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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JOHN ARMSTRONG, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. C94 2307 CW **PLAINTIFFS' RESPONSE TO COURT EXPERT'S REPORT REGARDING TREATMENT OF PEOPLE WITH DISABILITIES AT SATF [DKT. NO. 3446]** Judge: Hon. Claudia Wilken

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INTRODUCTION

After a year-long investigation of the state's largest prison, the Court's Rule 706 Expert found "a system that is failing its disabled population." Dkt. No. 3446 at 5. People with disabilities "are living diminished and needlessly difficult lives. They face harsher prison conditions, and thus greater punishment, than their peers." *Id.* at 4. They are left "hopeless." *Id.* at 5. At times, they "have just given up and try to get by with inadequate accommodations." *Id.* at 4. The Court Expert found "systemic failures" related to provision of reasonable accommodations—the very foundation of the *Armstrong* Remedial Plan ("ARP") and Americans with Disabilities Act ("ADA"). *Id.* at 14. The Court Expert described a staff culture of indifference and professional burnout, and found that SATF leadership is unable to "self-diagnose and address problems" as necessary to achieve "sustainable compliance with the ARP and ADA." *Id.* at 57.

Defendants' response amounts to little more than a shrug and a prescription for the status quo. Defendants do not contest any of the Court Expert's findings. Dkt. No. 3453 at 3. Defendants downplay the experiences of people who were not given accommodations to eat, urinate, defecate, write, ambulate, and participate in prison programs for over a decade as instances where people "appear not to have been well served." *Id.* Almost all of the responsibility, in Defendants' view, lies solely with the Receiver in *Plata v. Newsom*, Case No. 01-cv-01351 (N.D. Cal.). Defendants' threadbare plan to address the remaining areas consists primarily of issuing a one-page memorandum restating existing policy, re-training, and assurances that they have "carefully reviewed [the] Court Expert's report and [are] mindful of his recommendations." *Id.* at 22.

That is not nearly enough.

It has been 22 years since the *Armstrong* Remedial Plan was filed, and Defendants still are not able "to self-monitor and self-correct in the manner that would justify a lesser level of scrutiny by the Court and other outside monitors." Dkt. No. 3446 at 5. For the third time in recent years, this Court must take action to help realize the promise of the ADA and ARP for people with disabilities confined in the state prison system.

ARGUMENT

Plaintiffs agree with the Court Expert's findings. As the Court Expert found, "much at [the California Substance Abuse Treatment Facility and State Prison, Corcoran ("SATF")] has to change." Dkt. No. 3446 at 6. The systemic failure to provide reasonable accommodations will require immediate and comprehensive action to address top-to-bottom system failures related to population composition, staffing and culture, identification and improvement mechanisms, and disability accommodation processes.

Plaintiffs also agree with the Court Expert that Defendants have not yet demonstrated the ability to implement necessary changes on their own. *See* Dkt. No. 3446 at 5 ("Self-correction has to be the goal, and our investigation showed it is a long way off."). Most if not all of the issues identified by the Court Expert were or should have been known to Defendants—either through direct reports from class members or unsuccessful attempts by Plaintiffs' counsel to address the issues—and Defendants failed to identify or resolve them. *Id.* Even after a year-long investigation by the Court Expert to confirm those reports, Defendants' response amounts to business as usual, with only meager, half-formed plans. A firmer hand and outside expertise is necessary. This Court should adopt the undisputed findings of the Court Expert and issue an Order directing Defendants to work with independent experts, in consultation with the Receiver, to rebuild systems at SATF necessary for sustainable compliance with the ARP and ADA. The Order should establish strong oversight mechanisms. *See Armstrong v. Newsom*, — F.4th —, Nos. 20-16921, 21-15614, 2023 WL 1458888, *10, *12 (9th Cir. Feb. 2, 2023) (explaining that "[l]ess intrusive means have been tried—and have failed—here," and "[c]onsidering that history, the district court was justified in concluding that more specific measures were required to remedy violations of class members' rights this time around"); *see also Armstrong v. Brown*, 768 F.3d 975, 986 (9th Cir. 2014) (same).

With this response, Plaintiffs submit a proposed order that will accomplish the necessary reforms and that complies with the requirements of the Prison Litigation Reform Act. *See* 18 U.S.C. § 3626(a)(1)(A).

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I. COURT OVERSIGHT IS NECESSARY TO ENSURE DEFENDANTS PROVIDE THE RESOURCES NEEDED TO ACCOMMODATE PEOPLE WITH DISABILITIES AT SATF.

"Sustainable compliance" with the ADA and ARP, the Court Expert found, "will require a fundamental mindset shift" by staff at SATF. Dkt. No. 3446 at 51; *see also id.* at 51-55 (discussing staff culture at SATF); *id.* at 6 ("SATF must become a place where the institution understands from the top on down that *Armstrong* class members are … human beings who are in SATF's care.").

> Based on what we heard from custody staff and others, it appears that many custody staff believe it is the responsibility of SATF's ADA Office, and not individual custody staff members, to ensure compliance with the ADA. Some staff at SATF also appear to believe that class members are only entitled to accommodations when they advocate for those accommodations and when existing policy requires SATF to provide the particular accommodation the incarcerated person requests. These attitudes do not serve incarcerated people well, and they do not serve SATF well in reaching sustainable compliance with the ADA and ARP.

Id. at 51.

Similarly, the Court Expert found credible reports from class members that certain healthcare staff "treated them in a manner that was rude and dismissive," noting that such reports were consistent with the fact that "class members had to go to extraordinary lengths to receive basic and necessary accommodations." Dkt. No. 3446 at 52; *see, e.g.*, *id.* at 36 (finding that "RN's response demonstrated a lack of empathy and a lack of understanding" for people experiencing incontinence). The Court Expert explained that "for many who work in direct services, anger and cynicism or a lack of empathy can be one of the first signs of professional burnout or trauma-exposure response (also known as secondary trauma or vicarious trauma)." *Id.* at 53-54.

Professional burnout "is caused by chronic workplace stress that has not been successfully managed and that results from an imbalance between job demands and resources." Dkt. No. 3446 at 54 (internal quotation marks and citations omitted). "Thus, the first step in preventing professional burnout in healthcare professionals is to ensure that they are adequately supported in their work. This includes ensuring staffing is adequate so that demands on healthcare workers are reasonable …." *Id.* at 54.

1 The Court Expert concluded that "SATF, and CDCR as a whole, needs to consider
2 why SATF has become such a problematic institution for people with disabilities" and that
3 "a sense of overwhelm in dealing with the needs of its population … may require changing
4 the makeup of the population at SATF or the staffing model at the institution." Dkt. No.
5 3446 at 6; *see also id.* at 5 ("Prisons are a very difficult place to work, and a prison like
6 SATF, with its enormous size and complex population, is particularly difficult."). The
7 Court Expert made a series of related recommendations, including that Defendants
8 evaluate whether to change "the makeup of the population at SATF to enable it to better
9 serve the population it houses" (Recommendation 39), whether to add "an upper-level
10 management position, such as a captain, in the ADA Office of SATF" (Recommendation
11 32), whether to offer "special incentives for ADACs who remain in the position longer
12 than three years" (Recommendation 33), and whether to add "a second lieutenant position
13 to supervise FTS sergeants at SATF" (Recommendation 34). *Id.* at 65.

14 In response, Defendants inexplicably suggest that they can house ***more*** people with
15 disabilities at SATF, asserting that "SATF has a total bed-count of 6,038 and, of these
16 beds, approximately 1,400 are vacant. Essentially, in light of its construction, every bed at
17 SATF is cleared for class-member assignment with one DPP code or another."[1] Dkt. No.
18 3453 at 22. But the problem is not available bed space. It is that existing staff are
19 overwhelmed by SATF's current "enormous size and complex population" and cannot or
20 will not adequately accommodate people with disabilities and treat them with dignity,
21 respect, and empathy. *See* Dkt. No. 3446 at 5, 6. Filling empty beds with additional
22 people with disabilities will only exacerbate the problem. And no amount of "re-training
23 concerning the elimination of implicit bias" and "responsibilities relating to incarcerated
24 people with disabilities," Dkt. No. 3453 at 22-23, can make up for inadequate resources to
25

26 [1] In fact, SATF is at 145% of its capacity, and hundreds of the vacant beds are set-aside for
27 purposes of isolation and quarantine. Declaration of Rita K. Lomio in Support of Plaintiffs' Response to Court Expert's Report Regarding Treatment of People with
28 Disabilities at SATF ("Lomio Decl."), filed under seal herewith, Exs. 1-2.

1 meet the needs of the population and address staff burnout.[2] *See* Dkt. No. 3446 at 54.
2 The flip side of reducing the size and complexity of the population is scaling up
3 staff to meet existing needs. But Defendants ignore entirely the recommendations for
4 additional staff in the ADA office, notwithstanding the Court Expert's finding that if the
5 ADA Coordinator ("ADAC") "had additional staff support, they would be able to focus on
6 self-auditing compliance with the ADA and ARP." *See* Dkt. No. 3446 at 59. Defendants
7 also ignore the recommendation that they consider incentives to avoid constant turnover in
8 the ADAC position, even though the Court Expert found that "SATF has seen four
9 ADACs in the last five years" and that the "high level of turnover in the position … hurts
10 the overall ADA program." *See id.* at 60. And Defendants ignore the recommendation for
11 a lieutenant position to supervise FTS sergeants, even though the Court Expert found that
12 "one shift of FTS sergeants has no direct supervisor during their working hours." *Id.* at 56.
13 Instead, Defendants say only that "CDCR continuously evaluates its staffing needs
14 at its institutions" and "will continue to evaluate the appropriate staffing levels for each
15 yard with attention to those requiring ADA accommodations." Dkt. No. 3453 at 21. That
16 rings hollow. There is no indication that Defendants have ever conducted a meaningful
17 evaluation of staffing needs in light of the large and complex *Armstrong* population at
18 SATF.[3] The institution's current ADA staffing was created by court order or after
19 demands by Plaintiffs.[4] This includes the Staff Services Analyst in the ADA office and the
20

21 [2] Jennifer Edgoose *et al.*, How to Identify, Understand, and Unlearn Implicit Bias in
22 Patient Care, Family Practice Management, American Academy of Family Physicians 29,
31 (2019), https://www.aafp.org/dam/brand/aafp/pubs/fpm/issues/2019/0700/p29.pdf
23 ("[S]tressful, time-pressured, and overloaded clinical practices can actually exacerbate
unconscious negative attitudes. … Like any habit, it is difficult to change biased behaviors
24 with a 'one-shot' educational approach or awareness campaign. Taking a systematic
approach at both the individual and institutional levels, and incorporating a continuous
25 process of improvement, practice, and reflection, is critical to improving health equity.").

26 [3] Defendants cite to a Declaration of Connie Gipson, Director of the Division of Adult
Institutions. Dkt. No. 3453 at 21. But that declaration only restates verbatim Defendants'
27 response brief. *Compare id. with* Dkt. No. 3453-1 at 18-19 ¶ 32.

28 [4] *See* Dkt. No. 1045 at 5, 2007 Injunction (ordering Defendants to "appoint one full-time
(footnote continued)

1 addition of a captain over F and G yards that Defendants tout in their response.[5]

2 As the Court Expert found, "[g]iven the number of 1824s that are filed at SATF, as
3 well as the complex and large population the prison serves, a single leader in the ADA
4 Office shoulders a disproportionate load as compared to smaller institutions that also have
5 one ADAC." Dkt. No. 3446 at 60. Compare, for example, SATF and Pleasant Valley
6 State Prison ("PVSP"), both located in rural areas in the Central Valley, 50 miles from one
7 another. Last year, SATF had almost twice the total population as PVSP (4,437 compared
8 to 2,559), and over eleven times the people designated as *Armstrong* class members (785
9 to 69).[6] Lomio Decl., Ex. 3. In addition, the type and complexity of disabilities differed
10 substantially. SATF housed 610 class members with impacting placement disabilities,
11 including 175 wheelchair users, 90 people with severe vision disabilities, and 12 deaf
12 people; 126 people with prescribed incontinence supplies; 210 people in the
13 Developmental Disability Program; and 495 people in the Enhanced Outpatient Program.

14

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16 staff member at the Associate Warden level or higher as the ADA Coordinator at each institution designated to house prisoners with disabilities impacting placement …, with a
17 supervising correctional counselor as an assistant"); Dkt. No. 3218 at 6, Five Prisons Order (ordering Defendants to "significantly increase supervisory staff by posting additional
18 sergeants on all watches and on all yards at" SATF).

19 [5] *See* Lomio Decl., Ex. 27 at 1, 3 (Apr. 8, 2021) (letter from Plaintiffs' counsel stating: "**Defendants should designate an SSA position in the SATF ADA office to help**
20 **manage the volume of appeals, ensure that disability-specific expertise guides appeal processing at all levels, and ensure that all deadlines are met** …. Much of the burden
21 falls on the AGPA. When we asked her last year about the frequent missed deadlines, she acknowledged that workloads did not always allow her and others in her office sufficient
22 time to meet the requirements of the CDCR 1824 process and that they instead had to 'reprioritize,' **each day**, appeals raising PREA, use of force, and safety concerns over
23 disability-related appeals."); *id.*, Ex. 7 at 8 (Jan. 10, 2022) (Budget Change Proposal stating: "The PLO [Prison Law Office] has focused on the CDCR's inability to meet
24 deadlines on RAP requests, and cites the cause is due to the analyst in the Grievance Office is overtasked. Providing an analyst to the ADA Office will lessen the burden on the
25 Grievance Office, taking action to be responsive to the PLO's request."); *id.* ¶ 8 (Plaintiffs' counsel recommended F and G yards at SATF each have a full-time captain assigned).

26 [6] Since then, the number of class members at SATF has increased, and the number at
27 PVSP has decreased. Declaration of Skylar Lovett in Support of Plaintiffs' Response to Court Expert's Report Regarding Treatment of People with Disabilities at SATF ("Lovett
28 Decl."), filed herewith, ¶¶ 9-11.

Lovett Decl., Ex. A. PVSP, by contrast, housed only 37 people with impacting placement disabilities, including 12 wheelchair users, no people with severe vision disabilities, and no deaf people; one person with prescribed incontinence supplies; no people in the Developmental Disability Program; and eight people in the Enhanced Outpatient Program. *Id.* The differences between the institutions in number and type of people with disabilities make for drastically different workloads; for example, SATF processed 2,006 requests for disability accommodation (CDCR 1824s) in 2021, while PVSP processed only 63. Lomio Decl., Ex. 4. And yet ***both SATF and PVSP have one ADA Coordinator***. *Id.*, Ex. 5.

Defendants' assertions that they will "continue to evaluate" staffing levels and population and "continue to provide updates to Plaintiffs' counsel and the Court Expert" therefore are inadequate. *See* Dkt. No. 3453 at 21-22. We are far past the point in this case of deferring to statements of good intentions and past processes. "Federal courts are not reduced to … hoping for compliance." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 440 (2004). This Court should appoint independent experts to work in consultation with the parties, Court Expert, Receiver in *Plata*, and Special Master in *Coleman v. Newsom*, Case No. 90-cv-00520 (E.D. Cal.), to develop recommendations on what resources and systems are necessary for SATF to meet its obligations under the ARP and ADA.[7] One expert should conduct a population, workload, and staffing analysis, and another expert should conduct a review of workplace stress, culture, professional burnout, and trauma exposure.

[7] The expert reviews should include consideration of the views of former and current staff. The Court Expert noted that "the former ADAC requested the addition of a captain position within the ADA Office to assist in responding to 1824s and advocacies, in order to allow the ADAC more time to monitor trends and self-audit." Dkt. No. 3446 at 60. In addition, the CEO and CME had requested "additional support in the form of another Chief Physician and Surgeon for SATF," but the request was denied in September 2021, and the CNE did not receive as many additional positions as requested. *Id.* at 54 nn.82-83. (SATF, like PVSP, has only one Chief Physician & Surgeon, who may serve on the Reasonable Accommodation Panel. Lomio Decl., Ex. 6 at 25, 29; Dkt. No 3453 at 10.)

II. COURT OVERSIGHT IS NECESSARY TO ENSURE THAT SATF DEVELOPS PROCESSES TO IDENTIFY AND REMEDY VIOLATIONS OF THE ADA AND ARP.

A. Defendants Must Adopt Processes and Provide Sufficient Resources to Allow SATF Leadership to Proactively Analyze Trends, Look for Systemic Issues, and Work at Self-Auditing and Prevention.

"Leadership's ability to self-diagnose and address problems is critical to sustainable compliance with the ARP and ADA." Dkt. No. 3446 at 57. Plaintiffs agree with the Court Expert that "SATF needs to adopt processes to enable it to identify and remedy" problems:

> Whether through receipt of disability accommodations requests, review of healthcare grievances, or observation of class members who were plainly not receiving the accommodations they needed, management had before it evidence of real problems at SATF for people with disabilities. However, it was not management that identified these problems; it was Plaintiffs' counsel….
>
> We find that SATF leadership failed to proactively identify and correct several systemic problems at the institution that they either knew or should have known of. We also find that staff and leadership need additional support to be able to identify and remedy such systemic problems and to adequately accommodate class members. We find that leadership has not been effective in self-monitoring the institution for ADA compliance and self-correcting when failures are identified.

Id. at 5, 6, 8; *see also id.* at 57-60. The Court Expert offered several possible reasons "why SATF did not identify and remedy" the serious problems he found:

> One explanation could be the institution does not have the capacity to do so; SATF may be simply too consumed by managing the needs of its large and complex population to be able to recognize when there are systemic failings in the treatment of its disabled population and to fix those failings. Another could be that there are inadequate measures to monitor systemic failures, and so there are not the mechanisms in place for SATF management and staff to recognize patterns or widespread problems. And a third explanation could be that the needs of disabled incarcerated people are simply not sufficiently prioritized.

Id. at 5; *see also id.* at 59-60 ("Currently, the ADAC is the equivalent of a fire marshal of a large city being asked to manage an entire fire department while personally responding to every 911 call …. With that amount of responsibility, it is difficult for the ADAC to spend time critically thinking about trends, looking for systematic issues, or working at self-auditing or envisioning ways to prevent issues, rather than just responding to them.").

Plaintiffs agree with the Court Expert that "SATF has not demonstrated that it is

1 able to self-monitor and self-correct in the manner that would justify a lesser level of
2 scrutiny by the Court and other outside monitors." Dkt. No. 3446 at 5. Defendants in their
3 response offer only canned language that lacks any concrete solutions: "CDCR has
4 carefully reviewed [the] Court Expert's report and is mindful of his recommendations as it
5 moves forward and develops a policy to promote self-auditing and system-failure
6 corrections to ensure compliance with the ADA and ARP." Dkt. No. 3453 at 22.
7 This Court therefore should appoint an independent expert to, in consultation with
8 the parties, Court Expert, Receiver, and Special Master, develop processes to enable SATF
9 to identify and remedy problems on its own, including through utilization of existing
10 avenues of information, including 1824s, 7362s, 602s, 602 HCs, advocacy letters from
11 Plaintiffs' counsel, and CCHCS dashboard data. Every six months, the parties and Court
12 Expert should meet with SATF management to discuss the operation and results of these
13 processes and report to the Court on the progress.

14 **B. Defendants Must Conduct Root Causes Analyses to Identify When**
15 **Policies or Systems Need to Be Developed or Revised.**

16 Another reason for SATF's inability to identify and fix problems on its own is a
17 myopic approach to examining only whether a particular staff person violated existing
18 policy, and not whether policies need to be developed or revised, as in many of the cases
19 identified by the Court Expert. *See, e.g.*, Dkt. No. 3446 at 23 (noting need for automatic
20 continuation of DME upon transfer), 41 (noting need to provide computer-assisted, real-
21 time captioning or another reasonable accommodation), 45 (noting need to clarify policies
22 regarding provision of assistive devices).
23 The Court should order Defendants to develop and implement a root cause analysis
24 process, already employed by the Office of Inspector General and commonplace in the
25 healthcare context, to evaluate whether policies or systems should be developed or revised
26 in order to mitigate risk of harm to people with disabilities. *See Jensen v. Shinn*, No. CV-
27 12-00601-PHX-ROS, 2023 WL 431819, at *9 (D. Ariz. Jan. 9, 2023) (draft injunction
28 containing detailed provisions requiring prison officials to "evaluate errors, system

problems, and possible system problems that come to their attention through sources, including but not limited to the near-miss and preventable adverse event reporting systems, [and] mortality reviews" and directing that a "root cause analysis shall be conducted as appropriate, from which an effective and sustainable remedial plan is implemented in a timely manner" and "monitored for effectiveness").[8]

The focus of the review should be "prevention, not punishment, and the analysis focuses on the 'how' and the 'why' and not on the 'who.'" *See Plata v. Newsom*, No. 01-CV-01351-JST, 2019 WL 11794090, at *1 (N.D. Cal. Dec. 30, 2019) (internal quotation marks and citation omitted).

> When bad things happen in criminal justice systems, they are rarely the result of a single actor, action, or decision, and are often indicative of a system weakness. However, most jurisdictions review errors solely through a lens of blame, looking for individual practitioners to punish. This blame-oriented approach ignores the multiple system causes that contributed to the bad outcome and remain in place to contribute to another, similar event in the future.

Nat'l Inst. Justice, U.S. Dep't of Justice, Empowering Local Communities to Advance Justice: NIJ and BJA Launch Sentinel Events Initiative National Demonstration Collaborations (2017), https://nij.ojp.gov/topics/articles/empowering-local-communities-advance-justice-nij-and-bja-launch-sentinel-events.

Put simply, the current focus of the noncompliance inquiry process is to identify violations of existing policy by individual staff members. *See, e.g.*, Dkt. No. 2180 at 22. This is critical. But it also is important to review serious events with an eye toward whether policies and systems need to be developed or improved, and whether negative outcomes could have been avoided by taking alternative actions. This can be seen in Defendants' investigation after an elderly, full-time wheelchair user and a Deaf man at SATF were bludgeoned to death. Lomio Decl., Exs. 45-49. The Court Expert "did not find evidence that the deaths were caused by a lack of staff concern specifically for

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[8] Plaintiffs have long requested this relief after people with disabilities have been assaulted and killed at SATF. *See* Lomio Decl., Exs. 25, 26, 43, 44.

Armstrong class members." Dkt. No. 3446 at 46. That may be true based on the investigation files available to the Court Expert but, short of uncovering difficult-to-obtain evidence of animus against deceased class members, staff misconduct investigations—the subject of extensive litigation just last year—also currently stop short of asking important systemic and remedial questions such as whether the institution could have done more to mitigate the risk, even if staff did not violate existing policy. Asking such questions after the double homicide, for example, would have allowed Defendants to consider whether housing a Deaf person, with a conviction offense that already made him a target, alone in a building without any other people who know sign language and without any means, such as a laptop equipped with video remote interpretation software, to allow him to readily communicate with housing officers in sign language may have placed him at unnecessary risk even if the decision to do so was not caused by an intentional lack of concern for his disability. Right now it is Plaintiffs, not Defendants, who are conducting that analysis. *See, e.g.*, Lomio Decl., Exs. 25, 26, 27, 29.

In addition, in the aftermath of the double homicide, SATF nursing and custody staff posted on social media celebrating the deaths. Dkt. No. 3446 at 46. Although the staff misconduct investigation resulted in individual discipline for a small number of staff in the form of pay reduction, training, and a letter of instruction from the warden, *see id.*; Lomio Decl., Ex. 50, the institution missed an opportunity to identify and address a serious institutional problem. Specifically, during the investigation of a nurse who posted a YouTube link to the song "Another One Bites the Dust," the nurse stated that posting was her and other medical staff's way of "coping" with violence that puts a "toll" on them. *Id.*, Ex. 50 at 7. By focusing on causative factors, and not individual accountability, Defendants could have recognized the serious breakdown in staff culture at SATF and developed a plan to address it. That is similar to the Court Expert's approach in his investigation. *See* Dkt. No. 3446 at 52 ("We did not investigate any individual healthcare staff member. Rather, we sought to understand systemic factors that may be contributing to the breakdown in relations between some staff and the population they serve.").

Similarly, a custody officer working an overtime shift was "terminated for falling asleep on shift, leaving incarcerated people to yell 'man down' and scream for help for over an hour after an incarcerated class member was murdered by his cellmate." Dkt. No. 3446 at 46; Lomio Decl., Ex. 51 at 6. But there is no indication that SATF considered whether the class member, an elderly, hard-of-hearing wheelchair user with incontinence, was properly housed with a 37-year-old cellmate or whether any other action could have been taken to mitigate the risk. *See* Lomio Decl. ¶¶ 36-37 & Ex. 51.

In sum, when a person with a disability is or could have been seriously harmed, or when another serious disability access issue occurs, prison officials must conduct root causes analyses to determine whether policies and systems should be developed or improved to mitigate risk and provide better protections in the future.

C. Defendants Must Provide Substantive and Timely Responses to Correspondence From Plaintiffs' Counsel.

The Court also should order Defendants to timely respond to Plaintiffs' letters raising individual and systemic disability access concerns.[9] *See Jensen*, 2023 WL 431819, at *5 (draft injunction requiring prison officials to "provide substantive and timely responses in writing to concerns raised by Plaintiffs' counsel regarding individual treatment or systemic issues"). Plaintiffs' ability to monitor and collaboratively and expeditiously resolve noncompliance issues at SATF and other institutions has been obstructed by long delays in receiving responses to correspondence, including delays of over two years. Declaration of Penny Godbold in Support of Plaintiffs' Response to Court Expert's Report Regarding Treatment of People with Disabilities at SATF ("Godbold

[9] Plaintiffs repeatedly have requested without success that Defendants timely respond to advocacy letters. Godbold Decl. ¶¶ 8-13, Exs. A-C. A 30-day requirement would be reasonable; Defendants have 30 days to respond to a request for disability accommodation submitted through a CDCR 1824. *See* Lomio Decl., Ex. 60; Dkt. 1559-1 at 80 (Aug. 14, 2009). Plaintiffs have recommended that to help Defendants better respond to correspondence, Defendants hire a disability access consultant or ensure that ADACs are knowledgeable and experienced in ADA issues.

Decl."), filed under seal herewith, ¶¶ 3-7. Defendants' failure to timely respond results in the need for repeated advocacy on the same topic and unacceptable delays in accommodating people with disabilities. For example, Plaintiffs sent letters regarding SATF's failure to accommodate Person F on October 21, 2020; January 8, 2021; and April 14, 2021. Dkt. No. 3446 at 44; Lomio Decl., Exs. 19-21. Defendants did not respond until May 11, 2021—***202 days*** after the initial advocacy letter. Dkt. No. 3446 at 44; Lomio Decl., Ex. 22. And that did not resolve the issue. As the Court Expert found, "[d]espite three years of advocacy through 7362s, 1824s, 602s, and requests by Plaintiffs' counsel, Person F still has not received an assistive device to accommodate him in writing."[10] Dkt. No. 3446 at 14; *see also id.* at 23 (making similar findings as to Person B); 31 (Person C); 35 ("It is difficult to understand why SATF healthcare leadership resolved this issue [of pull-up diapers] only after Plaintiffs' counsel raised it and had engaged in advocacy about the issue for over a year."); Lomio Decl., Exs. 10-15, 30, 31, 42.

Plaintiffs have played a critical role in identification of serious breakdowns of the disability accommodation system at SATF. As the Court Expert found, "it was not management that identified these problems; it was Plaintiffs' counsel." Dkt. No. 3446 at 5. A system needs to be put in place to ensure that Defendants timely review and address issues raised by Plaintiffs and that clear and open lines of communication are available in order to facilitate the identification and resolution of issues and, ultimately, this case.[11]

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[10] Most recently, on November 16, 2022, Plaintiffs again requested information about the status of the accommodation for Person F, as well as an explanation for the appropriate manner of processing the request for that accommodation. Lomio Decl., Ex. 23. Defendants have not responded. *Id.* ¶ 15(e).

[11] This may require allocation of additional resources, including to counsel for Defendants. Last year, Defendants submitted a Budget Change Proposal ("BCP") requesting additional staff to manage class action lawsuits, including *Armstrong*. Lomio Decl., Ex. 8 at 1. The BCP noted that additional staffing was necessary, in part, to handle the "necessary and indispensable work" of responding to advocacy letters from Plaintiffs' counsel. *Id.* at 2-3. The BCP stated that "there are insufficient legal and administrative resources available to make meaningful progress in these cases," which results in "a crisis-oriented, reactive litigation style, rather than a measured, well-reasoned, strategic, and proactive effort" designed to "demonstrat[e] the ability to take effective corrective action if and when (footnote continued)

III. COURT OVERSIGHT IS NECESSARY TO REPAIR BROKEN SYSTEMS MEANT TO ENSURE PROVISION OF REASONABLE ACCOMMODATIONS.

The Court Expert found "that SATF is failing to provide reasonable accommodations for people with disabilities in a timely manner, or sometimes at all." Dkt. No. 3446 at 14. The Court Expert described a number of "systemic failures at SATF," including related to accommodations during transfer into SATF; the ability to request accommodations; issuance and repair of accommodations, including diapers, disposable gloves, and bags for incontinence; and accommodations for deaf and hard-of-hearing people. *Id.* at 7, 14; *see id.* at 14-45. Court oversight is needed to ensure the system breakdowns identified by the Court Expert are expeditiously resolved.

A. Durable Medical Equipment, Assistive Devices, and Supplies

1. Defendants Are Ultimately Responsible for Ensuring Compliance With the ARP and ADA, and Must Do So In Coordination with the Receiver.

The Court Expert made a number of recommendations related to provision of Durable Medical Equipment ("DME"), assistive devices, and supplies. Dkt. No. 3446 at 60-64 (Recommendations 2-21). Defendants do not address most recommendations on the grounds that they "are directed solely to CCHCS and fall under the authority of the *Plata* receivership." Dkt. No. 3453 at 5; *see id.* at 7-14 (addressing only Recommendations 2, 4, 16-19, 21). But Defendants ultimately are responsible for compliance with their obligations under the ARP and ADA in this case, even if some of the processes currently in place to provide disability accommodations overlap with those overseen by the Receiver.[12] *Cf.* Lomio Decl., Ex. 92 (CCHCS policy requiring that "all staff comply with the requirements outlined in the Disability Placement Program" related to accountability).

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deficiencies are identified" and resolve issues "with program staff before those issues have an opportunity to become systemic." *Id.* at 2-3, 5-6.

[12] Defendants' approach also will result in matters falling through the cracks. Neither CDCR nor CCHCS, for example, address Recommendation 23, which implicates both entities. *See* Dkt. No. 3453; Dkt. No. 3453-1, Ex. A (Receiver's Status Report).

Indeed, "[t]he Chief Executive Officer and the Warden at each institution are ***jointly responsible*** for the implementation and monitoring of" CCHCS's DME and Medical Supply policy.[13] Lomio Decl., Ex. 64 (emphasis added). As the Court Expert found:

> [T]he Warden and the healthcare CEO must communicate more directly about ADA compliance. When systemic failures come to the attention of the Warden, such as the failure to devise a clear policy for how to issue and repair DME, the Warden must coordinate with the CEO and press for healthcare leadership to fix those problems. If class members at SATF are not receiving disability accommodations because of a problem with healthcare delivery or any other reason, that is ultimately the responsibility of the Warden.

Dkt. No. 3446 at 60.

To rebuild the disability accommodation system at SATF, CDCR and CCHCS must work together, viewing the system as a whole, and not divide it into individual territories under the auspices of one administrator and not another, with fragments parceled out between CDCR and CCHCS for separate remedy.[14] *Cf. Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *25 (N.D. Cal. Oct. 3, 2005) (noting that "provision of adequate medical care in [CDCR] presents a classic example of a 'polycentric' problem, … 'with a number of subsidiary problem "centers," each of which is related to the others, such that the solution to each depends on the solution to all the others'") (quoting William A. Fletcher, The Discretionary Constitution: Institutional Remedies and Judicial Legitimacy, 91 Yale L.J. 635, 645 (1982)).

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[13] The Warden is a CDCR employee and the Chief Executive Officer is a CCHCS employee. Dkt. No. 3453 at 7.

[14] SATF has a history of lack of collaboration between custody and healthcare staff. In 2021, "a retired Warden was stationed at SATF to provide advice and guidance to the ADAC, and a retired Assistant Warden with experience managing healthcare was stationed at SATF to provide guidance to the CEO." Dkt. No. 3446 at 56. Both "identified a disconnect and a communication breakdown between healthcare and custody, particularly at the leadership level." *Id.* (noting that the retired annuitants "were not asked to provide a written report to CDCR … and it is not clear that any action was taken based on their findings"); *see also* Lomio Decl., Ex. 88, SATF CCHCS Healthcare Facilities Maintenance Assessment Results at 20 (Sept. 29, 2022) ("The assessment team observed poor communication, a lack of cohesive partnership, and no mutual accountability between the disciplines," including custody and clinical staff).

2. Defendants' Meager, Half-Formed Plans and Conclusory Promises Are Inadequate to Address the Serious, Longstanding System Failures Identified by the Court Expert.

Defendants' plans to address the few recommendations they do view as within their purview are not plans at all—they largely are conclusory statements that they will come up with a plan sometime in the future.[15] Given the magnitude of the system failures, and the severity of the harm, that simply is insufficient.

In addition, the few actions Defendants have taken simply re-tread the same ground as before, with no reason to believe they will lead to a different result. First, CDCR and CCHCS jointly issued a one-page memorandum entitled, "Reiteration of Reasonable Accommodation Requirements." Dkt. No. 3453-1 at 180, Ex. G. Defendants state that this memorandum is responsive to Recommendations 16 and 19.[16] *See* Dkt. No. 3453 at 10,

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[15] *See, e.g.*, Dkt. No. 3453 at 5 ("CDCR will cooperate with CCHCS on areas jointly affecting their obligations and work towards promptly resolving those issues."); *id.* at 8 ("CDCR will coordinate with CCHCS to address custody-staff responsibilities related to any interruption to accommodations attributed to transferring into SATF."); *id.* at 9 ("CDCR will coordinate with CCHCS to address the issues raised by the Court Expert concerning DME and supplies as related to custody-staff responsibilities."); *id.* at 12 ("CDCR will coordinate with CCHCS as necessary to ensure a successful policy [related to incontinence supplies]"); *id.* ("To the extent custody staff members are involved in making these decisions while serving on the RAP, SATF commits to complying with the recommendation to meet its obligation under the ADA."); *id.* at 13 ("CDCR will coordinate with CCHCS to develop a process and policy [related to appliances and devices not considered medical DME] that implements the Court Expert's recommendations for a clear process that does not cause unnecessary frustration, confusion, or delay as illustrated in the report.").

Plaintiffs already have raised concerns with the adequacy of Defendants' August 16, 2022 memorandum regarding incontinence related services and supplies, which Defendants declined to adopt or share with institutions in the process of developing local operating procedures. *See* Dkt. No. 3453 at 11; Lomio Decl. Ex. 35 (Plaintiffs' letter regarding concerns with night-time access, access to wet wipes, par levels, timely replenishment, and confusing language regarding "unforeseen" incontinence), Ex. 36 (Defendants' response).

[16] **Recommendation 16**: "Members of the RAP must be retrained to emphasize they have an independent duty to provide DME where it is a reasonable accommodation, regardless of whether providers believe the DME is 'medically necessary.'" Dkt. No. 3446 at 63.

Recommendation 19: "Healthcare staff and all members of the RAP should also be reminded of the responsibility to provide individualized disability accommodations, even if doing so requires ordering nonformulary items." *Id.*

1 12. But Defendants do not explain how a memorandum that restates existing policy that
2 staff already were required to follow will provide a durable solution. *See* Dkt. No. 681 at
3 13, ARP § II.F; Lomio Decl. ¶ 44, Ex. 61 (memorandum issued by CDCR and CCHCS in
4 2020); *id.* ¶ 45, Ex. 62 (SATF LOP); *Braggs v. Dunn*, 383 F. Supp. 3d 1218, 1249 (M.D.
5 Ala. 2019) ("*Braggs I*") ("[T]he record has repeatedly shown that [prison]'s enactment of a
6 policy often does not translate to ground-level compliance").

7 Second, Defendants state that they have trained certain non-medical staff on how to
8 complete the current Intra-Facility Health Care Appliance Inventory Chrono, Dkt.
9 No. 3453 at 8 (Recommendation 4); the "independent duty to provide a reasonable
10 accommodation … even if the accommodation is not deemed medically necessary," *id.* at
11 10 (Recommendation 16); and the duty to provide reasonable accommodations "even if …
12 non-formulary." *Id.* at 12 (Recommendation 19). But mere invocation of additional
13 training on existing requirements is not a panacea; it is little more than a reiteration of the
14 status quo, which has not worked.[17] Defendants do not explain if and how this training,
15 which "reiterated … current policy," differs from previous training on the subjects—a
16 training which clearly did not work. *Id.* at 10-11; *see* Lomio Decl. ¶¶ 20, 46 & Exs. 28, 63
17 (previous RAP training). Indeed, after Plaintiffs requested copies of the training materials
18 for Recommendations 16 and 19, Defendants simply produced the one-page memorandum
19 on reasonable accommodations. *See* Lomio Decl., Ex. 90 at 3.

20 Nor do Defendants provide a way to evaluate efficacy of any training.[18] The most
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22 [17] Plaintiffs have the same concern with Defendants' response to Recommendation 1,
23 regarding legal mail processes. Defendants issued a memorandum that simply restated existing policy and provided a one-time, 30-minute training. *See* Dkt. No. 3453 at 6; Dkt.
24 No. 3453-1 at 35, Ex. C (training sign-in sheet). *Compare* Dkt. No. 3453-1 at 27, Ex. B (September 1, 2022 memorandum), *with* Cal. Code Regs., tit. 15 § 3141(d).

25 [18] *See Jensen v. Shinn*, No. CV-12-00601-PHX-ROS, 2023 WL 431819, at *8 (D. Ariz.
26 Jan. 9, 2023) ("A sustainable plan is one which outlives staff memory from a single training after the review or staff turnover."); *Thomas v. Bryant*, 614 F.3d 1288, 1320-21
27 (11th Cir. 2010) (affirming injunctive relief even though prison officials conducted additional training where, among other things, "the record calls into question whether the
28 … training has had any success"); *Braggs v. Dunn*, 562 F. Supp. 3d 1178, 1360 (M.D. Ala. (footnote continued)

information Defendants provide relates to training on the Appliance Inventory Chrono; but even then, Defendants simply produce a sign-in sheet that shows one sergeant and six officers received a 15-minute training on "Status Report in Response / OP 430." Dkt. No. 3453-1 at 161, Ex. E. OP 430 requires custody staff to monitor pill lines; it does not pertain to completion of the Chrono.[19] *See* Dkt. No. 3453-1 at 233-243, Ex. Q. This Court should require that all training "instruct in the skills addressed to a level that the trainee has the demonstrated proficiency to implement those skills as, and when called for, in the training." *See* U.S. Dep't of Justice, Lake County Jail Settlement Agreement (Aug. 2010), https://www.justice.gov/sites/default/files/crt/legacy/2011/01/05/lake_co_jail_settle_12-03-10.pdf.

B. Accommodations for People Who Are Deaf or Hard-of-Hearing

Next, the Court Expert found that Defendants for years have denied deaf and hard-of-hearing people reasonable accommodations, including real-time captioning, effective communication of announcements, and accessible telephone technology.[20] Dkt. No. 3446

2021) ("*Braggs II*") ("effective training depends on regularity and consistency"); *Braggs I*, 383 F. Supp. 3d at 1249 (finding previously ordered training to be insufficient and not containing necessary amount of detail); *Clark v. California*, 739 F. Supp. 2d 1168, 1231 ¶ 272 (N.D. Cal. 2010) (same).

[19] It also is hard to imagine any training would be effective because it was meant to address the current Intra-Facility Health Care Appliance Inventory Chrono, which the Court Expert found was "not a model of clarity," and based on current policy, which the Court Expert found to be "unclear." *See* Dkt. No. 3446 at 15, 16. In addition, Defendants say generally that the Field Training Sergeants ("FTS") required by the Five Prisons Order "can also be relied upon to address the issue of missing or damaged durable medical equipment" because they "routinely survey[] staff and incarcerated people." Dkt. No. 3453 at 8-9. But Defendants do not suggest that the FTSs are tasked specifically with auditing Chronos by, for example, identifying and speaking to people with disabilities immediately upon their arrival to SATF and then checking the accuracy of their Chronos.

[20] The Court Expert noted that deaf people who use sign language reported having access to staff sign language interpreters and video relay phones. Dkt. No. 3446 at 37. Plaintiffs' counsel visited SATF in January 2023, for a regularly scheduled monitoring tour and identified several issues related to equal access for people who use sign language, including related to videophone access. Lomio Decl. ¶ 58. Plaintiffs have informed SATF leadership of those issues. Following a discussion with Plaintiffs' counsel during the tour, the ADAC issued a memorandum to expand videophone access. *Id.* ¶¶ 59-60 & Ex. 68.

1 at 37-42; *id.* at 64 (Recommendations 22-26).

2 This Court already twice has ordered Defendants to comply with Section II.E of the
3 *Armstrong* Remedial Plan, which requires these same accommodations. *See* Dkt. No. 681
4 at 10, ARP § II.E (requiring effective communication for people with hearing disabilities
5 and listing as auxiliary aids "captioned television/video text displays" and "Telecommuni-
6 cation Devices for the Deaf (TDD)"); Dkt. No. 1045 at 9 (Jan. 18, 2007) (ordering
7 Defendants to comply with, among other things, Section II.E of the ARP); Dkt. No. 1661
8 at 4 (Oct. 20, 2009) (same). Stronger relief is necessary.

9 **1. Computer-Assisted, Real-Time Captioning**

10 The Court Expert found that Defendants discriminate against deaf people who do
11 not know sign language by failing to provide computer-assisted, real-time captioning
12 ("CART") or an alternative accommodation.[21] Dkt. No. 3446 at 41, 64 (Recommendation
13 26); *see also* U.S. Dep't of Justice, ADA Requirements - Effective Communication
14 (Jan. 31, 2014), https://www.ada.gov/effective-comm.htm (describing CART).

15 Defendants now claim they "will implement CART or an alternative reasonable
16 accommodation for deaf people who cannot sign," but they provide no explanation of what
17 will be provided, when it will be provided, where it will be provided, and how it will be
18 provided. Dkt. No. 3453 at 17. Defendants represent that "CDCR is actively working
19 with Plaintiffs' counsel," *id.*, but have not given Plaintiffs concrete answers to the above
20 questions. Lomio Decl. ¶ 56; Dkt. No. 3452 at 13-14. Defendants also state that they are
21

22 [21] As an immediate, stop-gap measure, the Court Expert recommended that SATF use
23 autocaptioning software through Microsoft Teams. Dkt. No. 3446 at 64 (Recommendation 25). Plaintiffs' counsel and class members have raised serious concerns about the
24 adequacy of autocaptioning software. Lomio Decl. ¶ 65 & Ex. 65. In their response, Defendants represent that they have issued a memorandum to implement the Court
25 Expert's recommendation and all training will be complete by February 28. Dkt. No. 3453 at 16. In fact, Defendants already had indefinitely paused the training and policy revision
26 requirements of the memorandum pending a transition to a different autocaptioning platform (WebEx). Lomio Decl. ¶¶ 50-53 & Ex. 66. The new platform is undergoing trial
27 at CHCF, there is no definite completion date, and Defendants have not agreed to work with Plaintiffs to ensure implementation and training are successful, despite multiple
28 requests by Plaintiffs' counsel. *Id.* ¶¶ 52, 54-55 & Ex. 66.

"in the process of locating and retaining a subject-matter expert." Dkt. No. 3453 at 17. It is not clear what this expert is for, and if it will be yet another cause for delay.

This issue already has dragged on for years, with empty promises and no action to remedy this clear violation of the ADA and ARP. *See* Dkt. No. 3446 at 38-42. Plaintiffs first demanded CART in 2019, for Person E at SATF and then statewide. Lomio Decl. ¶¶ 14(a), 16 & Exs. 16, 24. That did not fix the problem. Plaintiffs added CART to the agenda of the parties' Deaf and Hard-of-Hearing Workgroup in 2020 and to the agendas of the eighteen subsequent workgroup meetings, including the most recent one on January 12, 2023. *Id.* ¶¶ 65(a)-65(s) & Exs. 69-87. That also did not fix the problem. All the while, Defendants made false or misleading assurances to the Court and Plaintiffs; first claiming that they had requested and obtained funding for CART, and then unilaterally announcing that instead of providing the accommodation, they would conduct a four-month "proof-of-concept," which was deeply flawed, did not begin until September 2021, and lasted over a year.[22] *See id.*, Ex. 65. Court oversight thus is needed to ensure that CART is implemented immediately so deaf people who do not know sign language have the same access to programs, services, and activities as their peers.

2. Effective Communication of Announcements

The Court Expert found that "custody staff at SATF are not complying with the requirement to ensure deaf and hard of hearing people receive announcements."[23] Dkt.

[22] *See, e.g.*, Dkt. 3266 at 25, Joint Case Status Statement (May 17, 2021) (Defendants' Statement) ("Defendants continue to request quotes to add [CART] for the next fiscal year beginning July 1, 2021."); Dkt. 3296 at 18, Joint Case Status Statement (July 15, 2021) (Defendants' Statement) ("now that funding has been approved, OCE continues to request quotes to add [CART] for the current fiscal year."); Dkt. 3341 at 17, Joint Case Status Statement (Nov. 15, 2021) (Defendants' Statement) ("Defendants launched a proof-of-concept (POC) program in September 2021 to evaluate three different captioning programs for the deaf and hard-of-hearing population."); Dkt. 3440 at 16, Joint Case Status Statement (Nov. 15, 2022) (discussing the proof-of-concept at CMF).

[23] The requirement to provide effective communication in the form of personal notification of announcements to deaf class members has been included in SATF's LOP since at least 2001. *See* Dkt. No. 784-3 at 39; Dkt. No. 3453-1, Ex. D at 44.

No. 3446 at 42. This problem also is not new. Plaintiffs' counsel raised the problem following monitoring tours in October 2016, March 2017, June 2018, September 2018, and December 2018. Lomio Decl., Exs. 38-41. A joint audit of SATF in 2018 by the Office of Audits and Court Compliance ("OACC") and Plaintiffs' counsel identified the problem, and in 2019 OACC directed SATF management to complete a Corrective Action Plan to address this issue. Godbold Decl. ¶¶ 15-19 & Exs. D-E. Deaf people at SATF repeatedly reported the problem to facility captains for consecutive months in 2019. *See* Lomio Decl. ¶ 57 & Ex. 67. Person E filed a CDCR 1824 requesting effective communication of announcements in 2020, and again in 2022, without success.[24] *See* Lomio Decl., Exs. 52-53. And Plaintiffs have attempted to resolve this issue with Defendants since at least July 2021, and have proposed a pager system that would generate a record of notifications that Defendants have refused to adopt. *See* Lomio Decl. ¶¶ 65(i)-65(s) & Exs. 77-87.

The Court Expert determined that "SATF leadership cannot continue to respond to complaints by deaf and hard of hearing about not receiving announcements by stating that staff will ensure they receive announcements." Dkt. No. 3446 at 42. But that is precisely what Defendants do, stating that they will "ensure that announcements are properly communicated to incarcerated people with hearing disabilities at SATF." Dkt. No. 3453 at 15. Defendants also represent that they have "created a workgroup to identify ways to audit staff communication of announcements," *id.* at 14—focusing narrowly on the Court Expert's specific recommendation to develop an auditing system and ignoring findings that

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[24] After the Court Expert issued his Report, Plaintiffs' counsel visited SATF and interviewed Person E. Lomio Decl. ¶ 61. Plaintiffs' counsel then told the Warden, ADAC, and other institution and headquarters staff that Person E still was not receiving effective communication of announcements and, in fact, was so discouraged that he simply gave up trying and would not tell the staff, including the facility captain, about problems because he saw no point in doing so. *Id.* ¶ 63. In response, the ADAC generated a poster to be placed at the officer's station and medical clinic with the class member's photo under block letters reading "**PERSONAL NOTIFICATION REQUIRED**," with detailed instructions. *Id.* ¶¶ 61-62 & Ex. 68. It is not clear whether the poster will be effective for Person E, or whether any action was taken to help other people at SATF in similar situations, but it demonstrates SATF's delayed and reactive approach and failure to "look[] for systematic issues." Dkt. No. 3446 at 60.

1 even when SATF has been aware of the issue, it has not been able to develop a durable
2 solution. Finally, and strangely, Defendants point to a December 1, 2022 memorandum
3 entitled, "Revised Expectations Regarding Failure to Report to Ducated Appointments."
4 *Id.* at 15. But that memorandum simply restates existing policy ***except that it omits the***
5 ***portion of the policy requiring effective communication to people with disabilities***.[25]
6 *Compare* Dkt. No. 3453-1, Ex. I, *with* Lomio Decl., Ex. 91. That, clearly, is not enough.

7 **3. Accessible Telephones**

8 The Court Expert stated that "SATF must ensure that deaf people who cannot sign
9 have access to TTY/TDD phone calls, or an alternative accommodation such as captioned
10 video calls, and are educated on how to request those calls and use the service."
11 Dkt. No. 3446 at 64 (Recommendation 24). In response, Defendants again simply restate
12 existing policy and assert that "CDCR will ensure the hearing-impaired incarcerated
13 people are aware that these devices are available in each facility and that the functionality
14 of these devices is properly maintained." Dkt. No. 3453 at 15-16. Regardless, TTY is
15 "old technology that is fast becoming obsolete." *See Heyer v. U.S. Bureau of Prisons,* 849
16 F.3d 202, 207 (4th Cir. 2017). Defendants have not provided captioned phones at SATF
17 and, as the Court Expert notes, have not required the tablets that have been provided to all
18 incarcerated people to be equipped with captioning or relay services. Dkt. No. 3446 at 42.

19 **C. Accommodations for People Who Are Blind or Have Low Vision**

20 The Court Expert found that desktop video magnifiers were broken in multiple
21 libraries at SATF, and that it was "not clear that the devices had been reported as broken or
22 when they would be repaired." Dkt. No. 3446 at 45. In response, Defendants propose that,
23 to supplement daily inventories and testing of auxiliary aids that they state librarians
24 already perform, SATF education staff "conduct quarterly inventories for the Merlin
25
26
27 [25] The memorandum also expressly permits staff to author RVRs against patients who do not report to appointments, other than mental health appointments. Dkt. No. 3453-1, Ex. I. Plaintiffs' counsel has raised serious concerns with that policy. Lomio Decl., Ex. 37.
28

devices" and maintain logs in the Special Programs Department. Dkt. No. 3453 at 14. As an initial matter, when Plaintiffs asked for documentation of the daily inventories that supposedly already are taking place, Defendants responded, "There are no responsive logs to produce." Lomio Decl., Ex. 90.

In any event, like many others in the response, Defendants' proposed remedy is half-formed; less frequent inventories of only one type of auxiliary aid are unlikely to resolve the deficiencies identified in the Court Expert's report. Even if Defendants ensure these critical magnifiers in the library are working, they will remain largely inaccessible due to modified programming (including due to COVID-19 and staffing shortages), limited library hours, and myriad other factors. Defendants have not committed to making these desktop magnifiers available to blind and low-vision class members in their housing units.

D. Disability-Related Safety Concerns

Plaintiffs agree with the Court Expert that representatives from CDCR, CCHCS, and Plaintiffs' counsel should form a workgroup to address the process for housing class members whose disabilities make them more vulnerable to abuse in prison. Dkt. No. 3446 at 48. Defendants seek to exclude Plaintiffs from this workgroup without explanation. *See* Dkt. No. 3453 at 19. That is inappropriate. The January 19, 2016 memorandum that Defendants discuss at length was the result of negotiations with Plaintiffs' counsel, and Plaintiffs' counsel have raised concerns with its current adequacy and efficacy in light of the problems identified at SATF and elsewhere. *See* Godbold Decl. ¶ 20 & Ex. F.

IV. COURT OVERSIGHT IS NECESSARY TO PREVENT IMPROPER PARTICIPATION BY HEALTHCARE STAFF IN DISCIPLINE AND PUNISHMENT OF PATIENTS.

Plaintiffs agree with the Court Expert that "nursing staff's issuance of RVRs has damaged relationships with incarcerated people" and that "[w]hen nurses are given the power to recommend punishment for their patients, even for minor rule violations, they are no longer just care providers; they are imposers of discipline. That creates a fundamental

shift in the relationship, one that likely affects both the nurse and the patient."[26] Dkt. No. 3446 at 50. Plaintiffs further agree that "[t]he excessive issuance of RVRs by nursing staff has surely contributed to [an] atmosphere" where people with disabilities feel disrespected. *Id.* One LVN, for example, issued an RVR to a class member with a mobility disability after he explained that he was late to pill call "because I was shaving for a visit I have later." Lomio Decl., Ex. 58. The LVN wrote that she told him that "shaving can be done at an alternate time" and that he "would be receiving disciplinary action." *Id.* At the time the LVN wrote this RVR, in-person visitation had only recently reopened, and many people incarcerated in state prison had not seen their loved ones in over a year. *Id.*, Ex. 89. This may have been the first time the class member was seeing his loved ones after months of COVID-19 lockdowns. *See also id.*, Ex. 59 (RVR issued by another LVN claiming that full-time wheelchair user, after being pushed to the medication distribution window, "proceeded to ramble on about his nephew and that he was doing good," and she had to tell him to "not just hang around holding up the medication lines" and "informed him next time if there was an issue it could be a 128," a type of RVR).

The new policy—that "healthcare staff should report administrative violations to custody staff either verbally or in a CDC-837 Crime/Incident Report" and "[c]ustody staff will determine whether the behavior merits an RVR," Dkt. No. 3446 at 50-51 (parentheticals omitted)—does not change the status quo. Healthcare staff still will be initiating RVRs against their patients, even if the RVRs technically are entered into the

[26] As the Court Expert found, "receiving an RVR, even for minor infractions, can have negative consequences for incarcerated people, particularly those being considered for parole." Dkt. No. 3446 at 49 n.77; *see also Armstrong v. Newsom*, 475 F. Supp. 3d 1038 (N.D. Cal. 2020); *In re Hare*, 118 Cal. Rptr. 3d 1, 13 (Cal. App. 2010) (finding petitioner to be a "strong candidate for release on parole" but affirming, under deferential standard of review, the Governor's parole reversal based on a six-year-old RVR); *In re Reed*, 90 Cal. Rptr. 3d 303, 315 (Cal. App. 2009) (affirming the denial of parole on the ground that petitioner had received a recent 128-A counseling chrono); *Menefield v. Board of Parole Hearings*, 220 Cal. Rptr. 3d 442, 448-49 (Cal. App. 2017) (holding that minor and administrative misconduct may be considered when determining a life prisoner is unsuitable for parole).

record system and issued by custody staff.

This Court should order Defendants, in coordination with the Receiver in *Plata* and Special Master in *Coleman*, to develop a written policy that limits healthcare staff referrals of patients for disciplinary action to exceptional circumstances—for example, where the patient's behavior poses a serious threat to the safety of others and the behavior, if proven, would constitute a crime.[27] This policy should describe specifically the role of custody and healthcare supervisors and leadership in tracking RVRs resulting from referrals to custody, which, for a provisional period of at least one year, should include review by the Class Action Management Unit ("CAMU") of each RVR, in coordination with CCHCS Regional and Headquarters staff and Plaintiffs' counsel. Defendants also should review and determine whether to void RVRs previously initiated by healthcare staff at SATF.

CONCLUSION

This Court should adopt the undisputed findings of the Court Expert and order the relief set forth in the proposed order filed herewith.

DATED: February 7, 2023

Respectfully submitted,

PRISON LAW OFFICE

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[27] Consultation with the Special Master in *Coleman* is appropriate because, as Plaintiffs have reported, mental health staff also initiated disciplinary action against their patients, including related to distribution of incontinence supplies. *See, e.g.*, Lomio Decl. ¶¶ 24-26 & Exs. 32-34 (RVR issued by Psych Tech to an elderly wheelchair user who requires a weekly provision of diapers and wipes to accommodate his incontinence, after he requested his diapers during pill call).