

STATE POLICE BULLIES VICTIMIZE BLACK PATIENTS AT COALINGA STATE HOSPITAL

In a series of at least three incidents which resulted in four vicious attacks on Black patients at Coalinga State Hospital ("CSH"), overzealous officers from the Hospital's Department of Police Services ("DPS") exhibit a pattern of racial violence, and apparently do so with government impunity.

Due to the confidentiality required by the Health Information Practices Act ("HIPA"), the involved patients' names cannot be disclosed in this article – only initials will be used, and the terms "resident," "individual," and "patient" are used synonymously.

In a 60-day time period, at least three separate unprovoked police assaults occurred on Black patients at CSH. A fourth incident has come to light, but is not detailed herein due to insufficient information at this point in time. On all of the reported occasions, DPS Sergeant Michael Walker and Sergeant Bisacca were involved in, or initiated, the alleged assaults. The first assault occurred March 23, 2007, on patient R.H. The second assault occurred April 21, 2007, on patient E.D. The third assault occurred May 19, 2007, on patient M.W.

According to written witnesses' statements, which were turned over to the Department of Mental Health ("DMH") by the patients' elected representatives, none of the individuals assaulted by the hospital police posed a threat to hospital staff during any of the reported incidents. However, the official hospital police version of each event is quite different from those given by the uninvolved witnesses. This discrepancy has resulted in patient allegations of a police and administration cover-up.

On May 15, 2006, the DMH issued a "Special Order," Number 119.06, requiring a procedure to be used by hospital staff to recognize the risk factors for violence, and then utilize proper preventive therapeutic behavior management skills to de-escalate a potential crisis or emergency event. This procedure is called "Prevention and Management of Assaultive Behavior" ("PMAB"). At no time was the required PMAB procedure utilized to assess, and if necessary stabilize, any of the patients prior to their being assaulted by the hospital police.

Instead, during two of these occasions, a takedown tactic known as a "Prone Position Takedown" was the method of choice by Sergeants Walker and Bisacca. Then, after the takedown of these unresisting patients, all of the police officers present participated in a "dog pile" event by jumping on top of their victim. At no time did the hospital police perform any "monitoring of the individual's respiration and physical well-being," which are procedures required by Special Order 119.06 whenever hospital police or staff perform a takedown.

The witnesses' statements regarding the March 23, 2007, incident are all very similar and provided the following information:

On March 23, 2007, a resident of CSH by the name of R.H., while on his housing unit, was approached by Sergeant Walker and two other DPS officers. Walker

requested R.H. accompany him to an interview room because he [Walker] wanted to interview R.H. At that time, R.H. stated that he did not want to speak with the sergeant but he would speak with a Psychiatric Technician. While R.H. had his hands in his pockets, Sergeant Walker grabbed and forcibly turned R.H. around to where he [R.H.] faced the wall of the unit's Nursing Station. This wall had a large "unbreakable" plate glass window. Sergeant Walker then repeatedly slammed R.H.'s face into the window before placing R.H. in mechanical restraints in order to move him a few feet to a "seclusion room."

The witnesses' written statements regarding the April 21, 2007, assault on patient E.D. by Sergeants Walker and Bisacca, and approximately fifteen other officers, are all similar in content and are summed up as follows:

On April 21, 2007, a resident of CSH by the name of E.D. was in the resident library. He was approached by several hospital police officers who requested E.D. submit to a search of his person. E.D. declined to be searched by the officers, requesting instead that the officers summon his housing unit Unit Supervisor and medical/psychiatric staff. E.D. was peaceful, but insistent, and at no time displayed any violent or threatening behavior. By this time, it was estimated that fifteen or more police officers had surrounded E.D.

At the same time, the head librarian, Mary Leal, asked all other persons who were not sitting at the same table as E.D. to temporarily exit the library. Librarian Mary Leal then attempted to block the library windows so as to obscure the view of any witnesses. She was only partially successful, as several witnesses were able to observe the event.

Witnesses looking through the library window reported that at no time did E.D. become resistant or aggressive. Nevertheless, the witnesses observed several sergeants, including Sergeants Walker and Bisacca, along with several other police officers, as they grabbed and physically forced E.D. to the floor in a "Prone Position Takedown." With E.D. now lying on the floor on his stomach, the officers then shoved his face into the carpeted floor with one officer placing his knee on E.D.'s neck and head. The officer then utilizing his body weight, through his knee held to E.D.'s neck, pinned E.D.'s face to the floor as other officers dragged E.D., thus giving E.D. painful rug burns on his face. Next, E.D. was placed in physical restraints and secured to a body board. Then, while E.D. was thus restrained in the prone position, he was transported through the institution on a golf cart to his housing unit. During this entire time, neither staff nor police performed any of the required monitoring of E.D.'s vital signs. He was then placed in seclusion.

The witnesses' statements regarding the May 19, 2007, assault on patient M.W. by Sergeants Walker and Bisacca, and approximately fifteen other officers, again are all similar in content and are summed up as follows:

On the morning of May 19, 2007, a physical altercation occurred between two

patients living on housing Unit 12. Long before any staff intervened, an uninvolved patient named M.W. intervened and broke up the fight. The combatants were disbursed and sent to different rooms of the housing unit by other patients without any staff involvement. Even though it was over, a "Red Light Alarm" was sounded. However, hospital police took another three to five minutes to respond to the housing unit.

Both Sergeants Walker and Biscacca were among the first responders to the red light alarm. Upon entering the Day Room area of the unit, and without doing an assessment of the situation, Sergeant Walker was loud, and according to all of the witness's statements, very aggressive. This verbal and physical aggression simply incited a new confrontation.

The written statement of witness K.C. reads:

"I entered the day room and saw that resident A.B. was seated and quiet and resident M.W. was standing near him. That approximately five minutes later Sergeant Walker appeared at the scene and started yelling at A.B. and M.W. At that point M.W. asked the Sgt., 'Why are you yelling at us? We are the ones who broke it up.' Sergeant Walker replied, 'What have you got to do with this? We are the ones who keep the peace.' Sgt. Walker then stated, 'mind your own business.' M.W. replied, 'F... you!' That at this point the sergeant was still at least 15 feet away. I went chest-to-chest with M.W. to insure that he did not cross any lines or break any rules. At no time did M.W. attempt to push me away or advance in anyway. That suddenly Sgt. Walker literally went through me [K.C.] to reach M.W., assaulting both me and M.W. He grabbed him [M.W.] with both hands, pushed him about 3 feet where M.W. dropped to the ground with Sgt. Walker on top of him. That M.W. offered no resistance of any kind."

The written statement of witness J.V. reads:

"In the time it took me to move from the window in hallway 2 to the entrance of the day room there was an eruption of voices. I got to the day room entrance in time to observe the newly arrived DPS officers pile on top of M.W. In my capacity as the UAC¹ Chairman-Acting, I attempted to observe the volatile situation from a position that I considered to be appropriate. Sgt. Walker and Sgt. Bisacca, who appeared to be in command, was yelling directives to have the day room cleared out while his - Sgt Biscacca's knee was on top of M.W. pinning him face down on the floor.

Sgt. Biscacca was trying to have me removed from the scene to an area that obscured my view. I would not allow this to happen, and declined to comply with this inappropriate directive. He ordered me to be placed in handcuffs and instructed his

¹. Unit Advisory Counsel ("UAC"). The elected housing unit Chairman is the patient representative who sets on the hospital wide Residential Policy Advisory Council ("RPAC") as a representative for his Unit.

officers to turn me toward the wall with the television stating that this was a crime scene and that I would be unable to observe, in any capacity, the conduct of the officers involved. It should be noted here that the officers instead sat me down while still handcuffed but Sgt. Biscacca ordered them to turn me around to face the wall. They strapped M.W. onto a gurney and wheeled him out of the unit."

M.W. was eventually transported to the Fresno County Jail and charged with assaulting the hospital police officers.

The hospital residents are represented by elected members of the patient population to a group known as the Resident Policy Advisory Council ("RPAC"). The RPAC representatives had been complaining to the hospital administration for several months about the hospital police violence, and lack of oversight. The hospital administration apparently failed to investigate the complaints, as no effort was made to stop the assaultive police behavior.

The DMH, like all state agencies, has a system for processing grievances. For patients in California's State Hospitals, that process involves filing a complaint with the Office of Patients' Rights ("OPR"). The OPR is staffed by Patients' Rights' Advocates. These Advocates are supposedly independent of the DMH. They are actually hired by contract to protect and advocate for the rights of patients. Patients' Rights Advocacy contract (DMH Contract #04-74280). The process looks good on paper. Apparently this process also doesn't work, as patient complaints through this process also failed to stop the assaultive police behavior.

After months of complaints of police abuse within the hospital, the M.W. incident became enough to definitively illustrate a pattern of abuse against Black patients. The hospital's Black patient population decided enough -was- enough and threatened retaliation if the abusive police behavior was not stopped. The RPAC representatives again requested the hospital administration effectively address this situation.

On May 21, 2007, a small group of RPAC representatives was granted a meeting with the hospital's Clinical Director, Dr. Gary Renzaglia, and Hospital Administrator Pam Allen, both of whom reviewed the written statements from witnesses provided by the RPAC, none of which had been included in the "official" police report.

On May 22, 2007, the RPAC Chairman, K.C., was approached by Staff Liaison Officer Gary Deike and informed that Dr. Renzaglia wanted copies of the statements regarding the May 19, 2007, events so he could fax them to DMH headquarters in Sacramento for the possible appointment of an independent investigator. The requested statements were provided to Gary Deike on the morning of May 23, 2007.

As of June 4, 2007, M.W. remains charged with assaulting hospital police, and there are no visible signs of any further investigation whatsoever, let alone an independent investigation.

Tom Watson
June 4, 2007