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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

No. 2:-90-cv-0520-LKK-JFM (PC)

vs.

ARNOLD SCHWARZENEGGER,
et al.,

Defendants.

ORDER

_____ /
This matter is before the court on the Special Master’s Report and Recommendations on His Expert’s Report on Suicides Completed in the California Department of Corrections and Rehabilitation in Calendar Year 2007 filed December 24, 2009 (hereafter December 24, 2009 Report and Recommendations). Therein, the special master recommends orders based on recommendations contained in the Report on Suicides Completed In the California Department of Corrections and Rehabilitation in Calendar Year 2007, filed September 17, 2009, (hereafter the 2007 Suicide Report). Defendants interpose several objections to the special master’s report and recommendations. Plaintiffs have filed an opposition to defendants’ objections, and defendants have filed a reply in support thereof.

The special master recommends the following orders:

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1 1. Defendants shall specifically identify inmates' known and/or
2 suspected medical problems and medications within these inmates'
3 mental health treatment plans, rather than merely allude to them by
4 reference to other records.

5 2. CDCR and DMH shall communicate and collaborate with each
6 other to ensure that the highest level of care provided by DMH to
7 CDCR inmates is given to any inmate who has been determined to
8 need it.

9 3. Defendants shall accord priority to access to inpatient care for
10 CDCR inmates at DMH facilities, particularly for Level III and
11 Level IV inmates. This involves requiring clinical staff to properly
12 assess suicide risk factors for inmates experiencing changes in
13 mental health functioning, particularly on placement in
14 administrative segregation or other single-cell housing. A vital
15 component of this process is appropriate crisis-level service in
16 treatment settings such as MHCBS, or limited treatment within
17 OHUs, until transfers to DMH facilities can be achieved. DMH
18 must be held accountable for its decisions on admissions or
19 rejections and cannot be permitted to avoid transparency behind a
20 pretext of patient "confidentiality."

21 4. Defendants shall fully and timely implement the suicide
22 prevention and review processes that are already in place, at both
23 the institutional and department levels, and shall give this priority.
24 This includes incorporation of revised policy and procedural
25 guidelines and court orders into these processes. It also entails the
26 identification of deficiencies at the facility and systemic levels,
appropriate follow-up of corrective action plans, and submission of
documentation to the Coleman special master on the outcomes of
investigations of staff misconduct, negligence, and error. This
process must include not only training but supervision and
appropriate supervisory action regarding staff performance.

December 24, 2009 Report and Recommendations at 2. The recommended orders are based on
several findings in the 2007 Suicide Report, including:

- The CDCR inmate suicide rate in 2007 continued "CDCR's pattern of exceeding the national prison suicide rate."
- The 2007 CDCR inmate suicide rate was "higher by 1.5 percent than the CDCR average annual suicide rate per 100,000 inmates for the preceding nine years."
- "In 82 percent of the suicide cases in 2007, there was at least some degree of inadequacy in assessment, treatment, or intervention, for the highest rate of inadequacy in these areas in the past several years."

- 1 • In 79 percent of cases, deadlines in completion and
2 submission of required documentation of suicides were
3 missed, and some reporting was not completed at all by the
4 time the 2007 Suicide Report was filed.
- 5 • Although three suicides were completed in Department of
6 Mental Health (DMH) facilities, DMH refused to provide
7 complete documentation of quality improvement and other
8 action plans to the special master.

9 2007 Suicide Report at 1-2.

10 At the outset, the court notes that the recommended orders are almost identical to
11 the four recommendations contained in the 2007 Suicide Report, which was filed on September
12 17, 2009. Id. at 18-19. On October 1, 2009, defendants filed a motion to modify that report.
13 Defendants did not object to the substance of any of the recommendations. Defendants did,
14 however, object to the request by plaintiffs, made in opposition to the motion, that those
15 recommendations be made orders of this court; defendants contended then only that none of the
16 recommendations meets the criteria for injunctive relief set forth in 18 U.S.C. § 3626. See
17 Defendants’ Reply Brief, filed November 6, 2009, at 11. By order filed November 23, 2009,
18 defendants’ motion was denied. Plaintiffs’ request that the recommendations in the 2007 Suicide
19 Report be made orders of this court was also denied, without prejudice, based on the court’s
20 determination that requests for such orders should come, if at all, from the special master. Order
21 filed November 23, 2009, at 14. On December 24, 2009, the special master filed the instant
22 request. Defendants now raise again their objection that the recommended orders do not meet
23 the criteria for injunctive relief set forth in 18 U.S.C. § 3626, and they raise additional objections
24 to adoption of some of the recommendations as orders of the court.

25 Suicide prevention and policy has been monitored by the Coleman special master
26 since late 1998, see Order filed Dec. 22, 2000, at 1 n.1, and the special master has filed annual
reports on completed inmate suicides in the California Department of Corrections and
Rehabilitation (CDCR) since October 2000. The first Suicide Report, filed on October 10, 2000
as part of the Sixth Monitoring Report, examined “completed suicides in the California

1 Department of Corrections (CDC) from October 1998 through December 1999” and included
2 several observations and recommendations. Coleman Suicide Report, October 6, 2000,
3 appended to Sixth Monitoring Report, at 1, 5-6. All of the observations and recommendations in
4 that report were adopted by this court in an order filed December 22, 2000. See Order filed
5 December 22, 2000, at 4.

6 Since the first report, the special master’s experts have conducted annual reviews
7 of completed inmate suicides, and their reports have been filed with the court either as part of the
8 special master’s monitoring reports or as separate stand alone reports. The 2007 Suicide Report
9 is the most recent of these reports. In addition, the special master has filed several other reports
10 and recommendations related to suicide prevention and policy. Many of the recommendations
11 contained in these reports have become orders of this court.

12 The issues undergirding the recommendations before the court have been the
13 subject of recommendations from the special master several times over the past decade. For
14 instance, the need for adequate consideration of information available in the medical records of
15 Coleman class members has been the subject of numerous observations and recommendations in
16 Suicide Reports filed by the special master. In the 2004 Suicide Report, filed May 9, 2006, the
17 special master’s expert observed that “[t]he failure of clinicians to make use of available
18 information to ensure that inmates are fully and appropriately screened, assessed and treated
19 remained a dominant problem. In too many cases, completed suicides occurred when
20 information in a UHR [Unit Health Record] or central file, had it been reviewed by mental health
21 clinicians during interviews with inmates, might have alerted mental health staff to inmates’
22 potential for suicide.” 2004 Suicide Report at 10. Similar observations were made in the 2005
23 and 2006 Suicide Reports. See 2005 Suicide Report, filed November 26, 2007, at 12; 2006
24 Suicide Report, filed September 12, 2008, at 10. On July 31, 2007, the special master filed a
25 report prepared by his psychiatric experts summarizing their review of completed suicides by
26 CDCR inmates from 1999 through 2004. That report also identifies the failure of clinicians to

1 “review fully and carefully available documentation, such as health and classification records, for
2 indices of prior suicidal activity or ideation” among “clinical practices . . . that ought to be
3 addressed.” Special Master’s Psychiatric Experts’ Review of Completed Suicides in the
4 California Department of Corrections and Rehabilitation in Calendar Years 1999 through 2004,
5 filed July 31, 2007 (hereafter Six-Year Suicide Report), at 9.

6 The need for effective communication and collaboration between CDCR and
7 DMH to provide Coleman class members with access to necessary levels of DMH care has also
8 been the subject of repeated observations and recommendations by the special master. Similarly,
9 defendants’ obligation to provide “timely access to DMH inpatient placements, particularly for
10 Level III and Level IV inmates,” 2004 Suicide Report at 11, has been the subject of numerous
11 recommendations by the special master and his experts. In the Six-Year Suicide Report, the
12 special master’s experts observed that three suicides in DMH facilities in 2001 revealed “the
13 need for better coordination and cooperation in the responses of both agencies.” Six-Year
14 Suicide Report at 7. The Six-Year Suicide Report highlighted, inter alia, “[t]he failure of clinical
15 staff to refer potentially suicidal prisoners to programs with more intensive monitoring and care”
16 and “[t]he provision of prompt and adequate access to higher levels of monitoring and care to
17 prisoners identified as potentially suicidal” among the items to be addressed by defendants. Id.
18 at 9. In the 2003 Suicide Report the special master’s expert reported that “74.2 percent of
19 suicides completed in 2003 involved some measure of inadequate treatment or intervention”
20 including “lapses in communication and inattention to documented concerns about the need for
21 an assessment or placement in higher level of care of individuals demonstrating significant
22 mental illness or past suicidal behavior.” 2003 Suicide Report, filed April 28, 2005, at 7. In the
23 2005 Suicide Report, the special master’s expert noted the need to repeat and to implement the
24 recommendation that there is a “need for clinicians to monitor suicidal inmates more closely and,
25 where appropriate, aggressively refer decompensating suicidal inmates, especially those at Level

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1 III and IV custody levels, to DMH programs.” 2005 Suicide Report at 14. A similar
2 recommendation was made in the 2006 Suicide Report. See 2006 Suicide Report at 12-13.

3 Finally, since 2001, when defendants were ordered to implement their Suicide
4 Reporting and Review Policy, the special master’s experts have repeatedly identified the need for
5 full implementation of these policies and for timely production of documents necessary to review
6 completed suicides. See 2000 Suicide Report at 7; 2003 Suicide Report at 10-11; 2004 Suicide
7 Report at 11; Six-Year Suicide Report at 9; 2005 Suicide Report at 13-14; 2006 Suicide Report
8 at 12.

9 Most of the foregoing matters have also been the subject of orders of this court.
10 The second and third recommendations are focused at the ongoing struggle to provide Coleman
11 class members with access to necessary levels of mental health care, particularly inpatient care.
12 All inpatient mental health care for Coleman class members is provided in DMH facilities, either
13 at state mental hospitals or in units operated by DMH at several California prisons. The shortage
14 of available inpatient beds, particularly for Level IV inmates, is extant in this record and has been
15 the subject of numerous court orders to date. In addition, several orders have directed defendants
16 to provide the special master’s experts with documents related to the suicide review process. See
17 Order filed June 13, 2002 at 2-3; Order filed January. 12, 2004 at 3; Order filed June 10, 2005 at
18 2.¹

19 The increase in both the inmate suicide rate and the percentage of suicide cases
20 with “at least some degree of inadequacy in assessment, treatment, or intervention” is deeply
21 troubling. The fundamental task at hand is for defendants is to take all steps necessary to reduce
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23 ¹ Defendants object on several grounds that DMH should not be bound by the order filed
24 June 10, 2005. Defendants have not adequately briefed the question of whether a subsequently
25 joined party is bound by existing court orders following such joinder. Nonetheless, the court will
26 direct the DMH defendants to meet and confer with the special master concerning production of
information essential to the special master’s suicide review process and to develop, if necessary,
appropriate policies and procedures for such production. This shall take place within the one
hundred and twenty day review period set by this order.

1 both the inmate suicide rate and the inadequacies in assessment, treatment and intervention found
2 in an unacceptably high percentage of completed suicides. As noted above, most of the issues for
3 which orders are presently requested by the special master have been the subject of repeated
4 recommendations by the special master, and some are already the subject of existing court orders,
5 yet both the suicide rate and the percentage of suicides with some degree of inadequacy in
6 assessment, treatment or intervention are rising. Before this court enters any further orders
7 directed at the problems of inmate suicides, both the CDCR defendants and the DMH defendants
8 will be directed to work with the special master to review all suicide prevention and review
9 policies, as well as any other relevant policies and practices, and the implementation of such
10 policies at all institutions, and to identify any modifications to such policies and practices or
11 implementation thereof that may be necessary to address the problem of inmate suicides.

12 In accordance with the above, IT IS HEREBY ORDERED that:

13 1. The special master's December 24, 2009 recommendations are not adopted at
14 this time;

15 2. Over the next one hundred and twenty days, under the guidance of the special
16 master, defendants shall review all suicide prevention policies and practices, all suicide review
17 and reporting processes, and the implementation of such policies, practices and processes. As
18 part of this review, defendants shall identify any and all specific modifications to their suicide
19 prevention policies and practices, their suicide review and reporting processes, and the
20 implementation thereof as may be required to address the problem of inmate suicides. Within
21 forty-five days thereafter the special master shall report to the court on the foregoing review.

22 3. DMH defendants shall meet and confer with the special master concerning
23 production of information essential to the special master's suicide review process and shall

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1 develop, if necessary, appropriate policies and procedures for such production. This shall take
2 place within the one hundred and twenty day review period set by this order.

3 DATED: April 14, 2010.

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7 LAWRENCE K. KARLTON
8 SENIOR JUDGE
9 UNITED STATES DISTRICT COURT
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