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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, Jr., et al.,

Defendants.

Case No. Civ S 90-0520 LKK-JFM

DECLARATION OF AARON J. FISCHER IN SUPPORT OF PLAINTIFFS' EVIDENTIARY OBJECTIONS TO DEFENDANTS' REPLY DECLARANTS AND MOTION TO STRIKE, AND RESPONSE TO DEFENDANTS' OBJECTIONS

Judge: Hon. Lawrence K. Karlton

I, Aaron J. Fischer, declare:

1. I am an attorney admitted to practice law in California, a member of the bar of this Court, and an associate in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs Ralph Coleman, *et al*. I have personal knowledge of the matters set forth herein, and if called as a witness I could competently so testify. I make this declaration in support of Plaintiffs' Evidentiary Objections to Defendants' Reply Declarants and Motion to Strike, and Response to Defendants' Objections.

2. Attached hereto as Exhibit 1, is a true and correct copy of excerpts from the transcript of the deposition of Joel Dvoskin taken February 27, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

3. Attached hereto as Exhibit 2, is a true and correct copy of excerpts from the transcript of the deposition of Edward Kaufman taken March 16, 2013 in Laguna Beach, California and lodged with this Court by Defendants on March 22, 2013.

4. Attached hereto as Exhibit 3, is a true and correct copy of excerpts from the transcript of the deposition of Jacqueline Moore taken February 21, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

5. Attached hereto as Exhibit 4, is a true and correct copy of excerpts from the transcript of the deposition of Pablo Stewart taken March 19, 2013 in San Francisco, California and lodged with this Court by Defendants on March 22, 2013.

6. Attached hereto as Exhibit 5, is a true and correct copy of excerpts from the transcript of the deposition of Diana Toche taken February 22, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

7. Attached hereto as Exhibit 6, is a true and correct copy of excerpts from the transcript of the deposition of Eldon Vail taken March 19, 2013 in San Francisco, California and lodged with this Court by Defendants on March 22, 2013.

8. Attached hereto as Exhibit 7, is a true and correct copy of the "Notice of Adoption and Implementation of California Code of Regulations, Statewide Use of Force Policy" and Exhibit A filed thereto (CDCR Notice of Change to Department Operations

Manual) filed in the Northern District of California in *Madrid v. Cate*, Case No. 90-cv-3094 (Hon. Judge Thelton E. Henderson, presiding), on August 30, 2010 (Docket Nos. 2181, 2181-2).

9. Attached hereto as Exhibit 8, is a true and correct copy of a letter dated March 22, 2013 from Joel Badeaux, MD, MPH to United States Attorney General Eric Holder, with four enclosures. As reflected in the email attached as the first page of Exhibit 8, Dr. Badeaux sent a copy of this letter and enclosures to Michael Bien at my office on Sunday, March 24, 2013. The letter, written by a Salinas Valley Psychiatric Program (SVPP) psychiatrist, details grave concerns about safety conditions within the California prisons' mental health system, and specifically the SVPP the provided *Coleman* class members with Department of State Hospitals (DSH) inpatient level of care. Dr. Badeaux states that the State is "unable or unwilling to provide a mental health system that can adequately provide for the health and welfare of the mentally ill" and others, and requests that the U.S. Department of Justice provide "urgent assistance and prevent further needless injury and death."

10. Attached hereto as Exhibit 9, is a true and correct copy of the Enclosure entitled "Mental Health Adseg/SHU/PSU," dated January 18, 2013, excerpted from Defendants' January Coleman Monthly Data, which is provided to plaintiffs via their FTP site. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. This document was uploaded to an FTP site used by the parties to facilitate document transfers by defendants and downloaded by a paralegal in my office.

11. Attached hereto as Exhibit 10, is a true and correct copy of excerpts from the transcript of the deposition of Charles Scott taken March 8, 2013 in Davis, California and lodged with this Court on March 15, 2013.

/ / /

/ / /

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct, and that this declaration is executed at San Francisco, California this 25th day of March, 2013.

/s/ Aaron J. Fischer
Aaron J. Fischer

Exhibit 1

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Transcript of the Testimony of:

Joel Dvoskin, Ph.D., ABPP

Coleman v. Brown

February 27, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JOEL DVOSKIN, PH.D., ABPP

WEDNESDAY, FEBRUARY 27, 2013, 9:14 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JOEL DVOSKIN, PH.D., ABPP, taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:14 a.m., on Wednesday, February 27, 2013, at Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

APPEARANCES OF COUNSEL:

FOR PLAINTIFFS:

BY: MICHAEL BIEN, ESQ.
AARON FISCHER, ESQ.
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BY: HEATHER L. McCRAY, ESQ.
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records system for CDCR as part of your work?

A. Technically, yes. Practically, no. It is a disaster.

Q. What --

A. I never had any success getting on it. So when I wanted to see something, I just asked somebody to find it for me.

So I was able to look at the EUHR for people, but I always had a guide because I found it very difficult to use. I would look for a treatment plan in the treatment plan section, and the person would laugh and say, "Well, might be there, but it might be somewhere else." And so we'd look in the "All Forms" tab and just -- so it was pretty time-consuming.

I think I made pretty clear in my record I cannot for the life of me understand why they don't have electronic medical record. It's inexplicable.

Q. What do you mean? They call that an electronic medical record.

A. No, they don't. Nobody calls it that.

Q. What do you --

A. I don't know who said that, but not with a straight face. It is not an electronic medical record.

Q. Okay. What -- in your mind, what's the difference between what you called an electronic medical

record and the EUHR system that you saw at CDCR?

A. Well, first of all, it's very time-consuming for clerical staff. They have to scan documents into it. Documents are often difficult to read because they're handwritten.

An electronic medical record is where everything is electronic. Forms are filled out electronically. They're instantaneously available. You don't have to wait for them to be scanned in. They're organized in a more useable fashion. The -- where things are filed isn't a matter of chance based on who scanned it but, rather, the form itself is designed to be in a predictable place.

This is not an electronic medical record.

Q. Okay. When I was touring the last couple of weeks, I was also -- been in the prisons. I had the experience, and I assume from your notes that you had the same experience, where you'd be in some unit and the -- the electronic medical record wasn't available because there was no computer.

Did you experience that when you were in CDCR?

In other words, to access the electronic medical record, you need to have a computer attached to the system. That seems obvious, but...

A. I quit asking about that early on. So what I

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 1, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 2

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Transcript of the Testimony of:

Edward Kaufman

Coleman v. Brown

March 16, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

AND NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	Case No. Civ S 90-0520 LKK-JFM P
MARCIANO PLATA, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	Case No. C01-1351 TEH

DEPOSITION OF EDWARD KAUFMAN, M.D., taken on behalf of the defendants, at 32392 South Coast Highway, Suite 250, Laguna Beach, California, commencing at 10:00 a.m., Saturday, March 16, 2013, before Audrey L. Ricks, Certified Shorthand Reporter, No. 12098, CCR, RPR, CLR.

APPEARANCES:

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For Defendants:

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"constitutional" was used.

Q So none of your evaluation was done with an eye to determine whether or not it was deliberately indifferent to the inmates' subjective or serious medical needs?

A Again, that's a legal term that I didn't use in my assessment of the condition.

Q Okay. So what did you base your assessments against?

A I based it on an issue -- first of all, certain community standards, certain standards of care in other correctional facilities that I have visited.

I based it on damage to the mental health of inmates and inmate patients, and on the adequacy of the therapy to treat the needs of mentally ill and seriously mentally ill inmates.

Q So when you were rendering the opinions that you issued in your report, you were looking at community standards, what you had seen -- observed at other correctional facilities, and then individual care of each patient that you evaluated?

A As to whether or not the treatment was inadequate or damaging to their mental health.

Q Okay. Are you aware that the

A Approximately 20.
Q And did you look to determine whether or not a diagnosis was made?
A Yes.
Q Whether medication was -- was prescribed?
A Yes.
Q Whether the medication was appropriately prescribed?
A To some extent, yes.
Q And did you look to determine whether or not the doctor was monitoring the medications?
A Yes.
Q Was there anything else that you looked at in those charts to determine whether or not the care was, in your opinion, within community standards?
A Well, I was looking at the charts to see if some of the comments made by inmates about their care was validated by the chart or not.
Q Okay. So after your conversations with the inmates, you then looked at their charts to confirm what they had told you?
A Correct.
Q Okay. With respect to the charts that you did review and the inmates that you interviewed -- well, I guess I will ask separately because the

were those inmates selected?

A When we went to each unit, my recollection is that we would ask for inmates who had prolonged stays.

I think there were a few inmates that Ms. Mendelson had advance knowledge that they have extended stays in SHU or AD-SEG.

Q Okay. Any other way that they were selected?

A Not that I recall.

Q Okay.

A By the way, I just recalled another mental health expert whose name I've heard, and that's Pablo Stewart --

Q Thank you.

A -- who is the other psychiatrist involved.

Q Okay. Thank you.

A Whom I have never met.

Q So for the 20 inmates that you interviewed, did you review all of their medical records?

A Yes -- actually, let me correct that statement. I -- I read each of their medical records. I didn't read all of their -- each of their records because I only read the record that

was provided to me.
Q Do you know what was provided to you?
A It's in an individual case, and it would be the record going back maybe a year or two, maybe some history dating back further. But it didn't seem to be a voluminous, total record, but rather a record of the last year or so in general.
Q Okay. And were there any specific parts to those records that you looked at?
A I focused mainly on the psychiatric evaluations, on the treatment team meetings and treatment team recommendations, on the psychiatric evaluations, the psychotherapy notes, and the compliance with medications.
Q Was there anything that wasn't provided to you that you wish you would have had to look at?
A Not to my knowledge.
Q So looking at your opinion on page -- starting at page 7 of your declaration regarding staffing shortages, I'd like to ask you some -- some questions about that. Okay?
A Yes.
Q So with respect to your opinion on staffing shortages, what are the basis for those opinions?

were visiting.

A Do you have the page?

Q No. I'm asking you if you know what the current --

A No. I don't know what they are currently, no.

Q Okay. What about at CCWF? Do you know what the current staffing ratios are?

A Not as of today, no.

Q What is your opinion on what the Constitution requires in terms of staffing?

A Again, you're using the term "constitution." I would use the term "the ability to provide humane treatment that avoids inmate suffering and psychological decompensation."

And basically, in terms of the numbers, what I'm pointing out is decreases in the system, unfilled positions within the system, and extended sick leave of almost a third of psychologists within the system of one facility.

Q Well -- and your position is that it adversely impacts their mental health care?

A Yes.

Q Okay. But can you give me any examples of an impacted health care?

your list here that that happened to? You talked about Prisoner B. But anybody else?

A Prisoner C was seen at cell front by her clinician because there was a shortage of staff escorts.

Q But how does that show that the amount of treatment was reduced simply because she was seen at the cell front?

A Because in general, the visits at the cell front, as I said before, do not provide sufficient therapeutic contact. Again, it's my impression they tend to be briefer --

Q Did you observe a cell-front visit?

A The only cell-front visit I recall observing was a psychiatric technician walking by a row of cells.

Q So when -- when you say that they're inadequate, you're basing that on what?

A Basing that on what usually happens when someone is seen cell front as opposed to seeing them in a confidential setting where the therapist can sit comfortably and have eye contact.

Q And how do you know what usually happens if you haven't observed one?

A I only know what is -- is my custom and my

understand, but on page 9 it specifically says that she's a CCCMS.

BY MS. ANDERSON:

Q So paragraph 49, you referenced Prisoner B as having a high number of cell-front contacts because of a lack of available confidential space.

Did you verify this with her health record, her medical record?

A Yes. The quote is from her medical file.

Q Okay. And did you see any other patients -- were you able to confirm in their medical record that contacts had occurred simply because of lack of available confidential space?

A Well, it says Prisoner A -- it said most of her interactions with clinicians consist of someone walking by her cell, presumably a psyche tech, and calling out, "Everything okay?" That's obviously not a confidential interaction.

Q Well, it might not be confidential, but it doesn't relate to whether or not there was a lack of available space, or are you now saying that Prisoner A was talking to the psyche tech at the cell front because of lack of available space?

A No, I'm not saying that. I'm referring again to paragraph 48, that several patients at CCWF

about mental health needs being met are more general rather than specific. To try to say that any one issue results in somebody decompensating is -- is difficult to do.

But what I'm saying is that the totality of the lack of therapy and the overall conditions, including the overcrowding, are what contribute to her decompensation.

Q And so is it your position that because of these circumstances, the medical -- mental health care providers should have known that she needed -- they needed something different?

A Yes.

Q Okay. So let me take you --

A Yeah. Let me -- we could go through every one of the 20 cases that I have, and I could elaborate on whether I think they fulfill a deliberate indifference or not, or my substitution for deliberate indifference, which is knowing that other more comprehensive and humane treatments would prevent unusual suffering and decompensation.

Q Okay. I'm going to direct your attention to 20 -- or page 22, in terms of Prisoner T.

We're -- we're still on the issue of medication management or medication interference.

A No.
Q So is that consistent with your position -- with my statement, that they shouldn't be in a prison?
A I think there are some mental -- there are some mentally ill people that have to be in prisons. But I think it's -- if we had adequate psychiatric facilities, the percentage of mentally ill that are in prison would be enormously reduced.
Q Doctor, I'm going to ask you some questions now about your qualifications as an expert. Okay?
Do you have any prior experience before this case as working -- as working as an expert?
A Yes.
Q And could you please tell me every situation in which you've been retained as an expert?
A Well, besides all the ones in prisons that I mentioned, and I don't know if I mentioned Pennsylvania or not, but that was another one where I was retained as an expert.
In addition to prison work --
Q Let me just ask about prison work to save some time.

I, Audrey L. Ricks, CSR 12098, do hereby declare:

That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn pursuant to Section 30(f)(1) of the Federal Rules of Civil Procedure and the deposition is a true record of the testimony given by the witness.

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to text under my direction.

That the witness was requested to review the transcript and make any changes to the transcript as a result of that review pursuant to Section 30(e) of the Federal Rules of Civil Procedure.

No changes have been provided by the witness during the period allowed.

The changes made by the witness are appended to the transcript.

No request was made that the transcript be reviewed pursuant to Section 30(e) of the Federal Rules of Civil Procedure.

I further declare that I have no interest in the event of the action.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

WITNESS my hand this 17th day of March, 2013.

_____

Audrey L. Ricks, CSR 12098

Exhibit 3

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Transcript of the Testimony of:

Jacqueline Moore, R.N., Ph.D.

Coleman v. Brown

February 21, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JACQUELINE MOORE, RN, PH.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:50 a.m., Thursday, February 21, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

APPEARANCES OF COUNSEL:

FOR PLAINTIFFS:

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November -- the first site visit may have been in February.

BY MR. FISCHER:

Q. This is not including the initial visit to Sac; is that correct?

A. Exactly.

Q. Okay. Before I move ahead, in your report, is there any discussion of the overcrowding trial?

A. Not that I'm aware of.

Q. You're aware that Supreme Court made their decision in the overcrowding case in the summer of 2011?

A. Yes.

Q. Was there a decision not to include any discussion of overcrowding in this report?

MS. VOROUS: Objection. The questions with respect to overcrowding are beyond the scope of the issue -- beyond the scope of the issues raised in the motion to terminate and beyond the scope of what was requested in terms of the expert consultancy in this case.

Go ahead and answer if you can.

THE WITNESS: We didn't look at overcrowding.

BY MR. FISCHER:

Q. Did you think that overcrowding wasn't relevant to the issues that you were asked to look at?

MS. VOROUS: Objection. Again, beyond the scope of the issues to terminate in Coleman and the scope of the consultancy of Dr. Moore in this case.

Go ahead and answer if you can.

THE WITNESS: We had specific issues that we were looking at, and those issues consumed four of us for the time we were on site. We didn't have time to become involved in every issue that CDCR has.

BY MR. FISCHER:

Q. Including overcrowding?

A. Including overcrowding.

Q. Okay. On your tours, did you find that crowding was impacting care at any of the institutions?

MS. VOROUS: Objection. Beyond the scope of the issues that are in dispute with respect to the motion to terminate. Beyond the scope of Dr. Moore's motion to consult in this case and expert report.

I'm sorry. I'm speaking too low. Beyond the scope of the issues that are in dispute and beyond the scope of Dr. Moore's expert opinion in this case.

THE WITNESS: Do you want me to answer?

BY MR. FISCHER:

Q. Yes, please.

A. The areas that I went to -- and I did not go to every housing area in the jail -- I did not find that

discharge planning at the institution?

MS. VOROUS: Objection. Misstates her testimony.

THE WITNESS: Yes.

BY MR. FISCHER:

Q. Okay. And one last thing on CIM I wanted ask you about in your notes on the final page, 102633.

Most of the way down next to No. 5, it says: "Nurse UNFAM, SE, psy meds."

What does that note refer to?

A. Nurses were unfamiliar with the side effects of psychiatric meds.

Q. I imagine that's on your radar because you're a nurse?

A. I asked them.

Q. Why did you ask this question?

A. I asked all the institutions. That was one of the criteria on my audit tool.

Q. And here -- SE is side effects?

A. Side effects.

Q. And is this particular CIM of concern to you in your analysis?

A. Yes.

Q. Why is that?

A. Because it's a common practice that nurses

know the side effects of the medication that they're giving because very often you are the one that might observe lithium toxicity in an inmate.

Q. So it's important to be aware of the side effects of the psych medications in order to ensure the safety and well-being of those patients?

A. Yes, sir.

Q. Did you observe this problem at any other institutions? Do you remember?

A. Yes.

Q. Do you remember which institutions?

A. All of them except San Quentin.

Q. San Quentin?

A. Knew the side effects.

Q. They were good?

A. They were good.

Q. Did you raise this with -- at the exit interviews?

A. Each and every time.

Q. Did this make it into your report?

Direct you to page 26 of your report, Exhibit 4.

Tell me if I'm looking at the right -- bottom, "Nursing Medication Management." Just a short section.

Is that an issue you think could have been put

in the report if you were writing it?
A. I think I would have phrased it differently.
Q. What would you have phrased differently?
A. I would have made a recommendation that nursing education emphasize the side effects of the medication and that they have handouts or signs available where they dispense the medications so these things would be in front of them all the time.
Q. All right. Back on page 19 very briefly. It says: "At Corcoran, inmates reported from the EOP special needs yard that yard time was canceled for various reasons on a relatively frequent basis."
You didn't visit the EOP special needs yard?
A. No, I did not.
Q. Were you aware of this issue at the institution?
A. No, I was not.
Q. From a mental health perspective, is it concerning to you, given your expertise, for EOPs to be denied yard time?
A. Yes.
Q. And why is that?
A. Inmates need to go outside, exercise, socialize.
Q. And the lack of that opportunity can adversely

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

Megan F. Alvarez

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 4

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Transcript of the Testimony of:

Pablo Stewart, M.D.

Coleman v. Brown

March 19, 2013

Volume I

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UNITED STATES DISTRICT COURTS

EASTERN DISTRICT OF CALIFORNIA

AND NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. Civ S 90-0520 LKK-JFM P
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	
MARCIANO PLATA, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. C01-1351 THE
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	

DEPOSITION OF

PABLO STEWART, M.D.

TUESDAY, MARCH 19, 2013, 9:00 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: BRENDA L. MARSHALL, RPR, CSR NO. 6939

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. Civ S 90-0520 LKK-JFM P
MARCIANO PLATA, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. C01-1351 THE

The Deposition of PABLO STEWART, M.D., taken on behalf of the Defendants, before Brenda L. Marshall, Certified Shorthand Reporter No. 6939, Registered Professional Reporter, for the State of California, commencing at 9:00 a.m., at the U.S. Department of Justice, Office of the Attorney General, 455 Golden Gate Avenue, San Francisco, California.

APPEARANCES OF COUNSEL:

FOR PLAINTIFFS:

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Q. So you have based the opinions in your report, which I'm going to ask you about in detail, on your visits to five institutions; correct?

A. Well, on my visits to five institutions, as well as reviewing materials that have been provided, like management reports, special master's reports -- what's that one that gives you the statistics on amount of vacancies -- monthly statistical report. I forget all the names, there's a lot of reports, and I don't know if I can give you all the names right now, but it's those additional documents, besides my tours.

Q. Did you look at that information with an eye toward the institutions that you visited?

A. I looked at those materials both with an eye toward the institutions that I visited and to get a sense if -- to confirm whether or not the findings that I saw, the opinions that I arrived at, and the things that I found, basically, in the tour were present systemwide.

Q. And so your -- the information -- aside from what you personally observed at the five institutions, the information that you are relying on regarding systemwide comes from management reports and the special master reports, as well as this other statistical information?

A. Yes. And other documents that I list there.

Q. And those documents, are those the ones that are

attached to your declaration as well?
A. Yes.
Q. Okay. Please list for me the five institutions that you visited.
A. I visited Salinas Valley State Prison; California State Prison Sacramento; I call it Lancaster, but it's the Los Angeles County State Prison, something like that, R.J. Donovan, and San Quentin.
Q. Okay. And so let's start with the first one, Salinas Valley. How much time did you spend at Salinas Valley?
A. I spent a long day there.
Q. Okay. One day?
A. Yes.
Q. And define "a long day" for me. How many hours?
A. I got there early and left late. We had a meeting with staff that I believe began at 8:00, 8:15, in that range, and we went until 6:00. Something in that range.
Q. Okay. And how many facilities did you visit at -- was I asking about Salinas Valley first?
A. Salinas Valley, yes.
Q. And how many facilities did you go to at Salinas Valley?
A. What do you mean, "facilities"?

GP? Did you go to any general population yards and talk to CCCMS inmates?

A. I don't believe I did. I know I spoke with CCCMS in the ad seg unit.

Q. Okay. Counsel just raised a good point. You didn't provide any notes with your report --

A. Correct.

Q. -- right?

Did you take any notes during the visit?

A. I did not.

Q. Okay. Do you have a photographic memory?

A. Even though it may not seem that way today, I have a pretty good memory in the -- in the -- in sort of the short and intermediate term. So -- so, yes, to answer your question.

Q. Okay. You have -- you didn't take any notes, but then you were able to generate a 167-page declaration based on specific information regarding the visits --

A. Correct.

Q. -- correct?

So you didn't write anything down?

A. I did not.

Q. And how is it that you recall all the specific details to prepare the declaration without taking any notes?

A. Well, my way of working, and I've worked with Mr. Nolan in the past, so we have a -- our sort of style that has worked, to be able to produce a document like this is that immediately after the visit, we would review exactly what we did and go -- and review, like, okay, what did we do at the EOP ad seg, for example, what did we do at the EOP GP unit, and who did we see there, and let's review what the findings were, what my opinions were at that time, and he would then start -- I dictated to him the beginnings of the report.

Q. Okay. So did you do that in the car, or were you in another office, or where did you do that?

A. Well, because of the fact that, you know, the Salinas Valley visit was on a Monday, and then we were at CSP SAC on Tuesday so we did that in the car, immediately afterwards.

Q. Okay. And did he write down what you were telling him?

A. Yes.

Q. Okay. So that happened at Salinas Valley; right?

A. Yes.

Q. Okay. And so, then, after -- did that happen at every institution that you visited?

A. That was how we worked. Yes.

Q. That was how you worked. Okay. How much time did you spend talking about your findings at Salinas Valley State Prison, dictating to Mr. Nolan what -- what you had seen?

A. Well, when we left Salinas Valley, what -- I remember we did some work right in the parking lot. I wanted to get some ideas down while they were still fresh. And then we drove, and we stopped for something to eat, and we worked during our food stop.

And then we continued to drive. I was driving, and Mr. Nolan had his laptop, and so I was dictating while we were driving.

So the drive from Salinas Valley all the way to New Folsom, however far that area of Sacramento is, so at least those hours, plus time in the parking lot, plus time at our dinner stop.

Q. So would you say two hours? Three hours?

A. I'd say more like -- boy.

MR. NOLAN: Do you know the drive? The drive is probably about five hours. Four or five hours.

THE WITNESS: Yeah. I was going to say, you know, five hours minimum. Because we didn't get to the hotel that night until almost midnight. Something around in that range. So the whole time, we were working.

BY MS. ANDERSON:

Q. So for five hours, you were dictating to Mr. Nolan what to put in the report?
A. Yes.
Q. Okay. So just so I'm clear about the process, so you went to the prison, you dictated to him all your findings and the specifics about each inmate that you had met with, and then he typed that into the report?
A. Yes.
Q. Okay. And what about information that's in the report you reviewed after the fact? Because there's information regarding inmates that you reviewed later; right?
A. Yes.
Q. So how did you deal with that? Did you take any notes about that?
A. No. I did not take any notes. Are you referring to reviewing medical records?
Q. Yes. And other things. I mean, in your declaration, you reference medical records and other -- other documents that influenced your decision. So what did -- how did you deal with those? How did you insert that information into the report?
A. Well, when I reviewed it, you know -- again, Mr. Nolan and I worked on this together, and so he had gone to San Quentin, I believe, where they had the setup

to copy out medical records. So the people that we had seen, he had gotten their medical -- their pertinent portions of their medical records. And --

Q. Who decided what the pertinent portions were? Did you tell him what you wanted to look at?

A. Yes. I told him that I needed to have treatment plans that went back several iterations.

Q. Was there a period of time that you were looking at a -- I mean, I'm not sure what "several iterations" means. That could be a week, a month. How long -- how far back did you look at records?

A. It was a range. It was around a year to maybe a year and a half. Sometimes two years. And, also, besides just treatment planning, medication records, doctors' orders, progress notes, and any other events that may have happened to a particular inmate, such as MHCB admissions, DSH referral packets, and, in some of the cases, there were records from DSH, due to a recent DSH admission.

So those were all part of what I instructed Mr. Nolan to get.

Q. Okay. So did you actually physically look at any records, or you relied solely on what was provided by Mr. Nolan?

A. Oh, I --

Q. Did you pick up an inmate's medical file and

look at it?

MR. NOLAN: Just so the record is clear, the inmates in the CDCR don't have physical medical files. They have an electronic file.

MS. ANDERSON: I think that's in dispute. I think that's one of the issues that I'd like to explore with Dr. Stewart.

MR. NOLAN: Okay. Go ahead.

BY MS. ANDERSON:

Q. So --

A. Well, to answer your question, did I ever physically pick up a medical record during the tours?

Q. Or later. I mean, not just during the tour, but did you actually look at the medical record of an individual who you were talking to? Or evaluating?

A. Yes.

Q. And who -- which inmates were those?

A. Well, during the course of my tours, you know, I was accompanied by a whole group of individuals -- mental health people, chief psychiatrists, or acting chiefs, all these different people -- and, oftentimes, I would ask them -- I decided which people I wanted to interview, and then I said, "Could you please get me what their current diagnostic assessment is and what their current medications and treatment plan include."

And they would go to a -- you know, a kiosk, or however they do it, they print it out and bring it back to me so I'd have it there.

During the course of my interviews with inmates, or shortly thereafter, I certainly consulted with the staff about diagnostic assessments that they had of inmates.

Q. And were they printing -- you said they were printing it out. Were they printing it out from the EUHR, the electronic health record?

A. Yes. Yes.

Q. How did you decide which inmates that you wanted to interview at the institutions that you visited?

A. Well, it depended. I think we should be more specific about which institutions.

Q. So you had a different process at different ones? I'm just trying to find out --

A. No. I understand. It wasn't -- it was the same process overall, but it depended on where, like I said, we went, to the ad seg EOP versus going to a mainline EOP.

Q. Okay. And I know that in your report you indicated that, in some circumstances, you looked at the length -- the inmates who had been there the longest or had the most acuity, things like that.

A. Yes.

complaints by CDCR staff that people were sent back from DSH prematurely --

Q. Did you verify that yourself or --

A. Yes. And then I went to -- I interviewed these people, I evaluated them --

Q. The inmates?

A. -- the inmates, and found that, you know, they had recently, within weeks or maybe a month, at the most, had been in a DSH program. And that -- and then, soon after their return to the sending facility, they were deemed to need to go back again because they really hadn't gotten any clinical benefit of being there.

There was that. There was the complaints of the staff, one area that sort of alerted me to this problem. Then, evaluating these guys that had recently been returned really highlighted how sick they still were, in spite of recent stays in DSH.

Q. Can you tell me about the evaluations that you did on these inmates that had recently been returned from DSH? Did you --

A. Okay. Let me finish that other part about how I knew that these people were sent back.

In the most -- I don't want to say "elaborate," but the most detailed conversation I had about this issue was one of the treating psychiatrists in the unlicensed

MHCB at CSP SAC. He was a registry doctor who actually was going to have to stop working a week or so after I saw him because he had already expended his hours, but he -- I introduced myself to him, and he asked me if I wouldn't mind consulting with him, as a colleague, around this particular issue, around this particular inmate.

And so in this particular case, we had the medical record. He had it right there. It was actually a -- I don't remember if it was a paper record or electronic record in the unlicensed MHCB. But we looked at the medical record, we confirmed that this person had recently been sent back from a DSH program and was exceedingly psychotic and met referral criteria for DSH, and he was on two long-term, long-acting, injectable antibiotic psychotic medications.

So I was having a collegial consultation with this psychiatrist about how clinically -- because he was lost, what to do with this guy, quite frankly. He wasn't sure. So we were, you know, just consulting. You know, I said, "Well, maybe you want to try this med" or "do this sort of maneuver," trying to stabilize this guy while he was waiting to go back to DSH.

Q. Is that the psychiatrist that you're referring to in your report about the premature discharges?

A. If there's --

MR. NOLAN: Is there a particular place in his report that you would like to refer him to? He talked to many psychiatrists, I believe.

THE WITNESS: Yeah.

BY MS. ANDERSON:

Q. Well, you refer to staff, but you're not mentioning a specific position.

A. No. I believe, in the report, it was at the MHCB, unlicensed unit at CSP SAC, and the doctor was a registry person.

Q. Okay. So other than this -- this specific consultation that you had with this clinician, did you -- what process did you use to evaluate any other inmates that you thought had been prematurely discharged?

A. Well, again, I didn't -- I hadn't arrived at that opinion yet. I hadn't arrived at the -- I said, "Well, show me the people that were prematurely discharged, and then let me see them."

I -- I asked for who are the people -- I've forgotten -- the conversations with staff is usually the MHCB director and the psychiatrist. They would alert me to the fact that we had -- we sort of went through the MHCB and said, "What about this guy? What's going on with this guy?" And they alerted me that there were several people that had recently been discharged from DSH that

they needed to -- that they were holding there because they were rereferring them back.

Q. And did you review the discharge summary from DSH to see --

A. And in certain places, I reviewed the discharge summary, I looked at other -- their current medical record, I consulted with both the psychologist and the psychiatrist involved in the case, and I did a personal interview.

Q. So how many of these did you do?

A. Of the recent returns and --

Q. Yes.

A. I don't know an exact number. I know that at R.J. Donovan, in the MHCB, there was, like, 11 patients, and I believe it was -- five or six of them were in this category.

Q. What about at the other institutions?

A. And at CSP SAC, there was a significant number. I forget the number. It was more than 10 that were in this category. So it was -- I didn't look at all of them. Okay?

Q. But you did at Donovan and SAC?

A. No. I didn't look at everyone who was waiting to return back to DSH. I didn't look at every -- I didn't personally evaluate every inmate.

didn't have -- there was no evidence that it was occurring, during my tours, at least.

Q. Okay. Doctor, is recreational therapy constitutionally required?

A. If there's a serious medical need that's been identified that can only be addressed by recreational therapy and then they don't do it, then that would not be constitutional.

Q. And would that be a case-by-case basis?

A. Yes.

Q. Doctor, are you aware that telepsychiatry started at Salinas Valley State Prison January 31st of 2013?

A. I was informed that that was the plan. I'm not aware that it has actually happened.

Q. In paragraph 72 of your report, you mention that staffing problems at Salinas Valley played a significant role in the problems of the delivery of mental health care that you observed.

A. Yes.

Q. Can you identify a specific inmate for me who didn't get mental health care?

A. Well, all of the EOP members weren't getting proper mental health care.

Q. Because of staffing problems?

Q. Well, in your opinion, should -- based on your evaluation and your discussions with the staff, do you think he should have been forcibly medicated? You mentioned he doesn't meet the criteria for Keyhea, but did you think, in your opinion, he should have been forcibly medicated?

MR. NOLAN: That misstates what he says. Right here, it says not that that's the doctor's opinion, but possibly this is because of the belief that he does not meet the criteria.

MS. ANDERSON: Thank you.

Q. So staff didn't think he --- well, so what do you think?

A. Well, again, based on the severity of his symptoms and the fact that he had -- there were notes that he was -- had been obstructing staff and for assault from the last few months, it certainly seemed to me that he should at least be considered for involuntary medication.

Q. And you also mentioned that Prisoner W needs inpatient level of care before he hurt someone else.

Did you give your opinion to the chief psychiatrist? Did you tell anybody, not just the chief psychiatrist, but -- that you thought he should be put in inpatient level of care?

A. He was one of a relatively large group of

individuals that I felt needed to access higher levels of care, and in certain cases, I did relay my opinions to staff; in some cases, I didn't. And I don't -- I don't know if I did in this case.

Q. Why not?

A. Well --

Q. I mean why some, not others?

A. In some, the staff were available and willing to talk. Okay? In other cases, and I don't know if it's the case in this particular example, but I was blocked off from accessing staff. Other staff were involved in sort of shunning people away. When I would try to talk to them, they would take them away. And I had -- I didn't have, in all cases, ready access to the staff to have an open and unobstructed collegial conversation.

Q. Where were they shunning them away from you?

A. I'm sorry?

Q. Where were they shunning them away?

A. Oh, that happened in -- it certainly happened in R.J. Donovan, where I wanted to speak with the psychiatrist on a particular case. And when I approached the psychiatrist, the -- the -- I don't know if it was -- if she was acting or the actual chief of mental health, but a woman sort of literally got between me and this doctor and said, "I'm just talking to -- I'm talking to

one of my staff. You have to wait. You can't talk to him now." And then she took him off to the side and gave him a parting line is what it looked like.

So that certainly went on.

Q. So did that happen anywhere else besides Donovan?

A. It -- it occurred at -- to a lesser extent at Lancaster. It -- it didn't occur at Salinas Valley because the psychiatrist was nowhere to be found. So I didn't have access to the psychiatrist at all.

At CSP SAC --

Q. Well, can I --

MR. NOLAN: Let him --

THE WITNESS: -- I had fairly good access to the psychiatrist, and I described that one collegial discussion I had about unlicensed MHCB unit with that -- with the registry doctor.

BY MS. ANDERSON:

Q. So you said that there were -- or were there mental health staff from the prison that accompanied you on the tours?

A. Yes.

Q. Okay. So even if you couldn't have spoken to a psychiatrist, was -- could you have mentioned something to the person on the tour with you?

A. Theoretically, and in -- I'll tell you why I didn't speak to the staff, say, about my opinions where this guy needs to be in a hospital because that's my opinion, and I think it was a very well-founded opinion, based on review of the medical records, etc., but it was an opinion.

Now, if I felt someone were suicidal, on the other hand, then I would -- was acutely suicidal, then I would absolutely let people know, but I did not encounter that in any of my tours with someone I evaluated. I always asked about suicidality, and I never met someone who said, "Yes, I'm going to kill myself now" or "I'm thinking about it really seriously." Nothing like that.

In fact, there was a lot of times where I would counsel the members, people that were -- had reported to me that they feel suicidal a lot of the time, but they didn't feel suicidal at the moment, I'd ask them, "So what would you do if you're feeling suicidal?"

And they said, "I don't know."

I said, "Well, you should talk to your staff. Talk to staff."

So I would do that, but I didn't encounter anybody that I felt I needed to have an immediate clinical intervention on.

MS. ANDERSON: Okay. Are we now at an hour?

CERTIFICATION OF DEPOSITION OFFICER

I, BRENDA L. MARSHALL, CSR, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, hereby certify that the witness in the foregoing deposition was by me sworn to testify to the truth, the whole truth and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of said witness was thereafter transcribed by means of computer-aided transcription; that the foregoing is a full, complete and true record of said testimony; and that the witness was given an opportunity to read and correct said deposition and to subscribe the same.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, or in any way interested in the outcome of this cause named in said caption.

_____

BRENDA L. MARSHALL

CSR No. 6939

Exhibit 5

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Transcript of the Testimony of:

Diana Toche

Coleman v. Brown

February 22, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

DIANA TOCHE

FRIDAY, FEBRUARY 22, 2013, 9:00 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of DIANA TOCHE, taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:00 a.m., Friday, February 22, 2013, at the offices of Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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ALSO PRESENT:

MARC SHINN-KRANTZ, PARALEGAL

coming?
A. Right.
Q. Is that fair to say?
A. Yes.
Q. Were there layoffs in 2012 of mental health staff, to your knowledge?
A. You know what? I can't remember specifically.
Q. To your personal knowledge, you're not sure?
A. Yeah. I mean, there's spreadsheets of people and -- I mean, it's -- so...
Q. Okay.
A. If I had a spreadsheet, I could tell you.
Q. Let's talk about some specifics. I know it's hard to talk generalities.

So looking back at your declaration, in paragraph 6, you start off by saying that the state developed a comprehensive staffing allocation plan in 2009 for each mental health program and administrative function.

Are you familiar with the development of that staffing plan?
A. I know that they had a group work on it. That's how I'm familiar with it.
Q. Is that what you know?
A. Yes.

Q. Is that everything that you know about the development of that?

A. Yes. Pretty much.

Q. You write that, under that staffing plan, it was approved by the legislature in fiscal year 2011 to 2012. So the fiscal year 2012 to 2013 systemwide mental health position authority, which is based on the 2009 plan, totals 2,268.26.

What does that mean, "authority"?

A. That you have -- you can establish the positions.

Q. All right. Who says you can establish the positions or what says?

A. You're given authority.

Q. By?

A. By the legislature and department of finance to establish the positions.

Q. What does it mean to establish a position?

A. So you have funding behind the position and you can establish the position.

Q. And what does that look like on the ground? How is the position established?

A. I believe with a 607.

Q. Okay. What about when you write "funding allocations for fiscal year 2012 to '13 represent nearly

We're -- you know...

Q. Okay. So was there anything in particular going on in July that led to this, or was this -- was there anything in particular in July?

A. Like an impetus?

Q. Any particular impetus?

A. I don't recall if there was a particular impetus specific to July. I don't recall.

Q. You write in this memo -- and we touched on just a little bit early -- on the first page, your first bullet point there: "Current receiver's freeze exemption request process will continue to exist for filling of all MHP vacant positions."

A. Uh-huh.

Q. Can you explain to me what the freeze exemption request process is?

A. So in July they -- they fill out a freeze exemption to hire for specific positions.

Q. Why is that necessary?

A. It's necessary for the review due to the whole layoff process to ensure that we're staying in line with that process.

Q. So the receiver has a process to request exemption essentially from hiring freezes.

Is that my understanding?

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 5, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 6

TLS | THORSNES litigation services

Transcript of the Testimony of:

Eldon Vail

Coleman v. Brown

March 19, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

ELDON VAIL

TUESDAY, MARCH 19, 2013, 9:10 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of ELDON VAIL, taken on behalf of the Defendants, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:10 a.m., Tuesday, March 19, 2013, at the Attorney General's Office, 455 Golden Gate Avenue, 11th Floor, San Francisco, California.

APPEARANCES OF COUNSEL:

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FOR DEFENDANTS:

BY: JAY C. RUSSELL, ESQ.
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BY MR. RUSSELL:

Q. And when you say "too much gas," you're basing that upon what you viewed in the videos, correct?

A. Correct.

Q. You didn't see any reports about the measured amount of spray that was used in any of those videos, did you?

A. Well, as Mr. Martin points out, it's not measured in the State of California, so there's no way to tell exactly how much. You look at the size of the canister that's being used to deploy it, and you can count the seconds that the trigger is pulled. And you can count the seconds between the time the next trigger is pulled and you can add up how many times. And you count the grenades that are thrown in. And those were pretty darn frequent. Not just in the videos but in the use of force reports.

Q. But as you say, the fact is that there is no way to tell how much spray is actually being deployed in these videos; is that correct?

A. And that's a flaw.

Q. But that is correct, right? There's no way to tell?

A. There is no measurement of the spray in California.

of force videos; is that correct?
A. That the final total.
Q. Excuse me. Paragraph 30.
MS. CESARE-EASTMAN: I believe he reviewed every video provided by CDCR.
THE WITNESS: 18 is the number that was provided by CDCR.
BY MR. RUSSELL:
Q. How many of those did you see similar instances of too much paper spray used?
A. I didn't count them.
Q. At paragraph 59 you state you that "This pattern" -- and I presume that that's the pattern of too much spray used with too short of an interval between applications -- "is also reflected in a majority of the use of force reports."
Again, do the use of force reports talk about the amount of spray used?
A. Frequently.
Q. And how is it -- is that expressed in terms of volume or of -- how is that expressed in those reports of how much pepper spray is used?
A. It's usually, from what I was judging, there is frequency of disbursement -- if that's the right word -- where there was multiple times where they would

spray into the cell, where they would also list the kind of equipment that they would use to spray into the cell, when they would throw in a grenade in and how many grenades they would throw in.

And oftentimes it was in combination of multiple sprays from dispensers, sometimes different dispensers, including what's called the BRD, which is, I think, a battering ram device but attached to it is a fire extinguisher sized canister, and then also the different grenades that were dropped in.

Q. But, again, there's no actual measurement of the amount of chemical agent that's used in those instances that reflected in the use of force report, correct?

A. There's no actual measurement, that's correct.

Q. And when you say that -- that the pattern is reflected in the majority of the use of force reports, what do you mean by "the majority"?

MS. CESARE-EASTMAN: You're referring to paragraph 59?

MR. RUSSELL: Yes. I'm sorry. I should have stated that. I apologize.

BY MR. RUSSELL:

Q. As stated in paragraph 59.

A. Simple meaning of the word.

It's kind of a hard question for me to answer outside of the context of what I've written here, but I think much of this section about use of force would inform a different a appropriate to the policy.

Q. But you don't reference specific parts of the policy within this declaration, do you?

A. In terms of footnote, I don't believe I do. In paragraph 68, where you say "as required by CDCR's own policy in other situations," I reference it.

Well, no, maybe I do. If you look at the next page, 69, I think that's a direct reference. I think there might be one earlier in this portion of the declaration.

Q. Well, I guess I should ask: When you -- paragraph 69 talks about CDCR's DOM. And do you understand that to be the department operating manual?

A. Yes.

Q. Are you aware that there's a separate use of force policy apart from the department operating manual?

A. Maybe. Can you say more?

Q. Well, I'm just asking if you're aware if there is a statewide use of force policy that is separate and apart from the department operating manual?

A. There's a CCR regulations that I also read. Is that the same thing?

Q. I don't believe so, no.
A. Okay. So maybe I'm not -- I don't know. I don't know the answer to your question.
Q. Okay. As you sit here today, do you recall being provided a document that's entitled "CDCR Statewide Use of Force Policy"?
A. I may have. But right this minute, no, I don't recall it.
Q. And then turning to paragraph 69 where you do reference the department operating manual, specifically Section 51020.11.2.
And you state that that policy provides for immediate infliction of pain and punishment, or at least it's sanctioned and authorized by that policy.
Do you know which policy that is specifically within the department operating manual?
A. I believe it's the use of force DOM.
Q. It's the use of form DOM that relates to inmate handling or taking control of a food port?
A. That's what this specific reference is, I believe.
Q. Okay.
A. It's also might be -- you know, without having a chance to look at it, it might be about food trays as well.

Q. And your understanding is -- I think we've talked about this before -- is that the department operating manual allows for the discretion of the use of immediate force if an inmate either fails to return a food tray or takes control of a food port, correct?

A. Yes. It changes the policy language for this specific behavior.

There is some good policy language about not using force when it's not needed. But this is like an exception.

Where it says but in this case, you don't have to make a determination about whether there's an imminent threat of risk or serious harm; you can just go ahead and do it. And my position is that that's unnecessary.

If that stays as your base expectation, officers could still choose to use immediate force in the situation if there's something extra going on other than the irritation of having a food port open and not returning your food tray. They can still act. But to give them free reign, to give them permission to make a decision when it should instead be a controlled use of force situation, I think is an error in the policy and contributive to a climate of violence between staff and inmates.

Q. So are you equating the discretion to engage in immediate force in those instances with a practice of the immediate infliction of pain and punishment?

A. That's what it is.

Q. The use of immediate force is the immediate infliction of pain and punishment?

A. No. In this situation, when it oftentimes could be a controlled use of force and might result in a deescalation and no need to use force, giving the officers the authority because the inmate has done something irritating like keep their food port open and not return their food tray, to have them immediately be allowed to inflict pain and punishment without any other intervening review is inappropriate.

Q. And does the provision of punishment -- I mean, are you taking that department directly from department operating manual?

A. No. That's my characterization.

Q. Did you see any incidents either in reviewing use of force policy -- excuse me -- use of force reports packets or use of force videos where immediate force was used for the -- for the express purpose of inflicting punishment?

A. Well, I couldn't have seen it on video if it's immediate.

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 21, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 7

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

ALEJANDRO MADRID, et al., Plaintiff, **v.** **MATTHEW CATE, et al.,** Defendants.	C 90-3094 TEH **NOTICE OF ADOPTION AND IMPLEMENTATION OF CALIFORNIA CODE OF REGULATIONS, STATEWIDE USE OF FORCE POLICY**

TO THE COURT AND PLAINTIFFS' COUNSEL:

The Court's May 14, 2008 Order (Court Docket No. 2143) required Defendants to advise the Court within ten days of adoption and implementation of changes to the California Code of Regulations related to use-of-force. The California Office of Administrative Law approved the statewide use-of-force regulations on August 19, 2010. The California Department of Corrections and Rehabilitation (CDCR) subsequently approved related changes to the Departmental Operations Manual.

Attached as Exhibit A are true and correct copies of memoranda noticing the adoption of the statewide use-of-force policy and the training that implements CDCR's policy. Now that these changes are codified in regulation and in the Department Operations Manual, Defendants will meet and confer with Plaintiffs' counsel in an attempt to end this case without further Court proceedings.

Dated: August 30, 2010

Respectfully submitted,

EDMUND G. BROWN JR.
Attorney General of California
JONATHAN L. WOLFF
Senior Assistant Attorney General
MICHAEL W. JORGENSON
Supervising Deputy Attorney General

EMILY L. BRINKMAN
Deputy Attorney General
Attorneys for Defendants Cate and Lewis

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EXHIBIT A

	Department of Corrections and Rehabilitation **NOTICE OF CHANGE TO DEPARTMENT OPERATIONS MANUAL** **Chapter 5, Article 2** **Use Of Force**	**Transmittal Letter Number:** **10-18** **Revision Date:** **August 20, 2010**

The purpose of this document is to provide the Department Operations Manual (DOM) holders with information regarding the incorporation of Chapter 5, Article 2, Use Of Force.

This article is being adopted to assist CDCR in implementing remedial measures required by the federal court in *Madrid v. Cate* (U.S.D.C. N.D. Cal. C90-3094 TEH). In 1993 the *Madrid* court held that correctional staff at Pelican Bay State Prison routinely used unnecessary and excessive force against inmates, that uses of force were either not reported at all or were reported inaccurately and that the prison did not have an adequate system for investigating the uses of excessive force. In response the institution developed and the court approved a Use of Force Remedial Plan.

Regulations (Title 15) which provide the necessary authority for changes to the Use Of Force policy in the California Code of Regulations were developed, revised, and adopted on August 19, 2010.

Please inform all persons concerned of the contents of this notice, which shall be maintained and the information contained in this document utilized until it is incorporated into the next updated DOM.

Please direct any inquiries to Timothy M. Lockwood, Chief, Regulation and Policy Management Branch, at (916) 255-5500.

Original signed by:

SCOTT KERNAN
Undersecretary/Operations
California Department of Corrections and Rehabilitation

Department of Corrections and Rehabilitation

Memorandum

Date : June 8, 2010

To : Associate Directors, Division of Adult Institutions
Wardens

Subject: **UPDATED USE OF FORCE POLICY TRAINING SCHEDULED FOR JUNE 29, 2010**

The California Department of Corrections and Rehabilitation (CDCR) has revised the current Use of Force (UOF) Annual Training course to correspond with revisions made to the Title 15 language and the new Department Operations Manual (DOM), Chapter 5, Article 2, "Use of Force." Both the DOM and the Title 15 (currently under review by the Office of Administrative Law) are anticipated to be adopted between July 2010, and September 2010.

An eight-hour course of training has been scheduled for institutional UOF Coordinators and In Service Training (IST) Managers at the Correctional Training Center (CTC) in Galt on June 29, 2010. The class will be held in the Sierra Auditorium from 8 a.m. to 5 p.m. The institutional UOF Coordinators have been selected to attend for the benefit of receiving comprehensive training prior to implementation of the policy changes. IST Training Managers have been designated for attendance as they will be responsible for providing initial training to institutional managers, supervisors and UOF instructors. Participants are to bring a flash drive and a copy of the draft DOM section that was provided by email to all Wardens on May 12, 2010, to the training. Attendees will receive an electronic copy of the new lesson plan and power point presentation at the training to take back to their institution.

No overtime is authorized for those attending training. Therefore, travel to and from the training shall occur on June 28 and June 30. Staff shall utilize the most fiscally responsible means for travel, i.e., State vehicles. Lodging accommodations (double occupancy) will be provided on site at the CTC - Galt. Please keep in mind that if CTC housing is available, participants will not be reimbursed for off grounds lodging. Meals will also be provided at the Academy for the usual nominal cost.

Please provide the names, contact information and lodging needs for your institution's two attendees by email to Deavonne Long, Correctional Counselor II Specialist, at Dee.Long@cdcr.ca.gov by noon on June 18, 2010. If there are any special needs or accommodations required, please indicate this as well.

The Travel Exemption for the training and a CTC Visitor Information Packet is attached.

The UOF training plan will roll out in four phases. Phase One is the immediate On the Job Training described in the Director's memorandum dated June 8, 2010, and titled "Use Of Force Policy On the Job Training Requirement". Phase Two is the training at CTC Galt described on page one of this memorandum. Phase Three will accomplish the IST training of all managers, supervisors, and UOF instructors. Phase Four is to provide the IST training to the balance of all staff at the institutions.

- Phase Three: Immediately following Phase Two, IST Managers will be responsible to provide IST training (using the revised lesson plan and power point) to all managers, supervisors and designated UOF instructors at their institution by August 1, 2010. A proof of practice certification memorandum must also be submitted to the institution's Associate Director by August 2, 2010. Overtime is authorized for first watch staff. Efforts should be made, however, to have instructors train on first watch rather than keeping staff into second watch.

- Phase Four: Immediately following completion of the third phase, the updated IST UOF Training shall be provided to all staff in accordance with each employee's scheduled annual training. Therefore, it is anticipated IST training will take12 months to complete. Training in the fourth phase can be conducted by any manager, supervisor or qualified UOF instructor who received training in the third phase. The IST Manager is to ensure instructors do not deviate from the lesson plan.

  After completion of the first quarter's training (November 1, 2010), each institution must report to their Associate Director the number of staff who have completed the course. This reporting process shall continue each quarter thereafter (February 1, May 1 and August 1, 2011). At the conclusion of the 12 months of training (August 1, 2010), each institution shall also provide their Associate Director with a proof of practice certification memorandum noting all staff has completed the updated IST course.

- Institutions shall ensure all post orders are current in reflecting the updated policy information no later than October 1, 2010. In addition, copies of the new policy shall be made readily available to staff.

- The department is currently developing a UOF policy pocket reference guide specific to the needs of peace officer staff. Upon completion of development and procurement, all CDCR peace officers shall be provided with a copy of the new pocket guide outlining the revised UOF Policy. Headquarters staff will be providing these pocket guides to the field (e.g., institutions, CTC) this Fall or as soon as purchasing has been completed.

If you have any questions regarding this matter, please contact Brian Bevan, Associate Warden, High Desert State Prison, at Brian.Bevan@cdcr.ca.gov or Deavonne Long, Correctional Counselor II Specialist, High Security and Transitional Housing, at Dee.Long@cdcr.ca.gov.

GEORGE J. GIURBINO
Director
Division of Adult Institutions

Attachments

cc: Brian Bevan
Deavonne Long

Department of Corrections and Rehabilitation

Memorandum

Date : June 8, 2010

To : Associate Directors, Division of Adult Institutions
Wardens

Subject: **USE OF FORCE POLICY ON-THE-JOB TRAINING REQUIREMENT**

The California Department of Corrections and Rehabilitation (CDCR) has revised the current Use of Force Annual Training course to correspond with revisions made to the California Code of Regulations Title 15 language and the new Department Operations Manual (DOM), Chapter 5, Article 2, "Use of Force." Both the DOM and the Title 15 (currently under review by the Office of Administrative Law) are anticipated to be adopted between July 2010, and September 2010.

Since it is anticipated that it will take up to 12 months for all staff to complete formal In-Service Training (IST), the attached On-the-Job Training (OJT) document will serve as an interim measure to ensure all custody staff are familiar with the specific changes to the Department's Use of Force policy prior to completion of the IST training.

Document all training with a CDCR Form 844, "OJT/IST Sign-in Sheet," using "B2670, Use of Force DOM Policy – OJT" for the class code/subject title. Upon completion of this assignment, please provide a proof of practice certification memorandum to your Associate Director by August 2, 2010.

If you have any questions regarding this matter, please contact Brian Bevan, Associate Warden, High Desert State Prison, at Brian.Bevan@cdcr.ca.gov or Deavonne Long, Correctional Counselor II, High Security and Transitional Housing, at Dee.Long@cdcr.ca.gov.

GEORGE J. GIURBINO
Director
Division of Adult Institutions

Attachment

cc: Brian Bevan
Deavonne Long

* CDC 1617 (3/89)

USE OF FORCE ON THE JOB TRAINING
OJT CODE: B2670

The changes in the California Department of Corrections and Rehabilitation (CDCR) Use of Force Policy include a new Department Operations Manual (DOM) section and updated California Code of Regulations Title 15 section. Both these documents include previous information contained in various departmental memorandums and forms. Listed below is an overview of the new information not previously addressed in any other statewide documentation. More comprehensive information will be provided to designated staff and via In-Service Training.

NEW LANGUAGE

New Definitions of Types of Force: Non-conventional Force (Found in DOM Section 51020.4)

Non-conventional Force is force that utilizes techniques or instruments that are not specifically authorized in policy, procedures, or training. Depending on the circumstances, non-conventional force can be necessary and reasonable; it can also be unnecessary or excessive.

Safety Triangle/Soft Restraints (Found in DOM Section 51020.6)

Safety Triangle: This device is a handcuff retention device, used to prevent inmates from pulling restraint equipment into their cell and may be used at the discretion of on duty staff. The safety triangle may remain attached to the handcuffs if the inmate is being relocated in the housing unit or if attaching and detaching the safety triangle to and from the handcuffs presents a safety concern (such as an irate inmate who has threatened violence or an inmate upon whom force has just been used). The safety triangle is not intended to control the inmate outside the cell, nor is it intended to pull an inmate to the cell front in order to remove the handcuffs. The correctional officer controlling the safety triangle must be vigilant and efforts should be directed to prevent the inmate from pulling his hands inside the cell while the door is being closed.

Soft Restraints: Soft restraints consist of towels or sheets used to temporarily secure an inmate's ankles and/or arms together. After the application of soft restraints, mechanical restraints are removed, and staff are to exit the cell before the inmate has time to release himself from the soft restraints. Soft restraints are used on inmates who try to resist the entering of their cell and were developed in an effort to avoid using physical force on inmates. The Incident Supervisor may authorize the use of soft restraints. If force is used, it must be appropriately documented.

New Technique for Immediate Use of Force Involving Food/Hand Cuff Ports:
Immediate Use of Force in Cells (Found in DOM Section 51020.11)

When immediate force is necessary for inmates confined in their cells, oleoresin capsicum (OC) is the preferred option for carrying out the immediate use of force. A verbal warning shall be given before force is used unless the circumstances require immediate force that precludes a verbal warning.

Food Ports (Found in DOM Section 51020.11.2)

During routine duties, if correctional officers encounter an inmate who refuses to allow officers to close and lock the food port:

- The officer shall verbally order the inmate to relinquish control of the food port and allow custody staff to secure it. The officer shall issue a warning that chemical agents will be used if he/she does not comply.

- If the inmate refuses to relinquish control of the food port after the warning, the officer is authorized to administer chemical agents against the inmate to secure the food port. Alternatively, the officer may choose to contact a supervisor and await further guidance in formulating a response.

- If the inmate relinquishes control of the food port, it will be secured and designated staff will notify their supervisor and follow in-cell decontamination procedures.

- In the event the use of chemical agents does not accomplish the goal of regaining control of the food port, the officer shall back away from the cell and contact and advise the custody supervisor of the incident. Controlled force will be initiated while custody staff continue to monitor the inmate. Health care staff shall monitor the inmate at least every 15 minutes.

New Technique for Inmate Food Tray Retention and Confiscation of Potential Contraband: Food Trays (Found in DOM Section 51020.12.5)

- Accountability for food trays is an operational concern for the safety and security of institutions. It is important custody staff who issue food trays to inmates in cells account for all trays after the meal is concluded.

- If an inmate attempts to break a food tray, the immediate use of chemical agents is authorized to stop the threat of the inmate obtaining dangerous contraband.

- If the inmate refuses to return a food tray, the supervisor and the First or Second Level Managers shall be notified. Custody staff shall document the inmate's refusal to return the food tray on a CDC-115, Rules Violation Report.

- The inmate will be advised that he will not receive another meal until the first scheduled mealtime after the tray is returned. Additionally, the inmate – and all other inmates in the pod/section – will be placed on escort/restraint status to prevent passing of contraband items. Inmates may exit their cells to acquire various services. If the cell is vacated, staff will use that opportunity to retrieve the food tray.

- Notice shall be provided to staff members working subsequent shifts to ensure their awareness of the circumstances. Institution/facility staff shall implement security measures to deter and prevent the movement of the retained food tray from one cell to another.

- If the inmate retains control of the food tray for a period of 24 hours, the Manager shall determine if controlled force will be used to retrieve the tray. This does not preclude the Manager from making a determination, based on safety and security concerns, to retrieve the tray using force prior to the 24-hour time frame.

- If the goal of the controlled use of force is only to retrieve the tray, all staff shall be informed of this in advance. If the inmate has retreated to the back of the cell and the tray can be safely retrieved without the application of force, then custody staff shall retrieve the tray and exit the cell.

Revision to Previous Expectations Regarding Video Recording of Inmates Injured in Use of Force Occurrences: Video Records Made After Immediate Uses of Force that Cause Injury and Allegations of Unnecessary or Excessive Force (Found in DOM Section 51020.17.3)

A video recording of an inmate shall be made under the following circumstances:

- The inmate has sustained a serious bodily injury or great bodily injury that could have been caused by a staff use of force.

- The inmate has made an allegation of an unnecessary or excessive use of force.

Any visible or alleged injuries shall be video recorded. The video recording shall be conducted by persons not involved in the incident. The video recording should be made within 48 hours of discovery of the injury or allegation. The video recording shall also include a request of the inmate to be interviewed regarding the circumstances of the incident. If the inmate refuses to be video recorded, such refusal shall be recorded.

With the Exception of Training, All Firearm Discharges Require a Public Safety Statement: Response Supervisor-Additional Reporting Requirements for Deadly Force (Found in DOM Sections 51020.17.1 and 51020.17.5)

The supervisor shall ask the employee who used deadly force to provide a public safety statement immediately after the incident. This is the employee's oral statement. This statement helps determine the general circumstances of the incident, assess the need for resources, set the perimeter, locate injured persons, and determine the nature of the evidence to be sought. It shall provide basic information such as the number of persons involved in the incident, the number not yet in custody, and number and direction of shots fired. The statement shall not include, and the employee should not be asked to provide, a step-by-step narrative of the incident or a motive for his/her actions. It should be noted all instances of deadly force require the employee to give a public safety statement, including warning shots.

Time Constraints for Submission and Review of Reports:
Response Supervisor-Additional Reporting Requirements for Deadly Force (Found in DOM Sections 51020.17.1 and 51020.17.5)

Written reports regarding staff using force shall be documented on a CDCR Form 837-C. Reports must be prepared by the employee participants or witnesses, and reviewed by the

Incident Supervisor prior to the employee being relieved from duty. Staff shall not collaborate with each other in the preparation of reports.

New Supervisory Reporting Responsibility Time Parameters:
Incident Commander-Reporting Requirements (Found in DOM Section 51020.17.7)

It is the responsibility of the Incident Commander to notify the Office of Internal Affairs (OIA) and the Bureau of Independent Review (BIR) as soon as possible, but no later than one hour from the time the incident is discovered, of any use of deadly force and every death, great bodily injury or serious bodily injury that could have been caused by a staff use of force. Depending on the specific Memorandum of Understanding and the nature of the incident, a call to the county sheriff or police department may also occur.

New Use of Force Reporting Responsibilities and Use of Force Review Monitoring and Tracking: Allegations of Excessive or Unnecessary Force-Incident Commander and Appeals Coordinator Reporting Requirements (Found in DOM Sections 51020.18.2)

When informed of allegations of the use of unnecessary or excessive force, the Incident Commander and/or the Appeals Coordinator shall make an initial assessment of the information received and notify the appropriate First or Second Level Manager as soon as practical. The Incident Commander and/or the Appeals Coordinator shall determine whether the seriousness of the allegations and/or extent of the reported injuries warrant immediate notification of the First or Second Level Manager.

Additionally, the Incident Commander and/or the Appeals Coordinator shall:

- Ensure health care staff has evaluated the inmate and a medical report has been completed.
- Review written reports of witnesses and obtain statements from inmate witnesses, if any.
- Ensure that the inmate's injuries are video recorded and the inmate is interviewed within 48 hours in accordance with the requirements set forth in DOM Section 51020.17.3. This shall be done as soon as possible upon receiving verbal notification of the allegation.
- When an allegation is received, whether verbally or through the appeals process, the Appeals Coordinator or Incident Commander shall contact Investigative Services Unit or the Watch Commander and determine if the related incident report exists. The respective Appeals Coordinator or Incident Commander shall note the existence of the incident report by log number in their submittal prior to forwarding the allegation for administrative review.
- If the inmate has suffered serious injury or great bodily injury, the Incident Commander shall notify the OIA and the BIR as soon as possible, but no later than one hour from the time the incident is discovered. In instances where the allegation was submitted through the inmate appeal process and there is no corresponding incident report, the Appeals Coordinator shall, in consultation with the hiring authority, notify the OIA and BIR.
- If, at any point in the review, the Incident Commander and/or the Appeals Coordinator discovers information that leads him/her to reasonably believe or suspect an employee has committed any serious misconduct, the Incident Commander and/or Appeals Coordinator shall immediately forward all information to the Institution Head via the chain of command, recommending an internal affairs investigation, if appropriate.

- Prepare a Report of Findings, CDCR Form 3014, and/or Appeal Inquiry. The report shall contain the allegations made, an explanation of the incident, the written or verbal statements of the witnesses, the health care information, and a conclusion and recommendation.
- Submit the Report of Findings and/or Appeal Inquiry and evidence through the chain of command to the Institution Head. The evidence shall include copies of the medical reports, and any other documentation that is deemed significant to further document the incident/allegation. If the Incident Commander learns the verbal allegation is part of a reported incident, the incident package shall be included with the Report of Findings. Correspondingly, if the Appeals Coordinator learns the written allegation is part of a reported incident, the incident package shall be included with the appeal for administrative review.

Revised Time Constraints for Initial Institutional Executive Review Committee (IERC)/Use of Force Review:

Use of Force Coordinator Responsibility (Found in DOM Section 51020.19.4)

The Use of Force Coordinator shall normally schedule all logged use of force cases for review within 30 days of their logged occurrence. Any use of force incident or allegation review that is over 31 days old and has not received an initial review, shall be scheduled for review at the next scheduled IERC meeting. Unless there are outstanding issues or a corresponding investigation, this review will be both an initial/final review. This means most institutions will need to hold institutional reviews at least on a monthly basis.

Revised Institutional Use of Force Data Collection and Maintenance Expectations:

Use of Force Data (Found in DOM Section 51020.21)

Designated staff shall maintain a database containing use of force information. The Daily Incident Reporting System (DIRS) fulfills this new requirement.

The database should be capable of producing statistical reports to monitor trends and patterns of force used, whether the report is received in the form of an incident report, a verbal allegation of excessive or unnecessary force, or an allegation contained in inmate appeal. At a minimum the database should address the following categories:

- Date of incident.
- Specific area of institution.
- Staff involved.
- Controlled or immediate use of force.
- Reason for use of force.
- Use of impact munitions.
- Identified inmate disabilities and steps that were taken to reasonably accommodate the inmate during and after the use of force.
- Allegations of unnecessary or excessive use of force.
- Serious injury, great bodily injury or death.

New Use of Force Records Retention Expectations and External Review Oversight:
External Review of the Use of Force - The Use of Force Coordinator Responsibility (Found in DOM Section 51020.22)

For the purpose of an external review, the Use of Force Coordinator shall identify and retain use of force cases closed by the IERC during the review period. External reviews of closed use of force cases shall be conducted at least every 24 months.

Establishment of Use of Force Joint Use Committee:
Revisions - Use of Force Joint Use Committee (JUC) (Found in DOM Section 51020.23)

The Use of Force JUC is a committee of designated field staff and stakeholders tasked with reviewing and evaluating recommended revisions to the CDCR's Use of Force Policy and Procedures. The JUC shall meet quarterly as necessary, but not less than annually, to review recommended revisions.

NEW FORMS

CDCR Form 3034 IERC Allegation review

LANGUAGE AND TERMINOLOGY CHANGES

OLD POLICY	NEW POLICY
Emergency use of force	Immediate use of force
Calculated use of force	Controlled use of force
Serious Injury	Serious Bodily Injury

THE FOLLOWING DEFINITIONS AND PROCEDURAL GUIDELINES FOUND IN THE NEW USE OF FORCE POLICY HAVE THEIR ORIGINS IN CURRENT POLICY/TRAINING DOCUMENTS:

Response Supervisor definition and role.
Incident Commander definition and role.
Institutional Executive Review Committee definition and role/process.
Department Executive Review Committee definition and role/process.
Deadly Force Investigation Team definition and role.
Holding Cell definition.
No Choke Holds, unless deadly force authorized.
Leather restraint use/application.
In-Cell Assault procedures.
Cell extraction procedures.
Video recording procedures.
Controlled Use of Force involving serious mentally ill, procedure.
Cell extraction procedures.
Involuntary medication.
American Disability Act inmate restraints and searching.

Involuntary admission to medical facility.
Processing video records.
Use of less lethal weapons during Controlled Use of Force.
Maintaining visual contact with inmate after using chemical agents.
Chemical Agent Restrictions.
Chemical Agent Decontamination.
In-Cell Decontamination from chemical agents.
Application of Spit masks, positional asphyxia prevention.
Employee is granted 72 hours of Administrative Time Off after using deadly force resulting in death or Great Bodily Injury.
Reports are to be completed before being relieved of duty.
Public Safety Statement reporting requirement.
Health care staff Use of Force reporting requirements.
Incident commander, first/second level manager reporting requirements.
Reporting Allegations of Unnecessary/Excessive Force process.

Five factors for force evaluation:

- The threat perceived by the responsible individual applying the force.
- The need for the application of force.
- The relationship between that need and the amount of force used.
- The extent of the injury suffered.
- Any efforts made to temper the severity of a forceful response.

Review of the Use Of Force:

- Incident Commander
- First and Second level Manager
- Institution
- Department

Use of Force Coordinator Responsibilities:

Investigating Deadly Force (Deadly Force Investigative Team and Deadly Force Review Board) roles and responsibilities.

Forms:

3013	Interview guidelines
3014	Report of findings
3010	Incident commander's review
3011	First level manager review
3012	Second level manager review
3037	Controlled Use of Force manager report
3035	IERC Review and after action recommendation
3036	IERC Critique and Qualitative evaluation
837 (all)	

Attachment: CDCR 3034 - IERC Allegation review

Exhibit 8

From: Joel Badeaux <joel.badeaux@gmail.com>
Sent: Sunday, March 24, 2013 8:40 AM
To: Michael W. Bien
Subject: Request from SVPP colleague of Dr. Brim for USDOJ investigation of SVPP and state mental health care
Attachments: AG letter J Badeaux MD 3-22-13.pdf; SVPP 1st letter.pdf; SVPP 2nd letter.pdf; Brim deposition.pdf; Bien letter.pdf

Hi, Mr. Bien. As a colleague of Dr. Brim at SVPP, I am very worried about what will happen there and therefore felt compelled to write this letter to US Attorney General Holder. The other 4 attachments included are referenced in the letter and are part of the Coleman case. Although AG Holder will likely not see it, I am hoping that someone who can help the situation at SVPP and bring about mental health care reform in California will.

Sincerely,

Joel Badeaux, MD

SALINAS VALLEY
31625 Highway 101 – P.O. Box 1080
Soledad, CA 93960

Friday, March 22nd, 2013

Name The Honorable Eric H. Holder, Jr.
Attorney General, U.S. Department of Justice
Address 950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Dear Sir,

As a psychiatrist working for the state of California, I am writing you to express grave concern about safety conditions within the California mental health system. Most urgently, I would request that you investigate conditions at the Salinas Valley Psychiatric Program, which is part of the Salinas Valley State Prison.

The Salinas Valley Psychiatric Program is an inpatient level correctional treatment program administered by the California Department of State Hospitals. The program currently treats about 357 patients, admitted from all California state prisons. These patients are referred based on a high level of psychiatric need, requiring an inpatient level of care, and most are at significant risk of danger to themselves or others. In November 2012 the program had its first completed suicide.

In January and February of 2013 all psychiatrists working at this program including myself wrote letters to our Executive Director regarding a critical level of understaffing, which we believe had resulted in perilous conditions as far as safety (see enclosed letters). Since then, timely action was not taken, conditions have worsened, and ***now all nine psychiatrists working at this program just two months ago have either quit, gone on extended leave, or will be transferring to new positions by the end of April***. Five psychiatrists including myself will be leaving by the end of next week. For me, the lack of staff and resulting workload was simply not sustainable.

The administration has been unable to hire replacement psychiatrists and yet continues to admit new patients to the program. The administration has reported to the media that there is no anticipated staffing crisis at our program and has been focused on denying that there is a problem, apparently in an effort to win a major court case against the state (Coleman v. Brown) and end federal oversight of the prison system. One of my colleagues, Dr. John Brim, was deposed as a part of this case (see enclosures).

The Salinas Valley Psychiatric Program has come in millions of dollars under budget, primarily as the result of understaffing at all levels, but there has also been a lack of

basic provisions including clothes, soap, and blankets for the inmates. The oral medication diphenhydramine (Benadryl), which is the 'gold standard' of antihistamine treatment, and which is essential in psychiatry for the prevention and control of severe side effects from some antipsychotics, is not included on the California Department of Corrections and Rehabilitation medication formulary.

A Department of State Hospital staff survey of employees at the Salinas Valley Psychiatric Program conducted in September of 2012 found that 75% of staff either disagreed or strongly disagreed with the statement that the Department of State Hospitals has a desire to serve its staff well, and 86% of staff either disagreed or strongly disagreed with the statement that workplace morale was positive. 72% of staff either disagreed or strongly disagreed that there was a commitment to improving safety at its facilities, and 45% either disagreed or strongly disagreed that Department of State Hospital staff were effective in meeting the needs of their patients. From the results of this survey, you can see why employees, including psychiatrists, might want to leave the program.

As you are certainly aware, the state of California has a long history of inadequate mental health care delivery and has been under federal and Department of Justice supervision in the past. Unfortunately, when not under supervision, the state has shown a consistent pattern of drastically cutting spending on mental health. For example, when released from Department of Justice monitoring less than two years ago, more than a dozen psychiatrist contractors at Atascadero State Hospital were promptly laid off. California mental health care law (Title 22) is written such that there is no minimum psychiatrist-to-patient ratio, because clinical social workers and psychologists are considered to be equivalent to psychiatrists, even though they are not able to prescribe medication.

You should also be aware that mental health treatment outside of the prison system is inadequate to the point of jeopardizing the health and safety of the mentally ill, mental health workers, and the general public. As has been well-documented in the media, the California state hospital system has been plagued with violence. While I was working at Napa State Hospital, I was personally horrified when a psychiatrist friend who I trained with was badly assaulted by a patient and left state service.

According to media reports, the problem of violence in the California state hospitals actually got worse during past Department of Justice oversight. These reports have also documented actions resulting from the so-called 'Enhancement Plan' that could be considered nepotism or corruption. As far as psychiatric practice, I can tell you that recommendations from the Department of Justice court monitor deviated significantly from community standards in psychiatry, standing in contrast to the guidelines of the American Psychiatric Association. The policy changes that resulted from the Enhancement Plan included discouraging the use of an adjunctive antipsychotic medication for those with treatment resistant psychosis (sometimes erroneously labeled 'polypharmacy'), and discouraging the use benzodiazepines,

which are used effectively in psychiatric practice around the world to calm potentially violent, agitated, and psychotic patients.

Another concerning practice at California state hospitals and prisons is the use of the medication clozapine for purposes of restoration to competency, and the reluctance of forensic competency evaluators to declare a person unrestorable to competency without first having a trial of clozapine.

Clozapine is by far the highest risk medication in all of psychiatry. It has five black box warnings and was almost taken off the market due to the alarming number of deaths resulting from its use, which is monitored by a national registry due to its high-risk nature.

Atascadero State Hospital has had multiple patient deaths resulting from clozapine use, and while I was at Napa the majority of emergency medical sendouts resulted from adverse reactions to clozapine. While clozapine can be an effective and well-tolerated medication for some voluntary patients, I would submit to you that involuntary use of clozapine for purposes of restoration competency to stand criminal trial is inappropriate, especially considering the wide variety of safe and effective antipsychotic alternatives available on the market today.

As far as safety to general public, I think there is strong evidence that the current state mental health system allows for an unacceptable level of violence in the community that results from untreated or inadequately treated mental illness. As an example, while working at Napa State Hospital I treated a patient who was transferred to another Department of State Hospitals facility, and then later reportedly released into the community. After months wandering homeless, without adequate medication or support, he reportedly killed an innocent person.

By contrast, I can tell you that in the state of Arizona, where I trained and worked previously, all patients deemed to have serious mental illness and qualifying for Medicaid are provided with free medication, housing, transportation to appointments, and case management services including frequent home visits, assistance in applying for benefits, and close monitoring. ***Not providing adequate support, shelter, and medication for those with serious mental illness is inhumane and very dangerous to our society.***

Without adequate treatment or support in the community, it is not surprising that a large number of the mentally ill in California end up in the criminal justice system. Compounding this problem, the state of California has antiquated civil commitment laws (Lanterman-Petris-Short Act in effect since 1972, Mentally Disordered Offender law since 1986). By contrast, civil commitments in Arizona are easier to obtain and last for up to one year of outpatient treatment, and only rarely require the appointment of a conservator or guardian. Arizona law contains the Persistent or

Acute Disability standard, as well as the Danger to Self, Danger to Others, and Grave Disability standards.

Far too often in California a mentally ill individual gets treatment only after committing a violent or nonviolent offense. Apparently under the pretense of individual rights, California state law makes it difficult to get adequate involuntary mental health commitments for those who need help but are unwilling or unable to seek it voluntarily. But rather than preserving the individual's freedom, the effect of this is that the mentally ill are prosecuted by criminal law, rather than given treatment by civil commitment.

As an example from my own experience, I treated an individual at Napa State Hospital who had been criminally prosecuted for making seventy non-emergency phone calls to county 911 operators, with my job being to treat and potentially restore him to competency in order to stand trial. This patient's actions were clearly the result of his mental illness, so this would be an example of the 'criminalization of mental illness' which has resulted in exploding jail and prison population in California and across the United States. An individual like this could spend years hospitalized involuntarily, with no defined release date, at incredible expense to the Californian taxpayer. In Arizona, he would likely have been hospitalized involuntarily for only a few weeks and then committed for up to one year of outpatient treatment as Persistent or Acutely Disabled by Mental Disorder. Criminal charges would not have been pursued.

The current state government approach to mental health care seems to be that cheaper is better. Actually, if civil commitment laws were modernized in California and Assertive Community Treatment (ACT) were properly implemented, cheaper really would be better. The 'criminalization of mental illness' is of one reason why the United States has 5% of the world's population but has 25% of the world's incarcerated prisoners. Psychiatric hospitalization is estimated to cost about $500 per day, not including legal costs. Incarceration in California has been estimated to cost $50,000 per year for each inmate, but the cost for mentally ill inmates is much higher than that.

With a civil commitment a mental health patient might have a relatively short involuntary hospitalization and then get court ordered to have outpatient treatment for one year. With proper outpatient follow-up, this provides a lot of safety and does not cost a lot of tax dollars. Most of the mentally ill are not violent when they are taking their medication. I know if I were mentally ill, I would rather be locked up briefly against my will as opposed to locked up for many years against my will with a felony on my record, likely never able to get a job or have a chance to function in society again. ***Frankly, not providing mental health treatment to those with mental illness before they might commit serious criminal acts, and instead prioritizing criminal prosecution after the fact is a violation of the civil and***

human rights of the mentally ill and also victimizes the citizens of California.

Considering the 3rd strike laws, this type of inappropriate prosecution threatens to financially ruin the state of California. On my current caseload I have multiple individuals with serious mental illness serving 25-year sentences for nonviolent 3rd strikes. With the type of inappropriate, disproportionate, and inhumane sentencing that exists in the state of California, is it any wonder why hope runs short and suicide rates are alarmingly high in the California prison system?

Since state government seems unable or unwilling to provide a mental health system that can adequately provide for the health and welfare of the mentally ill, mental health care workers, and the citizenry of California, I am writing in hopes that the U.S. Department of Justice can provide urgent assistance and prevent further needless injury and death. Feel free to contact me at the e-mail address below if you have any questions, since I will no longer be a state employee after next week.

Sincerely,

Joel Badeaux, MD, MPH

Staff Psychiatrist
Department of State Hospitals – Salinas Valley Psychiatric Program

joel.badeaux@gmail.com

cc: Governor Jerry Brown, State of California
Senator Diane Feinstein, State of California
Senator Barbara Boxer, State of California
Amnesty International
Mental Health America of California

Enclosures (4)

Revised 3/23/13

STATE OF CALIFORNIA – DEPARTMENT OF STATE HOSPITALS
EDMUND G. BROWN JR., GOVERNOR

SALINAS VALLEY
31625 Highway 101 – P.O. Box 1080
Soledad, CA 93960

Wednesday, January 23, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Executive Director DaSilva,

As staff psychiatrists, we are writing you collectively to express our serious concern about the level of staffing at SVPP. At the end of January, we will have lost our 3rd psychiatrist in the past (6) weeks.

This will leave us only (7) full-time psychiatrists, including a senior, plus 1 part-time psychiatrist, covering (6) Units that average about 60 beds each. Other disciplines such as social work, psychology, and rehab therapy have 15 to 16 staff covering the same number of patients. The SVPP census issued today shows that there are 351 patients in the program. Across the (6) Units we have also been averaging about (2) to (3) admissions and discharges per Unit per week.

The DSH standard for Stockton and elsewhere is a (15) patient caseload for a team that does admissions, with about (2) admissions per week. When administration visited our facility recently to present the Stockton program, we were told that a 15 patient caseload would also be the standard at SVPP as well as Stockton. At present we have been averaging a caseload of about (40) with (2) admissions per week, and all psychiatrists are taking admissions. Some psychiatrists are already covering (60) patients daily, (4) times the accepted standard. We find a caseload of (40) to be unsafe, and a caseload of (60) is even more perilous.

As psychiatrists, we are united in our belief that the level of staffing currently present is not safe or appropriate for an ICF level of patient care. We believe that it potentially creates an unsafe situation for both staff and patients. When patient safety is at stake, we cannot in good conscience continue to take on a higher and higher caseload without making you aware of our concerns. In November, 2012 SVPP had its first completed suicide. Current staffing levels will create an unacceptable level of risk as far as patient safety.

We will continue to do our best for every patient, under every

circumstance. ***But we need to inform you that we will be working in a state of protest regarding our caseload and the rate of admissions.*** We are also extremely concerned about further attrition of psychiatrists, which seems very likely considering the present workload and conditions.

We understand that since SVPP is being downsized that it may be difficult to attract new psychiatrists. However, in the past, staff from other facilities have been brought in on a temporary basis. This would be a tremendous help. We also believe the situation could be made significantly better through a reduction in admissions as we scale back and prepare to close C and D yards.

Thank you for listening to our concerns.

Sincerely,

Joel Badeaux, MD

John Brim, MD

Gayle Gaines, MD

Minhas Kapadia, MD

Muhammad Saleem, MD

Mary Stoller, MD

Ariel Troncoso, MD

Lei Wei, DO

Indu Aramandla, MD

Position Staff and Senior Psychiatrists
Division DSH SVPP

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

STATE OF CALIFORNIA – DEPARTMENT OF STATE HOSPITALS EDMUND G. BROWN JR., GOVERNOR

SALINAS VALLEY
31625 Highway 101 – P.O. Box 1080
Soledad, CA 93960

Tuesday, February 12, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Dear Executive Director DaSilva,

This letter will confirm our verbal communication to you during the psychiatry meeting today. We alerted you to the severe psychiatry staffing shortage in our letter of three weeks ago. Now, as you know, our psychiatry staffing shortage has devolved from serious to crisis level. With three more psychiatrists leaving in the near future we must take urgent action. After extensive discussion and consideration, the psychiatry staff at SVPP have unanimously determined that we cannot safely manage more than 40 patients per psychiatrist. We will not abandon additional patients beyond this limit, but can provide only emergency psychiatry services for such additional patients.

Thank you.

Sincerely,

Joel Badeaux, MD — Ariel Troncoso, MD

John Brim, MD — Lei Wei, DO

Minhas Kapadia, MD — Indu Aramandla, MD

Muhammad Saleem, MD — Mary Stoller, MD

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G BROWN, JR., et al.,

Defendants.

Case No. Civ S 90-0520 LKK-JFM P

THREE JUDGE COURT

DECLARATION OF MICHAEL W. BIEN IN SUPPORT OF PLAINTIFFS' MOTION FOR LEAVE OF COURT TO TAKE THE DEPOSITION OF DR. JOHN BRIM

Judge: Hon. Magistrate Judge Moulds

MARCIANO PLATA, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, JR., et al.,

Defendants.

Case No. C01-1351 TEH

THREE JUDGE COURT

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, Jr., et al.,

Defendants.

Case No. Civ S 90-0520 LKK-JFM

DECLARATION OF MICHAEL W. BIEN IN SUPPORT OF PLAINTIFFS' MOTION FOR LEAVE OF COURT TO TAKE THE DEPOSITION OF DR. JOHN BRIM

Judge: Hon. Magistrate Judge Moulds

I, Michael W. Bien, declare:

1. I am a an attorney admitted to practice in California, a member of the Bar of this Court and the managing partner of the law firm, Rosen Bien Galvan & Grunfeld LLP, counsel of record for the Plaintiff Class. I have personal knowledge of the matters set forth herein, and if called as a witness I could competently so testify. I make this declaration in support of Plaintiffs' motion for leave of court to take the deposition of Dr. John Brim.

2. Defendants contend that they are providing "timely access to inpatient mental health care for all class members needing hospitalization." Docket 4275-1 at p. 17:20-22. Dr. John Brim is a psychiatrist employed by the Department of State Hospitals ("DSH") at the Salinas Valley Psychiatric Program ("SVPP") inside the walls of Salinas Valley State Prison. The SVPP is an inpatient psychiatric hospital that provides mental health services exclusively to *Coleman* class members. Plaintiffs' counsel and Plaintiffs' psychiatric expert inspected Salinas Valley State Prison and the SVPP on January 28, 2013. Based on that inspection and on additional information that we have received, it is my opinion that the deposition of Dr. Brim is necessary for Plaintiffs to respond to Defendants' termination motion.

3. Specifically, after the expert tour, my office received two letters signed by Dr. Brim and multiple other SVPP psychiatrists describing extreme clinical staffing shortages that are creating unsafe conditions and preventing these psychiatrists from providing Plaintiff class members minimally adequate inpatient care. A true and correct copy of the first letter, which is dated January 23, 2013, signed by Dr. Brim and eight other SVPP psychiatrists, and addressed to Charles Silva, the SVPP Executive Director, is attached hereto as **Exhibit A**. This letter was received by my office on February 4, 2013. A true and correct copy of the second letter, which is dated February 12, 2013, signed by Dr. Brim and seven other SVPP psychiatrists, and also addressed to Mr. Silva, is attached hereto as **Exhibit B**. This second letter was received by my office on February 15, 2013. Additionally, my office received additional confidential information from a non-party

source on February 20, 2013 that lead to my decision to depose Dr. Brim.

4. On February 22, 2013, my office hand served counsel for Defendants with a notice setting Dr. Brim's deposition on March 1, 2013, the final day of discovery.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration is executed in San Francisco, California on February 25, 2013.

/s/ Michael W. Bien
Michael W. Bien

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Michael W. Bien
Email: mbien@rbgg.com

March 4, 2013

VIA E-MAIL

Debbie J. Vorous
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California Department of Justice
P.O. Box 944255
Sacramento, CA 94244-2550
Debbie.Vorous@doj.ca.gov

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Jay.Russell@doj.ca.gov

Benjamin Rice
General Counsel
CDCR Office of Legal Affairs
P.O. Box 942883
Sacramento CA 94283-0001
benjamin.rice@cdcr.ca.gov

Re: *Coleman v. Brown*; Dangerous Staff Shortages in Department of State Hospitals (DSH) Programs
Our File No. 0489-03

Dear Ms. Vorous, Mr. Russell and Mr. Rice:

We are writing to demand immediate action by the Governor and Director Allenby of DSH to address the critical shortage of clinical staff, especially psychiatrists, at the DSH-operated state hospital programs located at Salinas Valley State Prison and California Medical Facility. These programs are operating at maximum capacity and each have waiting lists of additional patients referred for psychiatric hospitalization by CDCR clinical staff, "accepted" for care by DSH, but lingering in CDCR prisons due to the shortage of inpatient psychiatric beds. Thirty human beings are now waiting for acute emergency psychiatric care. There is also, of course, a wait list for ICF hospitalization, despite defendants' representations that no such wait list exists.

Under pressure to reduce spending in accord with the Governor's hiring freeze and Department of Finance instructions, DSH and CDCR have intentionally or negligently

started the process of shutting down major parts of the CMF and SVPP inpatient psychiatric programs by cutting staffing allocations, failing to use registry to fill vacancies, restricting overtime and even restricting allocations for patient clothing, soap and laundry. The result has already been the needless loss of one life in the inpatient psychiatric hospital at SVPP due to suicide in late November 2012.

The psychiatrists at SVPP have repeatedly complained to their superiors concerning the critical shortages of staffing and resources, both before and after the unnecessary and avoidable suicide at their facility in late November. They urged their superiors to restrict new admissions to the program as they felt that they were barely able to provide minimal care to the existing patients. They were told that they were under pressure to "reduce the wait list" and could not restrict new admissions, despite the danger to patients and staff. In addition to the suicide, SVPP in 2012 experienced a dramatic increase in injuries to patients and injuries to staff, directly attributable to Defendants' decisions to reduce spending on the program. The ICF program is required to provide between 20 and 35 hours of scheduled treatment and activities per patient per week. According to Dr. Brim, SVPP is now only providing one hour a day.

Freed from the USDOJ CRIPA Decree, DSH promptly reduced its staffing ratios for its ICF programs. Plaintiffs' counsel repeatedly raised the staffing shortages at SVPP and CMF VPP with Defendants and their attorneys in 2012. Defendants repeatedly assured plaintiffs' counsel and the *Coleman* Special Master that the programs were fully staffed and that the monthly staffing data, that showed large numbers of vacancies and limited or no use of registries was "inaccurate." In December 2012, plaintiffs' counsel again raised the issue and we were again assured in a face to face meeting, with the Special Master present, that SVPP was fully staffed and operating safely and appropriately. Dr. Brim's testimony, and the letters signed and written by each and every psychiatrist working in SVPP in January and February of 2013, demonstrate that the statements made by DSH officials, to say the least, misrepresented the true crisis that existed in November and December at SVPP and, apparently, has worsened since December.

DSH officials made a presentation in December at SVPP (and probably also at CMF), to recruit clinicians to move to the new facility under construction at Stockton. At the same time, they informed staff that more than half of the DSH programs at SVPP and CMF would be closing down. The result, as intended, was that numerous DSH staff have left their jobs or given notice. It is also apparent that DSH was making little or no effort to recruit new clinicians to work at CMF and SVPP despite the extreme and dangerous level of vacancies, nor was DSH making effective use of registries at SVPP. As a result,

only "emergency" psychiatry is taking place, and ICF level of care is not being delivered to the patients.

We have received reports of similar extreme clinical vacancies, especially in psychiatry, at the CMF VPP programs. These inpatient psychiatric programs were and remain at full capacity, yet Defendants' actions have directly put the patients and staff at grave risk.

Defendants are under court orders to continue to operate all of the inpatient programs at CMF and SVPP unless and until the court finds that they are no longer necessary. The court order also applies to the "temporary and emergency" MHCB's at CIM, CMC and SAC. Operating inpatient psychiatric hospitalization programs without the necessary clinical staff is a violation of the court's orders. Additional lives are at stake.

We demand that Defendants provide, by Friday, March 8, a full and complete list, under penalty of perjury, of all clinical and custody positions authorized for SVPP and CMF VPP, the names of each person that is currently filling that position, and whether they are full time, part-time or registry (and whether they have given notice to DSH that they are retiring, taking leave, or moving to another position within the next 30 days). We also demand CDCR's and DSH's immediate plan to address the dangerous and growing wait lists. Prompt transfers of patients to the numerous open beds at Coalinga State Hospital , Patton State Hospital and Atascadero State Hospital should be undertaken. CDCR could also transfer patients to the new inpatient psychiatric facility at CIW that has an empty wing. The Deputy Special Master suggests that an additional L-Wing floor at CMF be converted to acute inpatient care. Something must be done now.

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If and when Defendants complete construction, obtain licensing approval and hire and train clinical and custody staff, they can begin to transfer patients to Stockton. This has not and will not occur for many more months. We will not permit Defendants to endanger the lives of *Coleman* class members in order to balance the State's budget in the interim.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Michael W. Bien

By: Michael W. Bien

MWB:cg
cc: Special Master Lopes
Donald Specter
Diana Toche
Tim Belavich

Exhibit 9

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

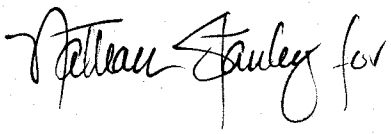
Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History**.**
2. MHSDS Hiring Activity Report**.**
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,



TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
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Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
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Mental Health Adseg/SHU/PSU

January 18, 2013

		MH POPULATION IN AD SEG			AD SEG CAPACITY	MH PERCENT OF AD SEG*		
		EOP	CCCMS	TOTAL		EOP	CCCMS	TOTAL
ASP	*II*	1	40	**41**	175	0.57%	22.86%	**23.43%**
CAL	*I,IV*		6	**6**	300	0.00%	2.00%	**2.00%**
CCC	*I,II,III*		1	**1**	175	0.00%	0.57%	**0.57%**
CCI	*I,II,III,IV*		107	**107**	327	0.00%	32.72%	**32.72%**
CCWF		3	49	**52**	61	4.92%	80.33%	**85.25%**
CEN	*III*		8	**8**	350	0.00%	2.29%	**2.29%**
CIM	*I*	2	90	**92**	356	0.56%	25.28%	**25.84%**
CIW		3	34	**37**	56	5.36%	60.71%	**66.07%**
CMC	*I,II,III*	62	31	**93**	226	27.43%	13.72%	**41.15%**
CMF	*I,II,III*	44	19	**63**	164	26.83%	11.59%	**38.41%**
COR	*I,III,IV*	70	125	**195**	460	15.22%	27.17%	**42.39%**
CTF	*I,II*	2	27	**29**	228	0.88%	11.84%	**12.72%**
DVI	*I,II*	2	45	**47**	303	0.66%	14.85%	**15.51%**
FOL	*III*	1	13	**14**	138	0.72%	9.42%	**10.14%**
HDSP	*I,III,IV*	3	35	**38**	343	0.87%	10.20%	**11.08%**
ISP	*I,III*		2	**2**	175	0.00%	1.14%	**1.14%**
KVSP	*I,IV*	3	70	**73**	396	0.76%	17.68%	**18.43%**
LAC	*I,III,IV*	64	150	**214**	450	14.22%	33.33%	**47.56%**
MCSP	*I,II,III,IV*	36	52	**88**	175	20.57%	29.71%	**50.29%**
NKSP	*I,III*	6	39	**45**	175	3.43%	22.29%	**25.71%**
PBSP	*I,IV*	4	90	**94**	246	1.63%	36.59%	**38.21%**
PVSP	*I,III*		152	**152**	350	0.00%	43.43%	**43.43%**
RJD	*I,III*	56	105	**161**	350	16.00%	30.00%	**46.00%**
SAC	*I,IV*	39	74	**113**	406	9.61%	18.23%	**27.83%**
SATF	*II,III,IV*	1	104	**105**	325	0.31%	32.00%	**32.31%**
SCC	*I,II,III*		15	**15**	175	0.00%	8.57%	**8.57%**
SOL	*II,III*	4	79	**83**	350	1.14%	22.57%	**23.71%**
SQ	*I,II*	10	69	**79**	379	2.64%	18.21%	**20.84%**
SVSP	*I,IV*	48	160	**208**	439	10.93%	36.45%	**47.38%**
WSP	*I,III*	2	39	**41**	175	1.14%	22.29%	**23.43%**
Totals		**466**	**1830**	**2296**	**5504**	**8.47%**	**33.25%**	**41.72%**

Mental Health and HIV numbers are as accurate as the information provided by the respective identifier systems.

*Ad Seg Capacities do not include "overflow." Therefore, MH Percent of Ad Seg may be artificially inflated.

COR Ad-Seg EOP housing is located in the SHU.

	MH POPULATION IN PSU			PSU CAPACITY	MH PERCENT OF PSU		
	EOP	CCCMS	TOTAL		EOP	CCCMS	TOTAL
PBSP *I,IV*	118	1	**119**	128	92.19%	0.78%	**92.97%**
SAC	238	5	**243**	256	123.96%	2.60%	**126.56%**

	MH POPULATION IN SHU			SHU CAPACITY	MH PERCENT OF SHU		
	EOP	CCCMS	TOTAL		EOP	CCCMS	TOTAL
COR *I,III,IV*	1	415	**416**	1400	0.07%	29.64%	**29.71%**
VSPW	0	0	**0**	44	0.00%	0.00%	**0.00%**
CCI	1	193	**194**	274	0.36%	70.44%	**70.80%**
Total	**2**	**608**	**610**	**1718**	**0.12%**	**35.39%**	**35.51%**

Mental Health and HIV numbers are as accurate as the information provided by the respective identifier systems.

Health Care Placement Oversight Program
1/18/2013

*Ad Seg Capacities do not include "overflow." Therefore, MH Percent of Ad Seg may be artificially inflated.

COR Ad-Seg EOP housing is located in the SHU.

Exhibit 10

TLS | THORSNES litigation services

Transcript of the Testimony of:

Charles Scott, M.D.

Coleman v. Brown

March 8, 2013

Volume I

THORSNES LITIGATION SERVICES, LLC
P: 877.771.3312 | F: 877.561.5538
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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

CHARLES SCOTT, M.D.

FRIDAY, MARCH 8, 2013, 9:06 A.M.

DAVIS, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of CHARLES SCOTT, M.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:06 a.m., Friday, March 8, 2013, at the UC Davis Immigration Law Clinic, Building TB-34, Davis, California.

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collecting data and tabulating it in some way?

A. I don't recall if on the very first meeting there was an organized data collection procedure finalized on the first meeting.

Q. Okay. Did you ever work up an organized data collection procedure?

A. Yes.

Q. When did that happen?

A. Over several months following that first meeting, a tool to help look at different components important to care, or potentially important to care, was developed. And my input was primarily into the medication piece. And to the degree that that also related to the mental health crisis bed, I had input into that as well.

Q. And was the plan to tabulate data from that collection and include it in your report?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: No, the plan wasn't to per se include all the data collection pieces in the final report.

BY MR. GALVAN:

Q. What were you going to do with the data collection pieces?

A. Have them available for review should we have an opinion that people would want to know the basis for the opinion.

Q. And did you actually do that? Do you have them available for review?

A. I turned them over, I believe, yes.

Q. When you say "turned them over" -- ask a different question.

When you talk about having something for review, do you mean something in which you -- you broke out or rolled up the results of your tabulation in terms of percentages or scores in some way?

A. I provide the entire data set so someone could verify it for themselves rather than rely on my own summary.

Q. Did you ever make your own summary?

A. I have a general impression from having reviewed the data. So having been at the institutions and collected the data, it's easy to learn it as you do it.

Q. Do you have a document with a summary of the data?

A. No, just what's in my head.

Q. Is it possible -- or do you know whether Dr. Bobb has a document with a summary of the data?

Dr. Paizis did with one of the other psychiatrists, that they could look at labs that aren't in EUHR. They took me to the CTC, they took me to the office room and verified that although it wasn't in EUHR, they could check it through 360.

So that work with them on this patient combined with what I found with EUHR, I felt clozapine was being monitored appropriately.

Q. You testified that they could check it on 360. Did they actually look up Mr. Jimenez --

A. Yes.

Q. -- and check the fasting glucose and the metabolic panel on 360?

A. We walked over to a Quest 360 computer because one was not near me. Dr. Paizis then opened it up and showed me.

Q. Why didn't you include it in your notes?

A. Because we -- I left my pad and I walked over there with them, and I didn't write it when I went back.

Q. If I looked in your database, would it be in your database?

A. The database didn't start until Chowchilla, so you would not see it in the database.

Q. Oh, the database starts in Chowchilla?

A. Well, the database starts with the first site

visit. But the computer collects data it's stored there. These are original database for the initial site visits.

Q. So we shouldn't expect to see anything in the database until -- so not for Vacaville, not for SAC, not for Centinela, not for RJD, but for Chowchilla and thereafter?

A. You may see some for Centinela because I think they were around the same time.

Q. Is it true to say that there weren't very many patients on clozapine that you were able to review, right?

A. I think at the Folsom site, that's correct.

Q. I mean, altogether through the project there's only a handful, right?

A. I would have to go back and count them.

Q. Certainly fewer than 10?

A. I don't know that. I'd have to count them.

Q. On the next page of these notes, at 919, there's a note here about a Mr. Bonila?

A. Yes.

Q. You have at the top of the page: "Suicide precaution."

Do you remember where you saw him?

A. My recollection was it was on their CTC.

some of those are blanks.

Q. Occasionally you have created a blank record here?

A. Yes. When it asks you how to enter new data, sometimes that happens.

Q. That seems to be just a few blank lines.

A. Yeah, at the beginning.

Q. I was going to go to the bottom and see how many records we have and get your general sense of whether you think we're in ballpark of having your whole database.

Looks like we have 132 -- 132 rows.

A. Correct.

Q. Although some are blank.

A. Yes.

Q. I don't think there are very many blanks, though.

A. Six or seven.

Q. So does this -- would you be -- can you testify that this is your whole database?

A. No.

Q. Okay. Can you testify that this seems to be a -- what would you need -- what more would you need to be able to testify this was your whole database?

A. First of all, the first, I believe, two or

three institutions, I tried to enter the data on the audit tool. And we've gone over those institutions, the number of cases. And so I would say my database involves the data entered into Bento, which is the equivalent of what would have been on an audit tool, plus the actual audit tool and handwritten notes.

So there are obviously more records, because we've gone over them, than the 125, if we extract the six or so here. So that's how I came up earlier with the number.

For medication reviews, at least 135. Some of these individuals -- and you'll even see it on this database. If I pulled their chart, a random system sample, and it said they'd been on Prozac, for example, when I went to open the record, that may have been discontinued at the time I did the review so they were no longer on meds. So I may: "On no meds, no medicine review."

So that's why, although there are more records than I testified to about the medical record review, it's because not all of the records necessarily were on the medicine. But the majority were.

Q. So limiting it to just what's -- just trying to nail down what is the Bento database versus database of conceptual database, can you testify that what we're

looking at now, you're -- this Excel export, is your Bento database?

A. I could testify that this is the Bento database, but the other database that we've gone over is not a conceptual one. It's an actual data collection but hasn't been entered into Bento.

Q. So this Exhibit 111 -- I mean Exhibit 13, Bates 111579 to 641, is the Bento database?

A. Correct.

Q. Exported to Excel?

A. Yes.

Q. I'll show you one other thing to increase your confidence in that being true. I think it has data -- oh, last modified by me. I've been playing with it in front of me. You've seen what I did it. I changed the way the cells display.

A. Saved to backup.

Q. Don't worry. I'm doing it off the CD, so I can't really save changes to this CD.

When you first open it from the CD, it says "Last modified by Charles Scott," but I can't show you that because of what we did to make it more readable.

It is your testimony that we have a true and correct representation of your Bento database in the Excel spreadsheet that you exported from us?

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 11, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470