

EXHIBIT 16

1 Daniel Pochoda (Bar No. 021979)
 2 Kelly J. Flood (Bar No. 019772)
 3 James Duff Lyall (Bar No. 330045)*
ACLU FOUNDATION OF ARIZONA
 4 3707 North 7th Street, Suite 235
 Phoenix, Arizona 85013
 Telephone: (602) 650-1854
 5 Email: dpochoda@acluaz.org
 kflood@acluaz.org
 6 jlyall@acluaz.org

7 *Admitted pursuant to Ariz. Sup. Ct. R. 38(f)

8 *Attorneys for Plaintiffs Victor Parsons, Shawn Jensen,*
Stephen Swartz, Dustin Brislan, Sonia Rodriguez,
 9 *Christina Verduzco, Jackie Thomas, Jeremy Smith,*
Robert Gamez, Maryanne Chisholm, Desiree Licci,
 10 *Joseph Hefner, Joshua Polson, and Charlotte Wells, on*
 11 *behalf of themselves and all others similarly situated*

12 **[ADDITIONAL COUNSEL LISTED BELOW]**

13 UNITED STATES DISTRICT COURT
 14 DISTRICT OF ARIZONA

15 Victor Parsons; Shawn Jensen; Stephen Swartz;
 16 Dustin Brislan; Sonia Rodriguez; Christina
 17 Verduzco; Jackie Thomas; Jeremy Smith; Robert
 18 Gamez; Maryanne Chisholm; Desiree Licci; Joseph
 19 Hefner; Joshua Polson; and Charlotte Wells, on
 behalf of themselves and all others similarly
 situated; and Arizona Center for Disability Law,

20 Plaintiffs,

21 v.

22 Charles Ryan, Director, Arizona Department of
 23 Corrections; and Richard Pratt, Interim Division
 24 Director, Division of Health Services, Arizona
 Department of Corrections, in their official
 capacities,

25 Defendants.

No. CV 12 -00601-PHX-NVW
 (MEA)

**SUPPLEMENTAL REPORT
 OF ELDON VAIL**

27
 28

1 1. I submit this report as a result of additional materials received from the
2 Defendants. These materials were not available at the time of my rebuttal report. My
3 opinions have not changed as a result of my review of this additional information.

4 2. In my rebuttal report,¹ I indicated that I had not yet received a post order for
5 the “rover” position referenced in Dr. Seiter’s report. I have now had a chance to review
6 that post order and it confirms my previous conclusion that this position does nothing to
7 ameliorate the extreme social isolation experienced by inmates housed in the Arizona
8 Department of Corrections (ADC) isolation units.² In fact, the instruction in this post order
9 is for the rover to limit his verbal interaction with inmates to “a few seconds.”³ Apparently
10 the purpose of this position is largely to circulate to make sure inmates aren’t hurting
11 themselves while housed in the isolation units. I have never heard of a similar position
12 deployed for this purpose in any jurisdiction of which I am familiar. The numerous acts of
13 self-harm, frequent use of force incidents, and pervasive mental health problems apparent
14 in the inmates on these units, which are exacerbated or caused by the conditions of extreme
15 isolation, are deeply concerning and create serious risks for both inmates and staff.
16 However, ADC’s creation of the “rover” position is an inadequate response to the risks its
17 policies and practices create for inmates housed in the system’s isolation units. The safer,
18 more appropriate and professional approach would be to remove mentally ill inmates from
19 the isolation units and improve the conditions of confinement for all inmates who remain
20 incarcerated in those units by decreasing the levels of extreme social isolation and idleness.
21 By creating a “rover” position directly ordered NOT to interact with inmates, ADC fails to
22 confront the fundamental problem in the operation of its isolation units. The result is that
23 these staff members are likely to interact with inmates only after some harm has occurred.
24 Instead of using staff primarily in crisis intervention roles, ADC should work to orient their
25 staff to talk to the inmates and develop relationships so that they foster an environment
26 where harm is reduced because of the positive interaction between staff and inmates. Such
27 an environment reduces risks for all. If ADC created more opportunity for meaningful
28

¹ Vail declaration 1/31/14, paragraph 31.

² ADC S000557-000561.

³ ADC S000560 and 000561.

1 interaction between staff and inmates the frequency of self-harm and suicide attempts in
2 the ADC isolation units, and the pain inflicted on all inmates in isolation, but especially the
3 seriously mentally ill individuals would be dramatically reduced.

4 3. The materials produced by Defendants also included additional Use of Force
5 (UOF) videos and reports cited in Dr. Seiter's report as the basis for his opinions regarding
6 ADC's use of chemical spray. Contrary to Dr. Seiter's conclusions, these materials
7 reinforce the concern articulated in my previous reports that ADC's use of chemical sprays
8 on seriously mentally ill inmates, many of whom are also taking psychotropic medications,
9 creates a risk of unnecessary harm.

10 4. In a UOF report from Kasson it describes a mentally ill inmate who refuses
11 to submit to restraints in order to be placed in a mental health watch cell.⁴ There is no
12 reference in the report that the inmate's actual behavior presented any kind of imminent
13 threat. He simply said that he was unable to move. After being ordered to comply the
14 inmate was sprayed with Oleoresin Capsicum (OC) three separate times and still did not
15 comply. The inmate was then forcibly extracted from the cell. As I said in a previous
16 declaration, "As is the routine practice in many prison systems across the country, mental
17 health interventions should be occurring with all inmates known to be mentally ill prior to
18 implementing use of force in a controlled situation, regardless of whether or not they are
19 housed in a designated mental health unit. In my experience, such interventions will
20 definitely reduce the need to actually use force, which will in turn improve the ability to
21 manage the inmate in the correctional environment, and not inflict unnecessary harm".⁵
22 This example, along with others, supports my opinion that the absence of this requirement
23 in policy and practice in the ADC regarding planned UOF events with mentally ill inmates
24 is deficient and results in use of force that is unnecessary.

25 5. A review of the related video of this planned UOF reveals additional
26 problems.⁶ In this planned use of force there is very poor planning. The staff are not
27 prepared to protect themselves or the inmate once the UOF event begins. They are not
28

⁴ ADC S000177-000188.

⁵ Vail declaration 1/31/14, paragraph 30.

⁶ ADC S000233, 20121207100952.MP4.

1 equipped with respirators. Some staff put handkerchiefs over their mouth and nose. After
2 two unsuccessful administrations of OC the staff decide they will need to perform a cell
3 extraction but they are not suited up and prepared to do so. The inmate is left in his cell for
4 approximately ten minutes, exposed to OC while the staff gets suited up in protective
5 equipment in order to perform the cell extraction. Once prepared, the inmate is sprayed
6 again. Staff then developed their tactical cell entry plan in front of the inmate's cell, in full
7 view and hearing of him and the other inmates on the tier. Once the staff do enter the cell
8 you can hear them coughing as they are effected by the OC spray. This lackadaisical
9 custody approach creates a risk of harm to the inmate and to the staff. It is likely a
10 reflection of a common understanding that the situation they are in is not a serious risk and
11 illustrates their casual use of OC on inmates when it is not necessary. A better approach
12 would have been to bring mental health staff to the cell front and attempt to talk the inmate
13 into cooperating. Mental health interventions may not be successful at de-escalating a
14 situation 100% of the time, but in my professional experience and opinion, such an
15 intervention often works and the attempt is absolutely necessary because the goal of policy
16 and practice should be to eliminate the need for use of force. This is especially the case in a
17 situation like this one where there is no imminent threat. Mental health intervention should
18 be required by policy in such situations. The fact that ADC does not require these
19 interventions increases the unnecessary use of force on inmates with mental illness.

20 6. Most troubling to me about this video and in another made available to me⁷ is
21 that the staff cuff the inmate behind his back and place him on a gurney face down while
22 they transport him to decontamination and placement in a mental health watch cell. This
23 practice is extremely dangerous and has been associated with positional asphyxia. The US
24 Department of Justice, National Law Enforcement Technology Center instructs, "As soon
25 as the subject is handcuffed, get him off his stomach".⁸ This apparently routine practice
26 should be eliminated and ADC should follow the guidance of the DOJ.

27
28

⁷ ADC S000233, 20121227085906.MP4.

⁸ US Department of Justice, National Law Enforcement Technology Center, *Positional Asphyxia—Sudden Death*, June 1995, page 2, available at <https://www.ncjrs.gov/pdffiles/posasph.pdf>.

1 7. This video of the use of force at Florence Kasson unit illustrated another
2 troubling aspect of ADC's treatment of mentally ill prisoners. During my inspections of
3 ADC facilities in July and August of 2013, inmates told me that placement in a mental
4 health watch cell sometimes occurred simply as punishment and not because someone was
5 actually at risk for suicide or self-harm. The conditions of confinement for the mental
6 health watch cells are much more restrictive than any other kind of confinement I have
7 witnessed in ADC. Inmates are forced to wear suicide smocks and are stripped of personal
8 property. They even have to ask for toilet paper. Quite understandably, most inmates see
9 placement on watch as punishment. In this video, you can actually hear custody staff
10 threaten to place an inmate on watch as punishment.

11 8. In this video the inmate is incapacitated on his stomach with his hands cuffed
12 behind his back and is on a gurney in a hallway.⁹ An unidentified staff member says to him
13 that if he starts to fight the officers he will be placed in a watch cell. If he does not, he can
14 return to a regular cell. I believe the implication here is clear. While fighting the officers
15 can never be condoned and must be addressed, the proper response would be to get the
16 inmate into a secure cell where he can't fight the officers. Threatening to place him in a
17 watch cell graphically illustrates that this is about punishment—rather than the prevention
18 of self-harm—and that such a placement is actually meant to be punishment without due
19 process. It is also another clear illustration of unprofessional conduct in ADC's use of
20 force and its treatment of mentally ill prisoners.

21 9. In another use of force video I reviewed from Lumley, the willingness to
22 quickly use OC spray when it might not have been necessary is again illustrated.¹⁰ In this
23 situation the inmate is angry about a recent disciplinary hearing. She is in her cell armed
24 with a weapon and threatens the hearing officer who is not present on the scene. There is
25 another inmate in the cell with her. The officer provides proper notification of the situation
26 and requests a supervisor and a response team. The officer then coaxes the inmate to lie
27 down her weapon and back away from the cell door so that her cell partner can exit the
28 cell. This occurs as directed but rather than close the door after the cell partner leaves and

⁹ADC S000233, 20121227085906.MP4.

¹⁰ADC S000234.

1 wait for a team, the officer decides to administer several seconds of OC spray while the cell
2 door is opened. The officer then pulls the inmate out of the cell by himself and takes her to
3 the ground. The inmate's face hits the pavement and you can see the blood from the injury
4 caused by this action. The cell door should have been closed after the cell partner exited the
5 cell and the officer should have waited until a team could be assembled. The opportunity
6 for a mental health intervention was missed and if that was unsuccessful, a planned cell
7 extraction could have taken place once the team arrived and the injury to the inmate may
8 well have been avoided. The review by the officer's supervisors failed to see how the
9 officer increased risk to himself and to the inmate from his rash action of unnecessarily
10 initiating use of force on his own. Their internal use of force review process was not
11 meaningful.

12 10. In my first report I wrote extensively about the ADC's policy of
13 unnecessarily assigning inmates to maximum custody.¹¹ In my second report I expanded on
14 this concern.¹² The ADC makes no distinction between maximum custody general
15 population and placement in isolation. If an inmate is designated as maximum custody
16 based on Arizona's classification policy, he or she will be placed in an isolation unit,
17 regardless of whether or not such extreme segregation and social isolation is necessary for
18 the actual safety of the inmate or others. In the additional materials made available there is
19 a lengthy study of the ADC classification system.¹³ The study concludes that the ADC
20 system is "valid" and makes recommendations for improvement.¹⁴ As I said in my first
21 report, "A prison system's classification scoring system, no matter if it has or has not been
22 validated bears no necessary relationship to the actual conditions of confinement found in
23 that system's prisons".¹⁵ Despite its irrelevance to conditions of confinement and the harm
24

25 _____
26 ¹¹ Vail declaration, November 8, 2013, paragraphs 21-25.

27 ¹² Vail declaration, January 31, 2013, paragraphs 10- 16.

28 ¹³ Validation of the Arizona Department of Corrections Objective Classification
System: Final Report, Patricia L. Hardyman, June 26, 2013 (hereinafter "Hardyman
report") (ADC_S000747-837).

¹⁴ The report lists a document entitled "Maximum Custody Placement Process" as
an ADC classification document provided to the researchers by ADC. No such document
was produced to the Plaintiffs although its title indicates that it would clearly fall within the
scope of discovery requests about the isolation units. Hardyman report, page 4.

¹⁵ Vail declaration, January 31, 2013, paragraph 10, lines 17-20.

1 created by the isolation units, however, this study does illustrate one of my points related to
2 the unnecessary use of isolation in the ADC system. It finds that there are populations of
3 inmates placed in the isolation units in ADC who clearly don't need to be there, especially
4 those with life sentences.¹⁶ As I said in both of my previous reports, placement in isolation
5 simply because of the committing offense is not necessary as many of these inmates are
6 quite capable of living in general population. However, because of ADC's flawed isolation
7 policies, these inmates are placed at unnecessary risk of harm.

8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

¹⁶ Hardyman report, page 36.

1 Executed on the 24th day of February, 2014 in Olympia, WA.

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28



Eldon Vail

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

Daniel Pochoda (Bar No. 021979)
Kelly J. Flood (Bar No. 019772)
James Duff Lyall (Bar No. 330045)*
**ACLU FOUNDATION OF
ARIZONA**
3707 North 7th Street, Suite 235
Phoenix, Arizona 85013
Telephone: (602) 650-1854
Email: dpochoda@acluaz.org
kflood@acluaz.org
jlyall@acluaz.org

*Admitted pursuant to Ariz. Sup. Ct.
R. 38(f)

Donald Specter (Cal. 83925)*
Alison Hardy (Cal. 135966)*
Sara Norman (Cal. 189536)*
Corene Kendrick (Cal. 226642)*
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710
Telephone: (510) 280-2621
Email: dspecter@prisonlaw.com
ahardy@prisonlaw.com
snorman@prisonlaw.com
ckendrick@prisonlaw.com

*Admitted *pro hac vice*

David C. Fathi (Wash. 24893)*
Amy Fettig (D.C. 484883)**
Ajmel Quereshi (Md. 28882)*
**ACLU NATIONAL PRISON
PROJECT**
915 15th Street N.W., 7th Floor
Washington, D.C. 20005
Telephone: (202) 548-6603
Email: dfathi@npp-aclu.org
afettig@npp-aclu.org
aquereshi@npp-aclu.org

*Admitted *pro hac vice*. Not admitted
in DC; practice limited to federal
courts.

**Admitted *pro hac vice*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

Caroline Mitchell (Cal. 143124)*
David C. Kiernan (Cal. 215335)*
Sophia Calderón (Cal. 278315)*
Sarah Rauh (Cal. 283742)*
JONES DAY
555 California Street, 26th Floor
San Francisco, California 94104
Telephone: (415) 875-5712
Email: cnmitchell@jonesday.com
dkiernan@jonesday.com
scalderon@jonesday.com
srauh@jonesday.com

*Admitted *pro hac vice*

John Laurens Wilkes (Tex. 24053548)*
Taylor Freeman (Tex. 24083025)*
JONES DAY
717 Texas Street
Houston, Texas 77002
Telephone: (832) 239-3939
Email: jlwilkes@jonesday.com
tfreeman@jonesday.com

*Admitted *pro hac vice*

Kamilla Mamedova (N.Y. 4661104)*
Jennifer K. Messina (N.Y. 4912440)*
JONES DAY
222 East 41 Street
New York, New York 10017
Telephone: (212) 326-3498
Email: kmamedova@jonesday.com
jkmessina@jonesday.com

*Admitted *pro hac vice*

*Attorneys for Plaintiffs Shawn Jensen;
Stephen Swartz; Dustin Brislan; Sonia
Rodriguez; Christina Verduzco; Jackie
Thomas; Jeremy Smith; Robert Gamez;
Maryanne Chisholm; Desiree Licci; Joseph
Hefner; Joshua Polson; and Charlotte
Wells, on behalf of themselves and all others
similarly situated*

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

**ARIZONA CENTER FOR DISABILITY
LAW**

Asim Varma (Bar No. 027927)
Sarah Kadar (Bar No. 027147)
5025 East Washington Street, Suite 202
Phoenix, Arizona 85034
Telephone: (602) 274-6287
jalewelt@azdisabilitylaw.org
avarma@azdisabilitylaw.org
skadar@azdisabilitylaw.org

J.J. Rico (Bar No. 021292)
**ARIZONA CENTER FOR DISABILITY
LAW**

100 N. Stone Avenue, Suite 305
Tucson, Arizona 85701
Telephone: (520) 327-9547
Email: jrico@azdisabilitylaw.org
cdooley@azdisabilitylaw.org

*Attorneys for Arizona Center for Disability
Law*