

1 Francis X. Hardiman Bar #140504  
Margaret M. Cahill Bar #138231

2 HARDIMAN & CAHILL  
3 Attorneys at Law  
4 1560 Brookhollow  
Suite 114  
5 SANTA ANA, CALIFORNIA 92705  
(714) 556-2233  
6 Facsimile (714) 556-5223

Richard S. v. Dept. of Developmental Serv. of Cal.



MR-CA-004-006

7 Attorneys for: Richard S. et al.

8 UNITED STATES DISTRICT COURT  
9 FOR THE CENTRAL DISTRICT OF CALIFORNIA

10  
11 RICHARD S., CYNTHIA R., VALDINA )  
12 R., and ROES 1 through 800, )  
13 individually and on behalf of all )  
those similarly situated by )  
14 WILLIAM CABLE, M.D. as Guardian )  
ad Litem )

14 Plaintiffs, )

15 vs. )

16 DEPARTMENT OF DEVELOPMENTAL )  
SERVICES OF THE STATE OF )  
17 CALIFORNIA, FAIRVIEW )  
DEVELOPMENTAL CENTER, SOUTH )  
18 COAST REGIONAL PROJECT, HARBOR )  
REGIONAL CENTER, REGIONAL CENTER )  
19 OF ORANGE COUNTY, SAN DIEGO )  
REGIONAL CENTER, SOUTH CENTRAL )  
20 LOS ANGELES REGIONAL CENTER, )  
WESTSIDE REGIONAL CENTER, DENNIS )  
21 G. AMUNDSON, as Director of the )  
DEPARTMENT OF DEVELOPMENTAL )  
22 SERVICES STATE OF CALIFORNIA, )  
HUGH KOHLER, as Executive )  
23 Director of FAIRVIEW )  
DEVELOPMENTAL CENTER, LILIA TAN )  
24 FIGUEROA, M.D., as Medical )  
Director of FAIRVIEW )  
25 DEVELOPMENTAL CENTER, DAWN )  
LEMONDS as director of SOUTH )  
26 COAST REGIONAL PROJECT, and Does )  
1 through 500, inclusive, )

27 Defendants )  
28

CASE NO:

DECLARATION OF JOCELYN  
DOROUGHTY, M.D., IN SUPPORT  
OF PLAINTIFFS' APPLICATION  
FOR TEMPORARY RESTRAINING  
ORDER AND PRELIMINARY  
INJUNCTION

Date: March 20, 1997  
Time: 10:00 a.m.  
Place: Federal District  
Court, Santa Ana, California

1 I, JOCELYN DOUGHERTY, M.D., declare

2 1. I am a Neurologist employed at Fairview Developmental  
3 Center, Costa Mesa, California since April, 1975.

4 2. I graduated with an M.D. from the University of Kansas  
5 in 1967. I completed my internship and Neurology residency from  
6 1967-1972 at Presbyterian Hospital, San Francisco and the  
7 University of California, Davis. I then completed a two (2)  
8 year fellowship in Neuro-ophthalmology at Columbia University  
9 Medical School, New York City. During my fellowship I was a  
10 member of the clinical teaching faculty at the Bronx V.A.  
11 Hospital, New York City.

12 3. I am a licensed Physician and Surgeon in the State of  
13 California (Lic.# C30577).

14 4. I have twenty one (21) years experience in the medical  
15 care of the developmentally disabled at Fairview State Hospital.

16 5. I am a Diplomate of the American Board of Quality  
17 Assurance.

18 6. I am presently a member of the Medical Executive  
19 Committee and Secretary of the Medical Staff at Fairview  
20 Developmental Center, Costa Mesa, California.

21 7. There is an urgent need to call a temporary halt to  
22 discharges from Fairview Developmental Center to community  
23 placement, skilled nursing facilities or other non institutional  
24 settings until the community homes are established to be  
25 reasonably safe. Many homes have LVNs and no RNs.

26 8. Deaths of our discharged clients are numerous enough  
27 to indicate an alarming trend.

28 9. If the discharges continue we may expect additional

1 deaths.

2 10. A 1996 published peer reviewed medical article by Dr.  
3 David Strauss shows a 74% increased mortality of the  
4 developmentally disabled adults in the community as compared to  
5 the institutions in California.

6 11. On or about December 15, 1996, and since the filing of  
7 the Cable lawsuit, client "JB", who had been a long term  
8 Fairview patient, and a patient of mine, was transferred from  
9 the skilled nursing facility at Fairview to a private skilled  
10 nursing facility in Long Beach, California. Within twelve (12)  
11 days of transfer "JB" died. Despite having personally contacted  
12 client records at Fairview who called the coroner's office I  
13 have been able to found out few of the facts concerning JB's  
14 death. Fairview client records told me that it might take  
15 months for me to obtain the autopsy report.

16 12. I personally reviewed the medical chart, of patient  
17 "X" who was transferred from the skilled nursing facility at  
18 Fairview Hospital to private community placement at one of the  
19 group "soccer homes" which were built on land adjacent to  
20 Fairview. Shortly after such transfer patient "X" drowned in a  
21 bath tub in the home.

22 13. On or about 1994 patient "Y", who had been a long term  
23 resident at Fairview and was under my care for a short time, and  
24 had a nephrostomy tube, died within six (6) months of transfer  
25 and discharge from Fairview. I believed that he should not have  
26 been transferred.

27 14. I had been informed that doctors were not to give  
28 their opinion about the suitability of discharges.

1           15. I was informed that doctors could not call the coroner  
2 regarding the cause of death of their patients and I took this  
3 to extend to patients discharged.

4           16. Part of patient care is discharge planning and we are  
5 not allowed to participate in that aspect of patient care.

6           17. Therefore, Fairview patients subject to discharge are  
7 not getting the medical input that is required to ensure that  
8 their medical condition is stable enough for the placement that  
9 is being offered by the State.

10           18. Physicians and staff at Fairview are justifiably  
11 fearful that if they complain about the discharges they will  
12 suffer retaliation. This has a deleterious effect on proper  
13 placement.

14           19. The patient population at Fairview has been slashed to  
15 less than one third of its peak census.

16           20. More than 90% of the clients remaining at Fairview are  
17 the most severely and profoundly mentally disabled with serious  
18 medical problems.

19           21. Clients whose discharge from Fairview requires  
20 considerable experience and judgment are essentially being  
21 discharged by social workers who do not have the training and  
22 experience to gauge the suitability of the placement.

23           22. My experience in the DDS system is that follow up  
24 reports from the community are not given to physicians. Most  
25 reports that I hear about arrive at Fairview fairly long after  
26 the event. I have never received individual case reports  
27 through official channels.

28           23. I believe that I have an obligation to know what

1 becomes of my discharged patients, but I am not allowed to know  
2 what happens to my patients.

3 24. A temporary halt to discharges is needed to ensure  
4 quality care.

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

7 Executed on: Mar 17 1997

8  
9   
10 JOCELYN DOUGHERTY, M.D., DECLARANT

11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28