Defendants claim that their quality review mechanisms demonstrate that their methods for screening and identifying prisoners with serious mental health needs are working adequately. Defs.' Br. at 19-20. Plaintiffs refute this claim in their opening brief. Pls.' Br. at 7-14.

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). Unfortunately, the victims here were large numbers of prisoners with serious mental illness who were denied treatment that could have alleviated their suffering.

Defendants claim that their studies of post-RGC admission to the mental health caseload prove that the mental health screening works to identify prisoners with serious mental health needs, regardless of the evidence of the failures of individual psychiatrists. Defs.' Br. at 19-20. That assertion flies in the face in the extremely large and consistent discrepancies in the rates of diagnoses of the various psychiatrists. One can assume that these discrepancies do not matter only if one assumes that mental health treatment does not matter.

More directly, the studies upon which Defendants rely are unpersuasive. Only at RGC do mental health staff actively look for persons in need of admission to the caseload and most of the other facilities do not have an out-patient mental health team that could look for the mentally ill, so only the most floridly mentally

ill prisoners would be likely to come to staff's attention. See R. 2609-03 at 6-7; Defs.' Exh. AA (App. 1190-1193) (showing that most of the prison system's facilities do not have an out-patient mental health team). Defendants rely on studies that do not include prisoners wrongfully not referred by the Psychological Services Unit to the out-patient team; that look only at admissions to the caseload within 60 days of a finding that treatment was not required; and do not include prisoners who are, subsequent to RGC, actually placed on the caseload in the 60-day period, as long as the prisoner is not diagnosed with a major mental disorder.[14] Defs.' Exh. X at unnumbered 4 (Supp. App. 1325); *see also* Pls.' Exh. 104 at 74-75 (Supp. App. 1317-1318) (official in charge of state-wide prison psychiatrists admits that an analysis of the effectiveness of RGC mental health screening would have to consider the accuracy of denials of treatment by both the psychologists and the psychiatrists).

Another internal study found that the RGC psychiatrists erroneously rejected treatment for 6.5% of those referred to them after mental health screening. Defs.' Exh. SS at 2 (App. 1276); Defs.' Exh. G (Supp. App. 1321). From the information given in the study, it appears that, even within the severe limitations of those counted by defendants, in any given year one would expect on a statistical

[14] Only a small minority of prisoners admitted to the caseload are diagnosed with a major mental disorder. Defs.' Exh. X at unnumbered 4 (Supp. App. 1325).

basis that the psychiatrists at RGC miss 48 prisoners who clearly need treatment. *Id.* As noted above, this statistic is simply the tip of the iceberg, and, given the enormous discrepancies in the psychiatrists' performance, it demonstrates a deliberate failure to supervise the psychiatrists. Finally, all the expert witnesses not affiliated with Defendants, including the two representatives of the court monitoring office, found a major problem with wrongful denial of treatment by the psychiatrists.[15] Even Defendants' own psychiatric expert condemned the one step that Defendants claimed they took to reduce under-diagnosis of mental illness, which was to make it harder for their psychiatrists to deny treatment for prisoners coming in with psychiatric medications than to continue treatment. *See* Pls.' Br. at 9-10.

C. The Failure of the Bridge Order to Cure the Lack of Proper Screening

Contrary to the implication of Defendants' argument, Plaintiffs are not challenging the bridge order policy simply because it does not result in the exercise of clinical judgment when discontinuing prescribing psychiatric medications for prisoners entering RGC. *See* Defs.' Br. at 31-32. Rather, as discussed in Plaintiffs' opening brief, the basic problem is that the bridge order

[15] R. 2773 at 3, 8-11, 14-17, 19-22, 24-26 (Cohen); T. 651-653, 675-676, 680-681, 684-686, 691-692, 696-698 (App. 937-939, 944-945, 947-948, 951-953, 954-958(Walsh); T. 871-872 (Dlugacz) (App. 979-980); T. 262, 275-276, 284 (App. 844, 889-890) (Kupers); T. 1047-1048 (App. 1012-1013) (Walden).

simply obscures, rather than fixes, the problem of the RGC psychiatrists causing harm to patients by systematically under-diagnosing mental illness in the screening process. The bridge order policy implemented by Defendants places patients only temporarily on the out-patient caseload, and many prisoners will necessarily have their treatment terminated unless the psychiatrists change their diagnostic practices when they actually evaluate the prisoners. *See* Pls.' Br. at 9-14.

D. The Need for Previous Treatment Records

Defendants attempt to create a conflict between the testimony of Plaintiffs' expert psychologist Robert Walsh, Ph.D., and their expert psychiatrist Dr. Kupers, where none exists. *See* Defs.' Br. at 25. In fact, Dr. Walsh stated that he is able to diagnose without previous records but that obtaining previous records reinforces the accuracy of the diagnosis. T. 732-734 (Supp. App. 1301-1303) (Walsh).[16] Dr. Kupers' testimony is completely consistent with this opinion, including the necessity of seeking records when they are available. T. 271-272, 350, 395-399 (App. 888, Supp. App. 1283, 1286-1291) (Kupers). Defendants' psychiatric expert Jeffrey Metzner, M.D., also volunteered that he tells prison systems that

[16] Defendants fail to give a record citation for their claim about Dr. Walsh's testimony. Plaintiffs believe that the pages here cited are those relied upon by Defendants.

they need to obtain previous medical records. T. 97 (App. 858) (Metzner).

E. The Failure to Use the Guardianship Process

Defendants' reference to the Michigan statutes related to involuntary guardianship proceedings (Defs.' Br. at 26-30) is simply a red herring. The issue is not Michigan guardianship law but Defendants' failure to use that law or take other appropriate actions when prisoners display symptoms of severe mental illness and refuse critical medical treatment as a result of that mental illness.[17] Defendants are not entitled to allow such patients to die simply because, by reason of mental illness, the patient is refusing medical treatment.

As noted in the opening brief, the head of the out-patient psychiatric services was a limited-license psychologist, Craig Crawford. Mr. Crawford gave as an example of appropriate mental health care provided in DWH the treatment of

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[17] As the Supreme Court noted in *Cruzon v. Missouri Department of Health,* 497 U.S. 261 (1990), "[a]n incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate." *Id.* at 280. *See also Morgan-Mapp v. George W. Hill Correctional Facility,* 2008 WL 4211699 at *14 (E.D. Pa. Sept. 12, 2008) (holding that failures of psychiatrists in a pre-trial detention facility to do more than encourage medication compliance when faced with a non-compliant and mentally ill patient who was refusing needed medical treatment could be found to be deliberately indifferent); *cf. Holley v. Deal,* 948 F. Supp. 711, 717 (M.D. Tenn. 1996) (noting that prison could not treat prisoner against his will but rather must proceed through state's procedures for guardianship; use of such procedures satisfies the constitutional interests involved).

a patient who, because of his delusions, refused a CT scan necessary to diagnose suspected cancer. Although Mr. Crawford knew of the patient's delusions in the summer of 2007, and knew of his urgent need for treatment by September 2007, as of the time of the trial in June 2008, the patient had not had a biopsy, the patient did not have a guardian and the guardianship proceedings the state had belatedly begun had been stayed by the state. *See* Pls.' Br. at 23-24. This case is in many ways similar to one of the cases that led to the preliminary injunction in November 2006.[18]

F. The Lack of Necessary Mental Health Coverage at DWH and C Unit

Defendants state that "at least one psychiatrist is available to RGC and [DWH] within an hour on an on-call basis after business hours and holidays." Defs.' Br. at 13. First, this claim is disingenuous, because in fact the record shows that DWH and C Unit had no psychiatric coverage at all beyond on-call coverage, and there are unacceptable delays in responding to psychiatric referrals. *See* Pls.'

[18] One of the deaths described in the opinion accompanying the preliminary injunction was P.H. He refused treatment for hyperthyroidism because he suffered from a delusion that staff were conspiring against him. P.H.'s condition deteriorated over more than a year while he refused treatment. Not until his death from heart and liver complications of his hyperthyroidism seemed imminent did the staff begin steps to seek a guardian. Even then, the guardianship petition form languished for more than a month in the Department of Corrections' central office before it was sent to the Attorney General's Office. The patient died the same month that his guardianship petition was set for hearing. R. 2186 at 11-13.

Br. at 22-23. Second, Defendants cite the testimony of Robert Cohen, M.D., the court monitor, in support of a claim that there is "no dispute" that the on-call psychiatrist system is working. Dr. Cohen first responds that "it seems to be." He then qualifies his statement substantially, noting that for an approximately eight-day period all of RGC had no psychiatric coverage, on-site or on-call, which he describes as "a management failure of the most extreme magnitude." T. 804 (Supp. App. 1306) (Cohen). He also noted that some psychiatrists come in after being paged more than others, so that a study is needed to determine if the psychiatrists are coming into DWH as needed. *Id.*

The involvement of Mr. Crawford, the lone psychologist who covers the health care unit is also minimal. T. 321 (Supp. App. 1285) (Kupers). As a result, patients who suffer from terminal or other serious physical illness and also suffer from major mental disorders lack meaningful access to mental health care. *See* Pls.' Br. at 24-25. While for other prisoners only psychiatrists prescribe psychiatric medications, psychiatrists are ordinarily not involved in prescribing or monitoring psychiatric medications in DWH. T. 1024-1027, 1040-1042, 1044-1045 (App. 1000-1003, 1006-1007, 1009-1010, Supp. App. 1308) (Walden); *cf.* R. 2773 at 12-14 (patient kept in restraints for days in DWH pursuant to telephone orders from a psychiatrist without a comprehensive psychiatric assessment of the

patient, even though the patient was receiving haldol and was in DWH because he was considered seriously suicidal). Psychiatrists drop DWH patients from the mental health caseload even if the patient continues to receive psychiatric medications. T. 1027-1029 (App. 1003-1004, Supp. App. 1307) (Walden); R. 2773 at 24-26.

G. The Special Management Housing Unit

Plaintiffs have obviously never claimed that the circumstance that a prisoner "could" have a serious mental health need means that any decision to place him in the Special Management Housing Unit ("SMHU") is automatically a violation of the Constitution, and tellingly Defendants cite nothing in support of their assertion that Plaintiffs have made such a claim. Defs.' Br. at 32-33.[19] Plaintiffs' concern is that, also contrary to Defendants' claims, the SMHU is used as an overflow emergency mental health unit, a purpose for which it is not suited, and that there is a substantial risk of serious harm to prisoners with serious mental health needs, as a group, from the failure to provide an alternative non-punitive environment to them. Pls.' Br. at 21-22.

[19] It is also noteworthy that Defendants cite nothing in support of their allegations regarding what the record shows about conditions of confinement and the availability of mental health care in the SMHU. *See* Defs.' Br. at 32-33.

H. The Training Requirement of the Preliminary Injunction

The November 2006 preliminary injunction reads in pertinent part as follows:

> IT IS FURTHER ORDERED that 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 necessary training to prevent staff and administrative indifference to the provision of care[.]

R. 2187 at 2 (emphasis in original). Defendants admit, however, that only a small percentage of their staff, those assigned to the SMHU, received any training as a result of the court's order. Defs.' Br. at 15. Defendants, on the face of their admission, thus deliberately and without explanation failed to comply with this aspect of the November preliminary injunction.

IV. DEFENDANTS' FACTUAL ASSERTIONS REGARDING THE RECORD CANNOT BE TAKEN AT FACE VALUE.

A number of statements in Defendants' Brief cannot be taken at face value as they do not accurately reflect the record or, unless the reader reviews the actual citation, the reader is likely to receive a misleading impression of what the record actually reflects. For example, Defendants did not present evidence, as they imply, that prisoners identified at risk of suicide are consistently referred to the

mental health out-patient team. Defs.' Br. at 16.[20]

As another example, Defendants claim that, between January and March 2008, on average it took less than a day for prisoners who arrived at RGC with psychiatric medications to see a psychiatrist and receive their medications. Defs.' Br. at 18. For this claim, Defendants cite their Exhibit SS (App. 1275-1281), a purported summary exhibit that one of their employees, Royal Calley, prepared.

Mr. Calley in fact admitted that this portion of Exhibit SS was completely unreliable, as the summary document on this point used the date that medication information was added to the pharmacy computer, not the date prisoners arrived at the facility, to calculate the average time from arrival to medication delivery. In fact, for the medical records that Mr. Calley was questioned about, there were two-week delays in the delivery of the medication. Pls.' Exh. 104 at 35-47 (App. 1108-1120). The court monitor calculated his own data regarding the delay in delivery of psychiatric medications to incoming prisoners who arrived with their prescriptions, and he found that one-third experienced delays of two days or more. R. 2797 at 3.

Defendants also claim that the court monitor "agrees that no mechanical in-cell restraints are being used in any *Hadix* facility." Defs.' Br. at 13 (citing T. 786

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[20] *See* R. 2773 at 17-19, 19-22; 26-28.

(Supp. App. 1305) (Cohen)). In fact, Dr. Cohen stated, in the cited portion of the record, that he had not seen any use of mechanical restraints in the housing units but that mechanical restraints had been used in DWH since the entry of the injunction, and he gave two examples of such use. T. 785 (Supp. App. 1304) (Cohen).[21]

Further, and critical to understanding the continuing saliency of the restraints issue, Dr. Cohen found that deficiencies in the mechanical restraint policies that Defendants adopted after the preliminary injunction could have easily led to a death. R. 2773 at 8, 14-17 (prisoner was repeatedly placed and continued in four-point restraints for a prolonged period in DWH; medical staff did not examine the patient to determine whether there was a continued need for restraints, but simply ordered the restraints continued). Like T.S., a prisoner who died in August 2006 in a *Hadix* segregation unit, this prisoner was restrained to his bed naked, and urinated on the floor. Also like T.S., this prisoner became seriously dehydrated; he was also hyperatremic (suffering from an excess of salt). This DWH patient developed sepsis and extensive pneumonia, and barely escaped death. *Id.; see also* R. 2186 at 2-9 (discussing the death of T.S. after four days in mechanical restraints).

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[21] The preliminary injunction covers all *Hadix* facilities, not just housing units. R. 2187 at 1.

Defendants claim that they have implemented weekly case conferences involving psychiatry and psychology staff. Defs.' Br. at 15. In fact, the minutes of these conferences demonstrate that staff discuss only prisoners who have been admitted to the caseload, and the meetings are not used to discuss perhaps the most critical problem of mental health care in the *Hadix* facilities – the inconsistencies in psychiatric diagnosis of mental illness and the resulting prevalence of untreated serious mental illness in the population. *See* Pls.' Br. at 7-14. In particular, the record shows that these meetings are not used to discuss any prisoners who are not already admitted to the mental health caseload by one of the psychiatrists.[22]

In addition, Defendants frequently go outside the record of the case and make claims that Plaintiffs never had an opportunity to test or rebut. For example, Defendants present statistics regarding the number of prisoners who were processed through intake in RGC during various periods of time. Defs.' Br. at 15-16. Defendants fail to cite any source for these statistics, and Plaintiffs know of no source in the record.

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[22] *See* Defs.' Exh. E (App. 1132-1178) (case management minutes 1/3/08-4/15/08); T. 1010 (App. 999) (Rome); T. 880 (App. 983) (Dlugacz); T. 478-481 (Supp. App. 1293-1296) (Baker); *compare to* Defs.' Exh. E (prisoner that staff member believed should have been identified as in need of treatment, but was not, not discussed in case management minutes).

Similarly, trial ended on June 12, 2008, so Defendants' claim to have implemented a new mental health screening instrument on June 30, 2008 can have no basis in the record. *See id.* at 16-17, 20-21. Nor are there any record citations for several other claims about the mental health screening process. *See id.* at 17-18, 20-21. Defendants appear to make a claim that incoming prisoners lose their psychiatric medications only after titration of their doses and a follow-up assessment. *Id.* at 18. For this claim, there is not a shred of evidence and indeed all the evidence in the record is to the contrary. In fact the record shows that the practice has simply been to refuse entry to the caseload to those whose psychiatric medications are not continued. *See* Pls.' Exh. 48 at 63 (App. 1078); R. 2773 at 20; R. 2609-02 at 11-12. Indeed, Defendants' written policy does not require maintenance on the caseload for prisoners receiving psychiatric medications at the prison for less than 30 days. Defs.' Exh. Q at 12 (App. 1181).[23]

CONCLUSION

For the above reasons, Plaintiffs request that the Court reverse the district court and remand with directions to grant Plaintiffs' requested relief.

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[23] Plaintiffs withdraw the contention that the district court's findings were "clearly erroneous" in finding that the terms of the November 2006 Preliminary Injunction had been satisfied to the extent that those contentions were based on any order other than the Preliminary Injunction of November 2006. *See* Pls.' Br. at 56-58 (discussing R. 2187).

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C) and Circuit Rule 32-1, I certify that Plaintiffs-Appellants' Reply Brief is proportionately spaced, has a typeface of 14 points and contains 5,704 words.

Dated: October 21, 2009 /s/Alicia Gathers

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CERTIFICATE OF SERVICE

I certify that on this date, October 21, 2009, Plaintiffs-Appellants' Reply Brief was filed with the Clerk of the United States Court of Appeals for the Sixth Circuit using the Court's CM/ECF system.

/s/ALICIA GATHERS