INTRODUCTION

None of the ten named plaintiffs in this action is a member of the relatively small but significant (6.5%) minority population of women prisoners. It is perhaps not surprising, then, that the Stipulation for Injunctive Relief-- an important victory for prisoners generally in its expansion of medical staff positions and the beginning of a health services delivery model that focuses on prevention and early intervention-- fails in many important respects to adequately address serious medical needs that are unique to female reproductive health or that otherwise disproportionately affect women.

Women prisoners with breast or cervical cancer or other serious gynecological illnesses are often untreated, inadequately treated, or actually harmed by the interventions of incompetent custodial or medical staff acting beyond their level of expertise; many women are maimed or even die as a result. Women who have survived sexual and physical abuse and other forms of violence— a description which research shows applies to most women prisoners— have physical or mental health conditions closely associated with their social histories; yet they are rarely screened or assessed, much less treated, for these serious medical needs. Prenatal care for prisoners is often delayed and inadequate when finally provided, especially for high-risk conditions. Pregnant women are transported to the hospital in restraints in all stages of labor and are shackled to their hospital beds, including at times during delivery. All of this jeopardizes two lives, as the many miscarriages and stillbirths suffered by women prisoners attest.

The settlement agreement fails to include adequate standards for: (1) pregnancy-related care; (2) comprehensive health assessments and necessary follow-up treatment for breast and cervical cancer and other gynecological problems, other health conditions related to surviving sexual and other physical and mental abuse, and other health care needs disproportionately affecting women prisoners; (3) medical evaluations after sexual assaults in prison; (4) pap

smears at sufficiently frequent intervals for women prisoners generally and HIV positive women prisoners in particular; (5) testing for the virus linked to cervical cancer, a leading cause of cancer deaths among young, low-income women, especially those with HIV and in prison; (6) distribution of medications to women with HIV or other chronic conditions; (7) ensuring that autopsies are conducted on HIV positive women when required; (8) a timely appeal process for urgent or emergency medical needs; (9) ensuring that instructions for LVNs and RNs are not inconsistent with patient safety; and (10) other basic health issues, as explained below.[1]

Unless these issues are adequately addressed, the settlement agreement will be unfair to women prisoners. The following objections, therefore, are submitted by Legal Services for Prisoners with Children on behalf of women incarcerated at Valley State Prison for Women (VSPW) and other women in the plaintiff class. Stipulation, ¶8, 5:8-11; Order May 23, 2002.

I. Standard for Approving the Settlement Agreement

To merit approval, the settlement agreement must be fair, adequate, and reasonable. *Class Plaintiffs v. City of Seattle*, 955 F.2d 1268, 1276 (9th Cir.), *cert. denied*, 506 U.S. 953 (1992). The burden to show that this standard has been met rests on the settlement's proponents. The reaction of class members is among the factors for determining whether an agreement meets the test. *Hanlon v. Chrysler Corp*. 150 F.3d 1011, 1026 (9th Cir. 1998). Courts have closely scrutinized whether the agreement prejudices the rights of a definable minority group within the class. *See, e.g., Van Horn v. Trickey*, 840 F.2d 604 (8th Cir. 1988).

The women class members here are a small but significant minority of the state prison population. Of the 161,483 prisoners now in California state prisons, 10,708, or 6.63%, are women. Exh. L, Table 1, Preliminary Prison Census Data, Number of Offenders in CDC

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[1] These issues were brought to the attention of plaintiffs' counsel as soon as possible after the agreement became public. Decl. of Lucy Quacinella, ¶¶2-5.

Institutions by Gender, CDC, July 2001.[2] Yet it is only in the last decade that the number of women in California prisons has grown to such levels. Owen Decl., ¶3. Women's concerns, therefore, have often been ignored in a system designed and historically operated for the 90% or more of the prison population who are men. None of the named plaintiffs is a woman. Unless the agreement is fair to women prisoners, it cannot be fair to what is now a significant yet still often overlooked part of the plaintiff class.

II. Women Prisoners and Their Health Care Needs

"The majority of women in prison come from poor minority communities. They have few educational or vocational skills and are mostly young mothers with personal histories of substance abuse, unemployment, physical and mental illness, and physical and sexual abuse [citation omitted.]" Decl. of Barbara Owen, Ph.D., ¶12. They face "several critical problems . . .and most are aggravated while incarcerated[:]. . .physical and mental health, substance abuse and staff sexual misconduct." *Id.,* ¶16; *see also*, ¶¶ 20-21 (physical and mental health needs and California authorities cited therein.)

Reports in recent years describe health conditions for women prisoners in Chowchilla, where the two largest women's prisons are located, as a "horrifying." Exh. G, Cooper, C., "A Cancer Grows," *The Nation* (May 6, 2002), pp. 30-34, at p.31; *see also*, Exh. I, Amnesty International (AI), "*Not Part of My Sentence:" Violations of the Human Rights of Women in Custody* (March 1999). In a one-month period in December 2000, seven women died at a single one of these prisons. Decl. of Karen Shain, ¶7.[3]

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[2] CDC estimates that by June 30, 2002, the total prison population will have decreased by 2.9%, to 156,846 prisoners. Exh. Q, Governor's Budget May Revision, 2002-03, CDC, pp. 63-64.

Until recently, incarceration rates for women prisoners had been skyrocketing, increasing from 1,316 in 1980 to 11,000 in 1997. Owen Decl., ¶3. California has the largest number of women incarcerated in the United States. Exh. H, Report U.N. Special Rapporteur (1/4/99), ¶85.

[3] Four of the women were terminally ill. *Id.*

III. The Settlement Agreement Is Unfair Because It Fails to Address Several Critical Aspects of the Women Class Members' Serious Medical Needs.

A. The Role of the Policies and Procedures and the Audit Instrument In Identifying the Eighth Amendment Standard of Care As Applied In This Case

The Stipulation requires defendants to comply with the Eighth Amendment in providing medical care to prisoners. Stipulation (Stip.), ¶ 4, 3:4-8. What care this obligates defendants to provide is, of course, the definitive question.

An important part of the parties' answer to this question lies in the California Department of Corrections (CDC) Health Care Services Division Policies and Procedures, which are "designed to meet or exceed the minimum level of care necessary" under the Eighth Amendment (*id*., 3:2-4). The Audit Instrument, which will be used to measure compliance, will specifically audit compliance with the Policies and Procedures. *Id*., ¶¶ 19-20. The parties have also agreed that a medical assessment or treatment plan will be "deemed adequate and appropriate" to meet defendants' obligations if it is "consistent with guidelines specifically adopted" in the Policies and Procedures. *Id*., ¶ 2, 11:10-19; *see also*, Prefatory Language. Indeed, substantial compliance is defined in terms of implementation of the Policies and Procedures. *Id*., ¶¶22 and 31. A process has been identified for resolving disputes over whether a provision of the Policies and Procedures or Audit Instrument or any change to either document meets "the minimum level of medical care necessary . . .under the Eighth Amendment" (*id*., ¶¶25 –28), and the Court will have jurisdiction to enforce acts required by the Policies and Procedures. *Id*., ¶30, 15:10-12 and 23-25.

The Policies and Procedures have thus been assigned the central role in the parties' agreement of encompassing at least the minimum level of care necessary to comply with the Eighth Amendment, and they are also the measuring stick to be used in the audit process. An omission or inadequate provision in the Policies and Procedures, therefore, will result in an ineffective compliance tool. Given this central role, it is imperative that none of the provisions included in either the Policies and Procedures or the Audit Instrument be inadequate for women's medical care.

It is no answer to objectors' concerns that changes to the Policies and Procedures can be made later or that a mechanism has been included in the settlement agreement to resolve disputes over the adequacy of any particular provision, for several reasons. First, since no women are among the named plaintiffs and serious medical issues affecting women alone were entirely omitted from the Stipulation filed with the Court, as discussed below, the Policies and Procedures and Audit Instrument warrant close scrutiny at the fairness hearing from the perspective of their impact on women. Second, the Stipulation (¶¶26-28) is silent on whether and how a class member can invoke this dispute resolution process for challenging a provision included in the Policies and Procedures or Audit Instrument, and the Class Notice makes no mention of it. Most importantly, women's health should not be put at risk if serious questions about the adequacy of the Policies and Procedures and Audit Instrument can be resolved now rather than being deferred to the dispute resolution process established under the settlement agreement.

B. The Settlement Agreement Is Silent on Pregnancy-Related Care.

Approximately 7 % of women incarcerated in California state prisons are pregnant. Exh. J, Characteristics of Incarcerated Women (CDC). Pregnant women prisoners are usually incarcerated at VSPW. Stoller Decl., ¶22; *see also*, Exh. H, Report of U.N. Special Rapporteur (1/4/99), ¶108 ("At any given time, there are approximately 100-175 pregnant women prisoners at VSPW.") Pregnancy-related care is a "serious medical need." Stip., ¶8, 5:8-10; *see also*, Robertson Decl., ¶11. Yet there were no provisions at all on prenatal, labor and delivery, postpartum, or any other pregnancy-related care in either the Policies and Procedures lodged with the Court on February 15, 2002 or in the Audit Instrument lodged March 8, 2002.

Given the history of women prisoners' experiences with poor medical care during pregnancy, the need for specific, clear, quality standards on pregnancy-related care in the Policies and Procedures is pressing. For example, a September 2000 report found that at VSPW,

half of the 15.7% of the women who reported a recent pregnancy had complaints about their care. Stoller Decl., ¶¶22 and 20 and Attachment C (Case Summaries).

Serious pregnancy-related care complaints persist to the present, including the shackling of pregnant prisoners during transport and while in the hospital for the delivery. *See*, Shain Decl., ¶7 (complaints of shackling in past year during transport, labor, and sometimes delivery), ¶9 (high-risk pregnant woman shackled around the waist throughout entire journey from San Diego to Chowchilla in 2001) and ¶11 (woman shackled to bed during most of time in hospital to deliver baby in March 2002). Indeed, a VSPW warden has confirmed that state policy is to shackle women to their hospital beds before and after they give birth. Exh. H, Report of U.N. Special Rapporteur (1/4/99), ¶ 108; *see also*, Exh. I, AI, *"Not Part of My Sentence:" Violations of the Human Rights of Women in Custody* (March 1999), pp. 63-66. The CDC official approach of putting a fine point on when a woman is "in" labor or when delivery "begins" and "ends"— assuming even for the sake of argument that correctional officers guarding the woman would be able to precisely identify such bounds and react quickly enough-- does not mitigate the serious concern that restraints place the pregnant woman as well as the newborn at serious risk.

The community standard for pregnancy-related care is the standard set by the American College of Obstetricians and Gynecologists (ACOG). Robertson Decl.,¶11. Experts agree these standards should be adopted in the correctional setting. *Id.,* citing Richardson.

(1) The ACOG Standards Should Be Adopted and Shackling Pregnant Women Must Be Banned. Objectors Should Be Given an Opportunity to Review and Formally Comment on Any Guidelines on Pregnancy-Related Care Before They Become Part of the Final Agreement.

On May 23, 2002, two years and 10 months after class counsel and defendants began their informal negotiations in July 1999 to improve prison medical services (*see*, Stip., ¶3, 2:6-7) and more than a year after the complaint was filed-- but just a few days before the final deadline

for submitting objections to the settlement agreement— defendants have adopted policies and procedures on pregnancy-related care. Quacinella Decl., ¶ 6.

Women class members and their counsel have not had an opportunity to review these provisions with their medical experts (*id*., ¶7), although our preliminary reaction can be summed up by "too little, too late." The ACOG standards should be adopted instead, to ensure the health of both women and newborns. Shackling pregnant women, especially at any time during labor and postpartum, must be clearly banned.

If the ACOG standards are not adopted, objectors should be granted an extension of time to have an expert review CDC's last-minute offer. The fact that pregnancy-related care was omitted from the original agreement makes an opportunity for expert review all the more pressing to ensure fundamental fairness for women prisoners. Pregnancy and childbirth perfectly illustrate the unique health care needs of this minority.

C. The Settlement Agreement Fails to Adequately Address Women's Unique Health Care Needs In Other Ways.

Since the parties have built their agreement around the Policies and Procedures as a stand-in for the Eight Amendment standard of care, the comments below analyze the provisions of this document and its implementation through the Audit Instrument and process. Objectors' only concern is whether defendants' compliance with whatever is required of them in these documents will actually result in adequate health care for women prisoners.

(1) The Policies and Procedures Do Not Provide for Adequate Assessments and Follow Up Treatment for Women.

Health screening and assessment are critical to quality health care, especially in a system, like the one involved here, that intends to incorporate features of a preventive services model and that relies to a large extent on screening and referral for appropriate care.

Without adequate screening, the audit process is also impaired, as it is designed to measure whether the care required by the Policies and Procedures as a stand-in for the Eighth Amendment has in fact been provided. In other words, a medical need or condition that is overlooked or misdiagnosed as the result of an inadequate screening or assessment performed in accordance with the Policies and Procedures cannot reasonably be expected to be measured through the Audit Instrument.

The screening tools adopted in the Policies and Procedures are inadequate to meet the standard of care for women's health care. Robertson Decl., ¶5-6. Missing is essential information about the individual's medical history, her family medical history, and her social history. *Id.,* ¶¶7-10, 12-18. Without this information, the managed care preventive services goals of the settlement will be undermined, and appropriate care cannot be provided for women prisoners who become sick or need chronic care.

Objectors are aware that under the Policies and Procedures, health screening will be required for persons entering the prison system (Vol. 4, Ch. 2, Reception Center) or who are being transferred from another facility (Vol. 4, Ch. 3, Receiving and Release). Two forms are used for these initial screenings at the new facility, one for all individuals (CDC Form 7277—Initial Health Screening), plus a supplement for women (CDC Form 7277A).[4] For transferees, medical information is also to be provided by the transferring facility (Vol. 4, Ch. 3, p. 1). But these policies and procedures and forms for initial screenings at the new facility are quite limited, as may be appropriate to reflect the short duration of an individual's stay at a reception center or

[4] For ease of reference, these two forms from the Policies and Procedures have been provided as Exh. K. The 7277a "Female Inmate" form differs only slightly in format, but not in content, from the 7277a that CDC currently uses; and while the new 7277 has additional screening questions on mental health (s*ee*, CDC forms, Attachments to Shain Decl., ¶7), these are insufficient to meet the need for comprehensive mental health screening for women prisoners, as explained above.

in receiving status, where the main goal is presumably to ensure stabilization. However, to serve as the basis for appropriate assessment, diagnosis, and follow-up care for any woman coming to the prison without comprehensive, up-to-date medical records as well as for any woman needing medical care after reception or receiving, much more is needed, as explained above.

The Policies and Procedures concur that more is needed, in that they require a complete history and physical examination within 14 days of reception. Vol. 4, Ch. 2, p. 1. Indeed, the notice to the class includes among "the most important improvements" of the settlement "[i]mproved new arrival screening; physical exam by doctor required within 14 days." In addition, a woman prisoner may be referred to a chronic care program from "sick call" (see, for example, the Vol. 7, Ch. 5, p. 1, Gynecology Chronic Care Program). Yet there is little additional information on screening, history or examination after reception or receiving or at sick call in the Policies and Procedures. Only general guidelines are provided on medical histories and physical exams after the initial screen.[5] While mention is made of a Medical History form (CDC Form XXX) and a Physical Examination form (CDC Form XXX) (Vol. 4, Ch. 2, p. 1), these have not been included in the Policies and Procedures, despite objectors' requests. Similarly, while the provisions for the Gynecology Chronic Care Program include a list of items to consider as part of the in-take evaluation (Vol. 7, Ch. 5, Attachment A), including "gynecological risk factors," "past medical history," "lifestyle factors," and "family history," along with a few examples, this list is vague. The missing gaps might be closed by the In-take Evaluation form mentioned for

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[5] "Inmates shall be evaluated for acute and chronic conditions and for communicable diseases including TB and STDs. This examination shall include . . . a breast examination, pelvic (bi-manual and speculum), and Pap smear for females. . . Laboratory testing shall include, but not be limited to: chemistry panel; complete blood count; serum pregnancy test (for females); urinalysis by dipstick; VDRL or RPR with confirmatory testing if positive; fecal occult blood if over 50 years of age, or if clinically indicated; urine screen or urethral culture for Gonorrhea/Chlamydia; cervical culture for Gonorrhea/Chlamydia; and additional diagnostic testing identified as relevant by the screening and health care evaluation." Vol. 4, Ch. 2, pp.2-3.

this program (Vol. 7, Ch. 5, p. 1), but this is another form that has not been included. More to the point, however, is that a complete history and physical examination should be provided for all women who enter the prison, go to sick call, or have medical emergencies, and not just to those who, on the basis of the initial screen, warrant referral to the Gynecology Chronic Care Program or any other chronic care program. Even for women who may not require follow-up treatment in the short run, a complete history and exam within the first 14 days of arrival is needed as a baseline for addressing medical needs at the prison in the future.

Without appropriate, comprehensive, and confidential screening, women prisoners will not receive the medical care to which they are entitled. The Policies and Procedures must be amended to address these concerns.

(2) Pap Smears Must Be Provided Annually to Women Prisoners.

Women would receive Pap smears only once every two years under the Policies and Procedures. Vol., 4, Ch.9, p. 1. Yet for high-risk women, such as the women class members here, the standard of care requires Pap smears on an annual basis. Robertson Decl., ¶19. This issue is of particular concern to young, low-income women, the group among whom cervical cancer is most frequently diagnosed. *Id.,* ¶20. Indeed, the concern about low-income women and this cancer led Congress two years ago to not only give states the option of expanding their Medicaid programs[6] to women who would not otherwise qualify, but to also encourage the states' exercise of the option by reimbursing them with an "enhanced" match covering two-thirds of the cost.[7] Even the United States Preventive Services Task Force (USPSTF) Guidelines, on which

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[6] Medicaid is a medical assistance program for the poor, funded by the federal and state governments. 42 USC §§ 1396 *et seq.* Federal financial participation, or the Federal Medical Assistance Percentage (FMAP), in California's Medicaid program is usually about 50%. 42 U.S.C. § 1301(a)(8); 65 Fed. Reg. 69,560 (Nov. 17, 2000) (FMAP for FY 2002).

[7] Breast and Cervical Cancer Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381 (2000). Low-income incarcerated woman may qualify for these federal Medicaid benefits if they need

the Policies and Procedures rely for cancer-screening for women (Vol. 4, Ch. 9, IV, p. 2), concur that low-income women and women at high-risk of STDs should have Pap smears more frequently than once every two years. *Id.,* ¶19; *see also*, Exh. C, USPSTF *Guide to Clinical Preventive Services*. Other experts agree: "' The vast majority of women entering jail or prison …fall into the normal-to-high risk category and…require yearly Pap smears.' " *Id.*, citing Keamy.

(3) Pap Smears Must Be Provided Every 6 Months to Women Prisoners With HIV.

The HIV Chronic Care program simply provides that women be given "pelvic examinations, as clinically needed." Vol. 7, Ch. 6, p. 1. The standard of care for women with HIV, however, is that, if the results of a Pap smear are normal, it should be repeated in six months and then annually. If results are not normal, then the Pap must be repeated at intervals of from two to six months, depending on the type of abnormality. *See*, Exh. C, USPSTF *Guide to Clinical Preventive Services* and footnote 113, citing Evaluation and Management of Early HIV Infection, Clinical Practice Guideline, No. 7, AHCPR Publication No. 94-0572, January 1994; and Exh. D, AHCPR Notice of unavailability of document cited in fn. 113; Exh. Levine A.M., Evaluation and Management of HIV-Infected Women, *Annals of Internal Medicine*. 2002; 136:228-242 (updating unavailable document cited in fn. 113), Table 6, p. 235.

For *incarcerated* women with HIV, there is a different standard. As these women are especially at risk for HPV and cervical cancer (see below), the standard of care for these women is pap testing every six months, even if results are normal. Exh. F, *HEPP News*, HIV & Hepatitis Education Prison Project, Brown Medical School, Office of Continuing Medical Education and the Brown University AIDS Program (May 2001), pp. 4.and 6. This standard must be included to

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in-patient hospital care to treat breast or cervical cancer and such care is provided off prison grounds. 42 U.S.C. § 1396(a)(A) and Exh. N, U.S. Department of Health and Human Services, *Memo to All Title XIX State Medicaid Agencies*, "Clarification of Medicaid Coverage Policy for Inmates of Public Institution," January 27, 1998 (MCD-SCG-LN).

protect the health of HIV positive women class members and provide a concrete measure for auditing the appropriate level of care.

(4) HPV Testing Must Be Provided After An Abnormal Pap Smear.

Pap smears are more likely to be abnormal among high-risk women. Providing the necessary follow-up to determine the appropriate treatment and care is clearly essential. The Policies and Procedures simply direct that additional testing be done as clinically indicated. Vol. 7, Ch. 5, p. 3. The standard of care, however, specifically requires follow-up with testing for the human pampilloma virus (HPV), which causes cervical cancer-- the cancer for which young, low-income women generally (Robertson Decl., ¶¶20-21), and HIV-incarcerated women in particular (Exh. F, *HEPP News*, at pp. 4 and 6), are especially at risk.

The Policies and Procedures must specifically direct that abnormal Pap smears be followed up with testing for HPV, plus other tests as clinically indicated.

(5) The Policies and Procedures for the Gynecology Chronic Care Program Are Too Vague, and It Is Unclear How Specialists Will Be Involved.

"Because of differences in reproductive biology, women are more susceptible to sexually transmitted diseases" (Robertson Decl., ¶15), which often involve gynecological disorders. The discussion of gynecologic chronic care in the Policies and Procedures (Vol. 7, Ch. 5), however, is inadequate. *Id*., ¶¶22-23. In contrast, far more specific guidelines have been provided for several of the other specialty areas of the Chronic Care Program in Volume 7 (*see*, *e.g*., Chapters 2 (Cardiovascular) and 7 (Pulmonary Disease).) Moreover, the CDC has indicated that it has developed "Medical Standards of Care, a Medical Scope of Services, and related policies. . ." Exh. P, CDC HSD Budget Change Proposal (BCP) for 2001-02, Narrative, p. 2; *see also*, Exh. R, BCP FY 2002/03, p. 8.

Additional problems are that gynecologists have not been included in the list of specialists to whom prison doctors will have access through telemedicine services (neither have

obstetricians or perinatologists) (*see*, Vol. 11, Ch. 2, p. 1), and the Policies and Procedures do not require the women's prisons to be staffed with gynecologists or that there be an OB at VSPW.

If CDC Medical Standards and Scope exist for gynecologic care, they should be included in the Policies and Procedures. If they don't exist, they should be developed and included. In either case, class members should have an opportunity to review them and comment before the settlement agreement is final.

In addition, the settlement agreement should specifically address staffing by gynecologists or family practitioners and how gynecology health care needs will be addressed if a women's prison does not have such medical staff.

(6) The Policies and Procedures Fail to Address the Unique Physical and Mental Health Needs of Survivors of Domestic Violence and Other Abuse.

The need to address the unique physical and mental health needs of women who have survived abuse is now widely recognized in the field of gynecology. Robertson Decl., ¶26. A social history of sexual and other abuse is a characteristic of women prisoners:

> 'Women entering correctional settings may also have a much higher than average prevalence of prior victimization through physical, sexual, or psychological violence." (Keamy, *supra*, at 189; *see also*, Fickenscher A., Lapidus J., Silk-Walker P., and Becker T., "Women Behind Bars: Health Needs of Inmates in a County Jail," *Public Health Reports*, 116:191-196 (May-June 2001) (79% of study participants reported a history of physical abuse, 67% reported a history of sexual abuse); Richie B.E., Johnsen C. "Abuse Histories Among Newly Incarcerated Women in a New York City Jail, "*J Am Med Women's Association*, 51:111-17 (1996)). '

Id., ¶16; *see also*, Owen Decl., ¶¶9 and 11. A study of women prisoners in California found that 80% have survived abuse. *Id*., ¶10.

Substance abuse is frequently the response. According to the CDC, approximately 85% of California women prisoners have drug histories. Exh. J, Characteristics of Incarcerated; *see also*, Owen Decl., ¶7 (rates of abuse of various substances among women incarcerated in California.) "Women are more likely to use drugs more often, use more serious drugs, and be

under the influence of drugs at the time of their crime than males [citations omitted]" (*id*., ¶6), and women substance abusers are "more prone to intense emotional distress, psychosomatic symptoms, depression and lower self-esteem than males" (*id*., ¶8).

Yet nothing in the Policies and Procedures speaks to these issues. As explained above, the in-take assessment procedures do not inquire into abuse. Moreover, there is no mention of referrals or care programs for these women, "such as individual and group therapy, self-esteem classes, AA groups, substance abuse treatment, and, for those with a dual diagnosis, for mental health treatment." Robertson Decl., ¶26. While all inmates are to receive a mental health evaluation (Vol. 4, Ch. 3, p. 3), there is no discussion of what this should involve or of whether or how referrals or follow up care will be provided for survivors of abuse. If the intent of the settlement agreement is to rely on *Coleman v. Wilson*, then protocols adopted there not only for screening but also for treatment for survivors of sexual and other abuse should at least be referenced here—but apparently such protocols do not exist:

> You must understand that in the mental health department you **must** be on psycholtropic medication to qualify for any and all therapeutic groups. 'Support' groups are not available. . .It is important again to repeat that if you are not under the CCMS program and currently on medication from that department, you do not qualify for any of the therapeutic groups nor are there any 'support groups' relating to domestic violence. In other words if you feel you need to address this issue, you could get yourself on drugs you do not need in most cases to get yourself into a group setting to deal with your problems. Most of us do not choose to do this for obvious reasons.

(Emphasis in original). VSPW Prisoner's Letter, Attachment to Shain Decl., ¶7; *see also, id*., ¶8.

The only other mention of mental health screening in the Policies and Procedures is in response to prisoner complaints. Vol. 5, Ch.14d, pp. 1-2. But women must also have access to preventive services; they should not have to wait until they have a break down to be identified as needing care to prevent or treat the "depression, severe emotional disorders, and other mental health conditions" that follow from abuse. Robertson Decl., ¶18; *see also*, Owen Decl., ¶24.

> There is no doubt that myself and the majority of the other women here suffer in silence and are harmed by this absence of 'support'. The physical wounds will heal, however the emotional wounds are left to be self-healed or in some cases are left unattended for the rest of our lives. It has always been my thought that leaving emotional wounds unattended will result in physical medical problems somewhere down the road.

VSPW Prisoner's Letter, Attachment to Shain Decl., ¶7.

Specific standards for screening and treatment should be adopted for the Policies and Procedures, and women prisoners should have an opportunity to review and comment on them before the settlement agreement becomes final.

(7) Privacy

The Policies and Procedures require that a female staff person be in the medical examination room whenever a woman prisoner is to have a physical examination by male medical staff. Only when "clinical assistance" is required must the female staff person be medical staff. Vol. 4, Ch. .6, H., p. 4. To prevent a breach of medical confidentiality, the female staff person in these situations must be medical, not custodial, staff even when clinical assistance with the physical exam is not required. The Policies and Procedures should be modified accordingly.

(8) Medical Evaluation after Sexual Assault

While the Policies and Procedures address medical evaluations after assault (Vol. 4, Ch. 27), conspicuously omitted are sexual assaults. The September 2000 study found that the greatest number of medical complaints at VSPW involved sexual assaults, defined as including verbal harassment as well as physical harassment by guards and medical staff. Stoller Decl., ¶¶11; *see also*, Exh. H, Report of U.N. Special Rapporteur (1/4/99), ¶¶87-100 ("California appears to have inadequate administrative or penal protection against sexual misconduct in custody" (¶87) and "[i]t was also alleged that women in the [Segregated Housing] Units live in constant fear of rape. . .(¶99)); Owen Decl., ¶23 and authorities cited therein.

Specific policies and procedures for medical evaluations in sexual assault cases should be added, and objectors should have an opportunity for comment before they are adopted.

(9) The Policies and Procedures Should End the Current Practice of Requiring All HIV Positive Women Prisoners to Get Their Medications from the "Pill Line."

Women prisoners at VSPW and elsewhere are required to get their HIV or AIDS medications in a daily "pill line." This is a major barrier to access because it breaches confidentiality and imposes physical hardships on sick people by making them wait, sometimes for hours, in long lines or in bad weather. Missing or delaying medications can significantly shorten the lives of women with HIV or AIDS, many of whom also suffer from other diseases or illnesses. Stoller Decl., ¶13. "Diabetics, asthmatics, . . ., and persons with heart disease, hypertension, cancer, and a host of other ailments are also put at grave risk when prescribed medications are missed." *Id.,* ¶14. Missed medications is at the top of women prisoners' health care complaints, with nearly 22% of women prisoners in a recent study reporting that they had missed important medications at least once and many reporting missing them repeatedly. Of those who missed medications, 21.6% suffered health complications as a direct result. *Id*., ¶12. The approach used in other states and in federal prisons, where HIV medications are distributed on a weekly or monthly basis (*id*, ¶15), should be adopted under these Policies and Procedures.

A separate but related problem involves the requirement that "direct observed therapy" (DOT) be used for administering medications "when appropriate" or when the medication is identified as "causing problems locally. . ." Vol. 9, Ch. 15, p. 1. To remove access barriers, this should be clarified to conform to the general rule in public health (Stoller Decl., ¶15): DOT will not be routinely required of any mentally competent prisoner with HIV or any other disease or condition except TB and except in cases where the medication is any of the controlled substances already referenced in Volume 9, Chapter 15 or is an antipsychotic, antidepressant, or antimanic agent or lockdown makes special procedures for DOT necessary.

(10) Prisoners Should Receive Timely Notification of All Diagnostic Test Results.

When diagnostic test results are deemed "clinically significant," the Policies and Procedures require that the prisoner be informed about the results by the primary care provider at a follow up appointment within a clinically appropriate timeframe. Vol. 4, Ch. 14, Part C., p. 2. But when the results are not "clinically significant," there is no timeframe for notification. *Id.,* Part D. Yet all test results, whether positive or negative, are clinically significant: that's the purpose of diagnostic testing. Not knowing the results can create severe anxiety, as, for example, when a woman prisoner has been biopsied for breast cancer. A reasonable timeframe, e.g., 14 days, for notice of test results not requiring a follow up appointment should be added.

(11) Autopsies Must Be Provided for HIV Positive Women Prisoners.

The two largest women's prisons, VSPW and Central California Women's Facility (CCWF), are both located in Chowchilla, Madera County. Just under 6,000 women, or 56% of the women prisoner class, are incarcerated in these two prisons. Exh. M, CDC Monthly Report of Population As Of April 30, 2002, p. 2. The Madera County Coroner refuses to perform autopsies if the decedent was HIV positive. Decl. of Corey Weinstein, M.D., CCHP, ¶4. This policy applies regardless of whether the cause of the woman prisoner's death is known or whether sufficient medical information was obtained before the death to assess what the cause may have been. *Id.* The Madera Coroner is apparently the only Coroner of a county in which a state prison is located who has such a policy, and CDC does not provide for autopsies when this Coroner refuses to provide one for a woman prisoner on the basis of his HIV policy.

Autopsies are essential in determining the cause of death. This includes HIV as well as diagnosed AIDS cases: not all persons with AIDS will have AIDS as the cause of death. *Id*., ¶ 8. Autopsies in the correctional setting are essential, therefore, not only with respect to the

decedent, but also as a quality control tool for women in the closed environment in which the death occurred. *Id*., ¶ 5-7.

The Death Reporting and Review Policy (Vol. 1, Ch. 7) should provide for autopsies for women prisoners in Madera County when the Coroner refuses to do a necessary autopsy on the basis of his HIV policy. The settlement cannot be fair if it leaves well over half of women prisoners without this means of quality control.

(12) The Timeframe to Appeal Urgent or Emergency Needs Must Be Clarified.

The 5-day timeframe for emergency appeals (Vol. 1, Ch.12, p. 3) should be clarified to apply to the entire process, i.e., to the second level review. From the current language it is impossible to tell how the 5 days applies at all. In addition, the definition should be modified to remove any ambiguity that problems such as finding a breast lump or having an abnormal pap but not getting follow up care meet the standard for 5-day review.

(13) The Process for Obtaining Medical Care Translations Without Breaching Confidentiality Must Be Specified.

Many of the women incarcerated in state prisons speak primarily Spanish and have difficulty accessing medical services due to language barriers. Shain Decl., ¶14. While prisoners "shall have access to an interpreter" (Vol. 1, Ch. 11, p. 2), the Policies and Procedures do not clearly state that CDC will provide translation services when necessary for medical care, nor is there any indication of what process a prisoner must use to get a translator. Both of these points should be clarified to ensure access to interpreter services, and the current practice of using other prisoners, and even prison guards, to provide translations (*see,* Shain Decl, ¶14) in violation of medical confidentiality must be banned.

(14) The Class Has Not Been Informed About Whether There Is An Agreement on Dental Care, Much Less Its Terms. Without Adequate Policies and Procedures on Dental Care, the Settlement Agreement is Unfair.

On dental care, all the parties have said in their agreement is that CDC is "currently updating the Dental Services Policy to include the most current policies, procedures and treatment guidelines. The HCSD expects to distribute the updated policy in 2002." Note in Table of Contents for Vol. 8, Dental Services. There is nothing in the Audit Instrument about dental care or other oral health.

Has an agreement been reached on dental care? If so, what is it? When will the class be informed of the specific terms? Objectors request an opportunity to review and comment.

Dental and other oral health care is essential not only for the teeth, but for overall systemic health as well. Decl. of Maria Perno, R.D.H., M.S., ¶¶13-14; s*ee also, Cooke v. Superior Court*, 213 Cal.App.3d 401 (1989). For pregnant women dental exams and cleanings to prevent periodontal, or gum, disease and treatment for gum disease are important, as the bacteria from gum disease are linked to both premature deliveries and low infant birth weights. Perno Decl., ¶¶3-12. People with heart disease or other systemic diseases are also at risk from dental infection. *Id*., ¶¶13-14; *see also, Cooke, supra*, at 406 (infection from dental abscess could result in rejection of artificial hip.) Therefore, lack of access to timely, basic dental care for pregnant women prisoners may put the health of both mother and newborn at risk.

(15) The Agreement Does Not Adequately Ensure that Prisoners' Health Will Not Be Jeopardized by LVNs and RNs Practicing Beyond Their State Law Authority.

Practice beyond what is authorized by state law for any level practitioner (as well as failure to practice competently within authorized bounds) can have serious, even life-threatening consequences for women prisoners. In the September 2000 report, "[t]he third most common complaint was miscellaneous access problems, including non-treatment, delayed treatment, and failure to provide follow-up care. Over 19% of the women complained of at least one problem

accessing the health care system itself, which is the first step to gaining adequate health care." Stoller Decl., ¶16. Many of these cases involved poor assessments and delayed or inappropriate medical responses. For over 13% of the women, the care provided by the medical staff was harmful to their health, sometimes very seriously, resulting in disability or even death. *Id.,* ¶19.

Objectors strongly support what seems to be a core premise of the settlement agreement: the quality of care can be improved in state prisons by increasing medical staff, primarily registered nurses (RNs). We also agree that in California, RNs are independent practitioners, and that the boundaries for their authorized practice as set in state law and regulations are broad enough to cover a wide range of prisoner health care needs competently. S*ee, e.g*., Exh. A, California Nurses Association (CNA) Analysis. Licensed vocational nurses (LVN) also have a legitimate role to play. *Id.*

Volume 5 of the Policies and Procedures sets forth detailed instructions for RNs as well as LVNs about patient care. The issue has been raised, however, that these instructions jeopardize prisoners' health in two different but related ways: (1) by directing LVNs to act beyond the scope of practice that is permitted by their licensing category under state law; and (2) by requiring RNs to perform disease-specific standardized procedures without the additional preparation and skills required under the California Nursing Practices Act. Exh. A, CNA Analysis. General instructions in the Policies and Procedures (such as to practice only within the scope of practice or training or skill level, to practice under the direction of others, or to make referrals "when in doubt" (Vol. 5, Ch. 1, pp. 1-2 and Ch. 5, p. 1)) would not cure these two defects if the specific instructions on practice are inconsistent with state law.

For example, according to the CNA, the Policies and Procedures do not limit RNs to nursing diagnoses and nursing treatment plans; instead, they specifically require RNs to make medical diagnoses and medical treatment plans without meeting specific conditions set by the

Board of Registered Nursing for role expansion in its Advisory Statement and Standardized Procedure Guidelines. Exh. A, CNA Analysis, at pp. 2-3 and examples therein. LVNs act beyond their scope of practice if RN or physician supervision is provided "telephonically or by written order" (Vol. 5, Ch.5, p. 1) without the RN or physician being present to observe the patient's signs and symptoms, provide clinical direction, and assess the LVN's current competency. Exh. A, CNA Analysis, p. 12. Similarly, the medical, psychosocial, and triage assessment responsibilities assigned to LVNs under the Policies and Procedures significantly exceed their licensure in numerous specific ways, according to the CNA. *Id*., pp. 13 -16.

LVNs will have a major role under the settlement agreement (in the prison guard employment classification of Medical Technical Assistants), as they will be the first responders to calls for medical help from prisoners in locked cells and elsewhere on the prison grounds, including in times of urgent or emergency need. Vol. 4, Ch. 18. RNs, in contrast, will usually not be in the areas of the prison where most prisoners are usually located and will generally only learn of urgent or emergency medical needs from the LVNs. *Id.* LVNs, then, are truly the gatekeepers to care in this prison system for urgent and emergency medical needs—precisely the needs involving the gravest health risks.

Practice beyond the scope or training or skill of any level practitioner leads to negligence and, for women prisoners, predictable results:

> [L]ate or no responses to calls for medical help, inaccurate assessments by the first responders of serious and even life-threatening medical conditions, dangerous delays in or denials of necessary referrals to advanced level practitioners, specialists, and hospitals, missed medications, and inadequate diagnostic and therapeutic care for the most seriously ill women and those with complex medical problems, and negligent designation, treatment and support of the disabled.

Weinstein Decl., ¶9. To protect patient safety, it is therefore imperative that the specific instructions in the Policies and Procedures for LVNs and RNs not be inconsistent with California

state law on authorized practice. The Policies and Procedures should be modified to strike the appropriate balance in the responsibilities for the various practice categories and levels.

IV. In the Absence of Appropriate Standards, the Audit Instrument Fails to Address the Women Class Members' Health Care Needs.

Objectors have explained above the significant ways in which the Policies and Procedures fail to meet women prisoners' most basic health care needs. In these same ways, the Audit Instrument, or Clinical Indicators, is flawed. They should be revised accordingly, and objectors request an opportunity to review and comment on any revisions before they become part of the final settlement agreement.

More general flaws also characterize the Audit Instrument. For example, there is no indication that the most serious and complicated health cases in a practice or specialty area will be reviewed: yet choosing only the "easy" cases, even if through a random sample, would mask significant unmet health care needs. Objectors also note that while the instrument may measure a lot about process, it would gather relatively little information about ultimate outcomes, thereby defeating its most valuable purpose. Examples of missing questions are provided as Exhibit B.

The importance of having a meaningful Audit Instrument cannot be overstated, as enforcement of the settlement agreement depends on it. See, Stip., ¶19-23.

V. To Be Fair to Women Prisoners, the Stipulation Must Be Clarified to Guarantee Implementation of Adequate "Treatment Protocols" Without Limitation to the "Availability of Additional Resources."

A. Funding Excuses Should Not Be Allowed for Failure to Implement Adequate Treatment Protocols at the Women's Prisons.

While nearly all of the women's prisons are scheduled for both implementation *and* audits during calendar year 2003 (Stip., ¶5, 3:16-17),[8] it is unclear from the Stipulation exactly what kinds of improvements defendants are committing to implement at the women's prisons or when.

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[8] One women's prison, Sierra Conservation Center, is in the 2008 group. *Id.,* ¶ 5, 4:5-6.

This ambiguity arises because the Stipulation also says that during 2003, "[t]reatment protocols set forth in the Policies and Procedures will be implemented at all institutions *subject to the availability of additional resources*" (Emphasis added.) ¶6, 4:9-10 and 15-16, ¶19. "Additional resources" means "money and staff." Class Notice, Summary of Medical Care Improvements Required by the Settlement, p. 2. "All other improvements" are also scheduled for the 2003 compliance group in 2003 (*id.*); while it is unclear what these "other improvements" are, they plainly exclude the treatment protocols, such as those for HIV or those ordered late last year for Hep C under the Pelican Bay pilot protocols.[9] Therefore, the settlement agreement could be interpreted to mean that *none* of the treatment protocols *ever* need be implemented at the women's prisons if money and staff are not available during calendar year 2003. The agreement must be clarified to ensure that defendants not be excused from the duty to implement adequate treatment protocols beginning with 2003 and continuing in following years for women prisoners (or men at the other prisons in the 2003 compliance group). In other words, the limitation should be clarified to apply only to implementing the treatment protocols during 2003 at the prisons included in the 2004-2008 compliance schedule.

A separate but related issue is the need for clarification as to when the Hep C pilot protocols will be imported to the 2003 compliance group.

B. Women Should Be Informed of When the Compliance Audit Is Being Held and Provided with A Copy of the Audit Results Shortly After It Is Completed.

For the women class members, the settlement does not contemplate additional medical staff or services.[10] Instead, the approach for improving health care at the women's prisons

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[9] *See*, Exh. R, CDC BCP for Fiscal Year 2002/03 (May 14, 2002), Narrative, p. 8.

[10] Beginning in fiscal year 2000-01, positions for medical and custodial staff and professional consulting services were authorized for VSPW and the four other women's prisons and the three men's prisons included in the Stipulation's 2003 compliance group. Stip., ¶5; Exhs. O and P, CDC Budget Change Proposals (BCP) for Fiscal Years 2000/01 and 2001/02, respectively.

appears to be through the adoption of the health care services Policies and Procedures and the related audit and compliance enforcement mechanisms. Objections about the Policies and Procedures and Audit Instrument have been raised above. Assuming these were adequately addressed, would the agreement be fair? We can't know without knowing what new medical staff and professional consulting services have already been made available for each of the women's prisons as well as defendants' comprehensive plan for medical staffing and services at each of the other prisons. Access to such information should be made available.[11] This is particularly important in view of the patient safety issues raised by the practice concerns described above, the fact that the Policies and Procedures mandate only one RN 24 hours a day (Vol. 5, Ch. 1, p. 1), and that it is unclear how women will have access to advanced level practitioners and specialists for gynecological or obstetrical care (see above).

The settlement agreement should also provide for notice to the women prisoners of when the audit is to take place at the prisons in which they are held, and the women should be provided with a detailed written report of the outcome of the audit shortly after results are available.

VI. Other Ambiguities About the Settlement Should Be Clarified Before It Is Approved.

A. The Stipulation and Policies and Procedures Should Clarify that the Settlement Agreement Covers Prisoners in the Community Prisoner Mother Program and in the Pregnant and Parenting Women's Alternative Sentencing Program.

"[T]he class consists of all prisoners in the custody of the CDC with serious medical

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However, information has not been provided about the distribution of these positions and contract services, how many of these new positions have been filled or where, how many have been re-assigned to Pelican Bay from each prison, or how many contracts have been arranged for services at each of these prisons. *See, id.* No additional medical positions are being added for the first compliance group in FY 2002/03, although positions re-assigned to Pelican Bay from any of the prisons are to be returned. Exh. R, CDC BCP for Fiscal Year 2002/03 (5/14/02).

Regardless of the actual medical staffing and contracting since FY 2000-01, health care remains frightfully inadequate for women prisoners two years after the first positions at VSPW and the other women's prisons were authorized. Weinstein Decl., ¶9; Shain Decl., ¶¶6-15.

[11] The information in the FY 2002/03 BCP (Exh. R) pertains to compliance years, not each prison, and the only explanation about distribution is that it will be proportional.

needs, except those at Pelican Bay." Stip., ¶8, 5:9-11. The Stipulation should confirm that women in the Community Prisoner Mother Program (CPMP) (Penal Code §§ 3410 *et seq.*) or the Pregnant and Parenting Women's Alternative Sentencing Program (Penal Code §§ 1174 *et seq.*), are in the class, and it should explain how health care services for them will be affected by the settlement agreement. Women prisoners there should receive class notice and be given an opportunity to comment.

B. The Stipulation and Policies and Procedures Should Clarify How the Skilled Nursing Facility Is Affected By the Agreement.

The only skilled nursing facility (SNF) in a California state prison is located at CCWF. Moreover, women from throughout the state's prison system who need long-term skilled nursing care are sent to this SNF. The Stipulation as well as the Policies and Procedures, however, are silent on the SNF, which is a licensed health facility under the California Health and Safety Code (see §§ 1250(c) and 1254(a)). The agreement should confirm the SNF's role in the medical system and that it will not be closed or converted to a Correctional Treatment Center, which would result in the loss of the skilled nursing level of care for long-term disabled women prisoners.

Dated: ___________________

Respectfully submitted,
LEGAL SERVICES FOR PRISONERS
WITH CHILDREN

By: ________________________
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