restraints.

There are different ways to do that, one of which is require every inmate receive an examination before going into restraints. That's one option.

If the facility finds that it is better to use the intake exam sheet, then they should ask questions that specifically address the risk factors for Red ID restraints. And I'll give you a quick digression and example.

When the HIV epidemic began, at that time history and physical examination focused on the risk factors for HIV, and at that time into the intake screening examination questions appeared in many jurisdictions. In fact, now in almost all jurisdictions about risk factors for HIV, because this is the ~~popular~~ population we care for.

Those included did you have a transfusion? Do you share needles? Have you had sex with men? So the practitioners can identify those individuals who are at risk who may be at a higher risk for HIV.

In a similar vein, in whatever format you would choose to screen people, whether that is via

A. You know, I've never seen them used at all, but I can tell you that I've seen impetigo transmitted inmate to inmate from contact, and it wasn't clear whether it was transmitted by contact via an object or whether it was transmitted directly from skin to skin.

Q. What is impetigo?

A. It's a staph skin infection and it's commonly transmitted by contact. Children get it. Wrestlers get it. And whether the bacteria can live inside the mitt is something I don't know, but it is, you know, likely.

And so, I think, that's why the manufacturer probably recommends sanitizing it.

Plus, you know, there are other bacteria that could be transmitted.

Q. Is there a reason that you didn't mention in your report the possibility of inmate pressure on medical staff?

A. In what context?

Q. Well, in the same context that you mentioned security staff pressure on medical staff.

A. No, there is no particular reason.

Q. Do you think age is a factor in whether

A tonic phase is a phase where the muscles are contracted continually, and the clonic phase is where they are repetitively jerking.

These phases result in extreme contraction and a jerking of the muscles. And if those events ~~recur~~ occur while someone is in an unnatural position, that is with their arms behind your back, I would suspect that some of them can even break bones.

And I think it would be dangerous to do that, so unfortunately, the whole area of epilepsy is one where there is some amount of gaming and also it is an area that physicians typically do not take very good histories of, so it's a tough one, but I believe that an attempt should be made to identify those people who have true epilepsy.

Q. When you say "true epilepsy, "do you mean grand mal epilepsy?

A. Yes, but any type of epilepsy.

Q. Petty mal seizures do not involve any physical movement of the limbs, right?

A. It has to also do with the level of consciousness. If someone becomes unconscious, whether they sustain a tonic clonic phase is

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------X
JAMES BENJAMIN, et. al.,
Plaintiffs

- against -

WILLIAM FRASER, et. al.,
Defendants

and related cases.
----------X

75 Civ. 3073
(HB)

DIRECT TESTIMONY OF MICHAEL PUISIS, D.O.

MICHAEL PUISIS, D.O. declares under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I have been asked by the Legal Aid Society to give an opinion of the medical consequences of the use of the Red ID restraint procedure in the New York City jails related to Benjamin v. Fraser.

QUALIFICATIONS AND BASIS OF OPINION

2. As reflected in my attached curriculum vitae, I am a Doctor of Osteopathic Medicine. I graduated from Chicago College of Osteopathic medicine in 1982 and completed an Internal Medicine Residency at Cook County Hospital in 1985. In 1985, I became Board Certified in Internal Medicine. I am licensed to practice medicine in the State of Illinois. I have worked in correctional health care for 17 years. I was previously the Medical Director of the Cook County Jail in Chicago from1991-1996. I have served as a consultant for the United States Department of Justice, and a number of other organizations on matters of correctional health care. I have

drafted policies and procedures for correctional systems and hospitals regarding the use of restraints on mental health patients and regarding the shackling of prisoners held in hospital wards. I edited the only textbook on correctional medicine, Clinical Practice in Correctional Medicine. I am a member of the National Commission on Correctional Health Care's Physician Panel on Clinical Practice and I served on the task force to revise the American Public Health Association Correctional Standards in 1999. I currently work as a consultant in correctional health care.

3. In order to render an opinion in this matter, I relied on my professional education, training and experience over my approximately seventeen years in correctional health care. I reviewed a number of documents, a list of which is attached to my testimony. In addition, I conducted a tour of the Bronx Supreme Court and Criminal Court buildings on April 18, 2002, accompanied by Chief Steven Conry, Eugene Miller, John Boston, Florence Hutner and other Department of Correction staff. During the tour, I inspected the manner in which persons confined by Red ID restraints are transported to the court and the manner in which they are held in holding cells pending their appearance in court. I spoke with prisoners who were restrained in the Bronx Supreme and Criminal court pens. I also visited the intake area of the George R. Vierno Center on Rikers Island to inspect the holding areas where Red ID persons are held prior to transport to court. I was not permitted to speak with any of the physicians or other medical staff who are responsible for developing policy, supervising the Red ID program, or monitoring the medical conditions of inmates who are restrained by the Red ID method. Lastly, both Gene Miller and I had the Red ID restraints placed on us in the manner that is used for inmates.

OBSERVATIONS, FINDINGS AND OPINIONS

4. It is my opinion that the Red ID restraint practice causes substantial pain to prisoners who are subjected to it, and additionally poses a significant risk of neurological, musculo-skeletal, vascular, and other injuries (including an increased risk of falls and of injuries from vehicular accidents or sudden stops). The medical screening procedures used by the medical provider are seriously inadequate in a variety of ways to control those risks and prevent injury and pain.

The Application of Red ID Restraints

5. Red ID restraints are placed as follows. Inmates first place their hands in a synthetic fabric mitt with a semi-rigid liner. The inmate then is made to place both arms behind the back with palms outward. The mitts have cuffs around which metal handcuffs are placed, securing the inmate's arms behind him. A metal rectangular box about 6 inches long is fixed around the lock of the cuffs, thereby fixing the cuffed arms in a rigid arrangement. After this, chains are secured between the ankles of the inmate so that the step is restricted to about a 2 to 3 foot span. A chain is placed around the waist and the waist chain and handcuffs are linked and secured with a lock. The movement of the arms is severely limited.

6. The Red ID restraint procedure is utilized on a class of inmates deemed violent by the custody officials. I was told that the categorization of Red ID inmates is made independent of classification, length of stay, or charge. This method of transportation and confinement is utilized on approximately 4% of the population of the jail system. This procedure is carried out whenever the inmate is transported off the facility grounds. The restraints are applied continuously for the time period the inmate is off grounds with the exception of a 15-minute to half hour break for lunch and restroom use at about 11 AM. When inmates enter the court, the

judge has the discretion to remove the restraints, though it appears from declarations that many prisoners report that they remain in the restraints in the courtroom. With the exception of the lunch and bathroom break, inmates may be in these restraints for prolonged periods. Inmates leave the jail in these restraints as early 5:30 AM according to inmates (7 AM according to security officials on the tour; prior to 7 a.m. according to some of the "Red ID Tracking Forms") and may remain in restraints as long as up to 6 PM depending on the when the inmate has his court presentation and when the inmate is taken back to the jail.

7. I am told that defendants have adopted a new policy of attempting to get Red ID status prisoners placed on a bus to return to their jail within two hours of the time they finish seeing the judge. Based upon the "Red ID/Enhanced Restraint Tracking Forms" I reviewed for the Red ID inmates seen in the Bronx courthouses in April, 2002, I do not believe that this policy is being accomplished. Moreover, even if this policy were to be in place, in many instances prisoners would nonetheless be in Red ID restraints for prolonged periods of time. Therefore, this new policy does not change my opinion in this matter.

The Transportation of Inmates in Red ID Restraints

8. Inmates are transported to and from appointments in buses. I inspected two of the buses. There was no air conditioning on these buses. I was told by DOC personnel that there is no air conditioning on any of the transport buses. On the bus, Red ID inmates are locked in cages that are fixed inside the buses. Some of the cages have ventilation; some do not. Those that do not have ventilation are sealed on the window side and have a Lexan type plastic on the front. The cages are approximately two and a half to three feet front to back. I question whether there is sufficient ventilation in these buses. I had the opportunity to be driven in a van (from the

jail back to our hotel when we were on tour) designed for inmate transportation in which the passenger compartment was similarly sealed and surrounded by Lexan. It was a hot afternoon and there was no ventilation in the van, a similar arrangement to the some of the seating on buses. I found the heat insufferable and asked to get out after a short ride. I believe this type of condition will be harmful to persons with cardiovascular disease or for persons taking certain types of psychotropic medication.

9. In addition, because Red ID inmates have their arms fixed behind their backs, and there were no seat belts, it did not appear that inmates could protect themselves during acceleration or deceleration such as during a sudden stop. There was also no padding to protect prisoners from striking the front or sides of these cages. Not surprisingly, several prisoner declarations report injuries occurring during transport in these cages. For the above reasons, I do not believe these transportation arrangements are safe.

10. When inmates move off and on the bus and when they come and go from the Bronx Supreme Court holding pens from the buses, they walk up and down stairs. This is dangerous given that they do not have use of their arms to protect themselves in the event of a fall and given that their legs are shackled and they lack the ability to move their feet more than a couple of feet. Some of the inmates we observed were escorted up stairs by an officer, but other inmates were not. On interviews, inmates stated that being escorted in this manner does not occur on a routine basis. I am not aware of any policy requiring that inmates in these restraints be individually escorted up and down stairs to prevent injury. However, this should be required.

Conditions in the Court Pens for Prisoners in Red ID Restraints

11. The conditions in the court holding pens are equally problematic. While in holding

pens, inmates are restrained even when they are held as the only occupant of a cell. The seating arrangements that are available (a shallow metal bench affixed to the wall) make it impossible to sit in a natural posture. I saw one inmate lying down. He was doing so in an awkward arrangement that looked precarious. Aside from standing there was no easy position that a person could maintain while being held in the court pen.

12. Officers transporting and guarding inmates while they are waiting in the court bullpens do not know the medical conditions of the patients. There is no apparent mechanism for inmates who complain of anything including numbness or pain to be evaluated. In fact, most inmates on the day of my tour complained of loss of feeling in their limbs, but they were not evaluated for this complaint. Inmates complained that their medical complaints relating to effects of the restraints are ignored. There was no mention in the Correctional Health Services policy or procedure of evaluation of problems that may occur as a result of this type of restraint.

My Personal Experience in Red ID Restraints

13. Gene Miller and I were placed in restraints for a brief period of time; less than five minutes. Both Gene Miller and I experienced pain and slight bruising from the restraints. (I examined Mr. Miller's wrists and inquired about his pain as I would with any patient.) The cuffing left an impression on my wrist; more so on Mr. Miller's wrists. I experienced pain in the wrist and shoulder area. The mitts are virtually sealed and my hands immediately began sweating. I understand that defendants' expert David Bogard asserted that he was placed in the Red ID restraints for almost one hour and, while he experienced some discomfort, he did not experience pain once he relaxed. This report does not change my opinion. Based on my own experiences and the experiences laid out in my report, Mr. Bogards experience appears to be the

exception. Mr. Bogard was not in the restraints for the duration that the prisoners are typically held, nor was he restrained under circumstances similar to those of a prisoner.

The Medical Policies Regarding Red ID Restraints Are Inadequate

14. I reviewed two Correctional Health Services ("CHS") policies regarding Red ID and Enhanced Restraints. The first was issued in January 3, 2001. The second, issued April 5, 2002, is a revision of the first. These Correctional Health Services policies entitled Medical Review of Red ID and Enhanced Restraint Status provide vague guidance on what the process is for approving restraints, but no guidance relative to the types of medical conditions that are contraindicated by restraints. Medical staff is left to determine what conditions are likely to cause a "significant adverse medical consequence."

15. The standard articulated in the policy is also troubling in that it seems to condone adverse effects as acceptable as long as the medical adverse events are not "significant." I do not believe this is an appropriate standard for medical practitioners because it is arbitrary and assumes some harm is acceptable. Some practitioners may not view pain and suffering as significant. In my opinion, this is not humane. Even if the organic basis for pain cannot be definitively determined, pain can result from injury and should be addressed.

16. The CHS policy's vague standard also leads to inconsistency. For example, I was told of persons with asthma who were not cleared and other asthmatics who were cleared and placed in restraints. (I agree with Dr. Parks that anyone prescribed an inhaler should have a modification of their restraints, to provide access to in the event of an exacerbation of their asthma. There is not even a policy requiring that a person experiencing an asthma attack be removed from restraints to allow for them to use their inhaler.) My review of the CHS

individual facility monthly "Enhanced Restraint Status/Red ID Medical Reviews" similarly reveal significant variance in the rates at which practitioners at the jails grant prisoners modifications, indicating inconsistent review practices by practitioners.

17. Another problem with the medical review system is the failure to provide the medical staff with appropriate information regarding the effects of the Red ID policy. According to Dr. Parks' deposition transcript, approximately 130 doctors in PHS jails conduct reviews of Red ID inmates. The initial CHS 2001 policy does not explain the nature of Red ID restraints, the conditions under which they are used, or their duration. I understand from Dr. Brown's and Dr. Parks' deposition transcripts that until the new CHS policy was issued in April 2002, medical staff were not provided with any information in this regard. The only information provided was a demonstration conducted by security staff for the approximately ten PHS jail medical directors sometime during the fall of 2001. It is unclear how anyone could evaluate the potential harm of a practice that was not described to them. The new CHS policy of April 2002 at least describes the restraints, however, it remains incomplete in that it still fails to provide information about the conditions in which they are used and the duration of their use.

18. The CHS policy's vague standard does not give medical staff sufficient guidance, especially in the context of a high-turnover jail system in which medical personnel may be under great time pressure because of the large number of tasks they must perform. More explicit guidance is also required where medical personnel may be called on to make judgments that may not be popular with security staff. I know from personal experience, and from experience reported to me by other staff, that in a jail setting there is always pressure-explicit or implicit-on medical staff to go along with security staff's inclinations and not raise potential medical

contraindications. The indications of security overrides of medical modifications I reviewed are consistent with this pressure.

19. The CHS policy additionally fails to provide guidance to practitioners regarding the need for physical examinations as part of the medical review of Red ID status inmates. The CHS policy allows medical practitioners to rely on chart reviews to determine whether to grant a modification of Red ID restraints. Chart reviews alone are not a reliable basis to clear someone for these types of restraints. Chart reviews rely on intake history and physical examinations. Physicians (and nurses) do not perform these histories and examinations with an eye towards information relevant to Red ID status. Therefore, it is inappropriate to clear someone for the restraints based on chart review; only the obvious persons at risk would be eliminated from restraint. However, even the obvious persons at risk will not be addressed unless criteria are written and consistently applied. In spite of these issues, the CHS individual facility monthly "Enhanced Restraint Status/Red ID Medical Reviews" reports indicate that a very small percentage of the initial and of the monthly reviews of persons in Red ID status are performed by physical examination.

20. Prior to "clearing" persons for Red ID restraints, the patient should be interviewed by a physician and, if risk factors are present, examined. Right now there are many significant questions that are not specifically asked in the intake history and examination (e.g. history of dislocations and fractures, deep vein thrombosis, or back injury). A focused set of questions administered as part of the jail intake history and physical examination procedure might substitute in theory for an interview and examination following placement in Red ID status. However, questions on intake would probably not capture all relevant information, since it would

not be the primary concern of the interview which takes place under rushed circumstances and since the prisoner might have experienced other medical issues between the time of intake and the time of placement in Red ID status. Thus, a personal encounter following placement in Red ID status is more likely to elicit accurate information. Limiting the focused inquiry to those placed in Red ID status would also conserve staff resources.

21. Even physical exams are of limited effectiveness in identifying those individuals placed in Red ID restraints who are likely to sustain injury, because, as set forth below, some conditions which increase the risk of injury are not readily apparent. Moreover, all patients are likely to have pain and suffer from the restraints. Temporary neurological injury is likely in many. Because there is little follow up of inmates and no survey of the type of injuries that may have occurred, no one knows the incidence of neuropathy that will occur.

22. There are also institutional factors that will make the medical clearance process ineffective. Making physicians "clear" individuals for the use of restraints is likely to cause tension between the medical staff and correctional staff. This exercise places individual medical staff in a very awkward position and compromises their ability to exercise good judgment. Again, my review of modifications "denied" by security supports this view.

CONSEQUENCES OF THE RED ID RESTRAINTS

23. The medical community has not studied restraint practices as prolonged and as severe as the Red ID restraint practice. However, injury secondary to front cuffing is well established in medical literature. A French study published in the Journal of Forensic Science, September of 2001, reported that neurological symptoms occurred in 6.3% of consecutive prisoners who have been rear cuffed. This compares to 100% of prisoners with neurological

symptoms who I interviewed during the tour who were cuffed in the Red ID manner with cuffs in the rear with palms outward. The previously mentioned French study reported that symptoms were related to the duration of restraints (mean time in restraints was 1.8 hours for asymptomatic patients and 3.7 hours for symptomatic patients). They conclude that the longer restraints are applied the greater the likelihood of potential injury. A study at Emory University presented in the June 2000 issue of the medical journal Nerve, reported that handcuff-related nerve injuries can be severe and permanent. That study documented nerve injuries utilizing electrodiagnostic studies. A report in the Archives of Physical Medicine and Rehabilitation reported cases of median and ulnar neuropathies (nerve damage) as a result of cuffing. The authors state that "significant disability resulted, and a rehabilitation program was indicated." It is my opinion that there is documented evidence that routine front handcuffing does cause temporary and permanent nerve damage. It is also my opinion that documented evidence suggests that similar injuries result from rear cuffing. Finally, it is my opinion that rear cuffing increases the potential for nerve damage and that cuffing with the palms outward further increases the risk.

24. My opinion is that Red ID restraints will result in a variety of muscular-skeletal, neurological and possibly vascular injuries for some prisoners. The position of the arms and hands in the Red ID restraint posture stretches a number of nerves entering the arm and nerves transversing the wrists. In addition, handcuffing compresses nerves in the wrists. The effect of the rear position (particularly with palms outward) is additive. Routine handcuffing causes temporary and permanent nerve injuries in some individuals. As reflected in the French study, cuffing prisoners for prolonged periods increases the likelihood of nerve damage. Prolonged cuffing in the unnatural posture imposed by Red ID restraints additionally increases the

likelihood of injury. The torsion (twisting) of the wrists exposes the wrists to additional strain and may result in joint fatigue and injury as well as increase potential for nerve injury.. In part, this is because the position is uncomfortable, which results in prisoners struggling with the cuffs to increase comfort. This struggle can increase the likelihood of neuropathy. The struggle to find relief may have the same effect as the imposition of excessively tight handcuffs.

25. Prolonged rear handcuffing also results in muscular-skeletal and joint fatigue and presents a risk of injury and pain. In addition, due to the posture, the individual restrained is more vulnerable to injury if a fall occurs. Walking, sitting down or standing up are more difficult with both arms shackled behind one's back. This increases the likelihood of a stumble or accident. This is especially true since inmates have to walk up stairs to get into the Bronx Supreme Court building. Traveling in the buses is not safe. There is inadequate ventilation in some of the cages and there is no means for the inmate to protect himself or herself in the event of sudden acceleration or deceleration.

26. Dr. Parks, in his Declaration states that he is "not aware of a single medical complaint secondary to rear cuffing" while he was with the New Jersey Department of Corrections. However, he does not indicate that the practice in New Jersey of rear cuffing inmates was of similar duration or posture as the practice in New York. He also states that "most rear cuffed inmates do not complain about injuries from rear cuffing." This was not my experience based on prisoner interviews and review of prisoner declarations. On the day of my tour, every inmate I interviewed in Red ID restraints was experiencing pain and numbness. Numerous inmate declarations describe pain and numbness. It may be that prisoners with medical complaints about medical problems from the use of Red ID restraints are not getting to

Dr. Parks' attention.

27. Dr. Parks also mentions that prolonged cuffing primarily causes temporary numbness that occurs equally with front or rear cuffing. I disagree. It is well established in medical literature that even front cuffing can cause traumatic neuropathy. The medical effect of prolonged rear cuffing has not been studied but rear cuffing puts more strain on the shoulders, wrists, and the neurovascular structures of the arms and hands than does front cuffing. It is my opinion therefore that rear cuffing would lead to more numbness and more serious medical problems. Rear cuffing appears to pose greater potential for permanent neuropathy than front cuffing, in addition to potential for other medical problems described elsewhere in this report.

28. The following are examples of other types of medical conditions that may result from use of these devices or types of conditions that should contraindicate use of these restraints.

A. Persons who have need of immediate intermittent self medication (e.g. persons using nitroglycerin or inhalers for asthma or chronic lung disease) will be at increased risk of harm by being unable to access their medication when they need to use it. Dr. Parks agrees in his deposition that these persons should be given a modification of Red ID restraints.

B. Prolonged restraint and immobilization can result in venous stasis (decreased blood flows in veins), thrombosis (clotting) and subsequent pulmonary emboli (clots to the lungs). The Red ID restraint significantly restricts movement and immobilizes the arms. Immobilization of a limb may place persons at higher risk for clotting and subsequent emboli (clots that float off into the circulation). While this type of event may

be infrequent, it is a serious consequence of immobilization of a limb.[1] Persons with other risk factors for increased clotting certainly should not be placed in these types of restraints. Dr. Parks agrees in his deposition to the extent that he believes persons with clotting risk factors should be examined to determine if a modification is necessary. Also, it is standard medical practice for persons in mechanical restraints to periodically move all restrained limbs out of restraints (e.g. every two hours) in order to prevent clots from forming. Decreasing the time in restraints or more frequent time out of restraints would reduce the potentiality of clots forming.

C. Individuals who may have underlying peripheral vascular disease may also suffer transient ischemia (loss or decrease of bloodflow) to the limb. Prolonged ischemia may potentially harm some individuals.

D. The manufacturer's directions for the using The Tube mitts recommend that the mitts be sanitized between uses. This does not occur. Persons with ulcerations or other skin disorders (impetigo) may transmit disease to other inmates. Mitts should be sanitized after each use as per instructions from the manufacturer.

E. Persons with edematous (swelling) disorders should be prohibited from being placed in these restraints because of the impairment in circulation and the resultant pressure effects on nerves.

F. Persons with coronary artery disease who require nitrates should not be placed in these restraints both because of the potential for an increased cardiovascular stress and

[1] I disagree with Dr. Parks' comment that a clot forming in the arm would probably never reach the lungs. Thrombosis of the veins in the arms is known to occur. The Red ID position immobilizes the arms and therefore the potential for clots exists.

because of the inability to immediately access sublingual nitrates.

G. Elderly persons who may be at increase risk of falls should not be placed in these restraints because of mobility concerns. Persons with any neurological disorder that impairs movement should also be prohibited from being placed in these restraints for the same reasons.

H. Pregnant women should not be placed in these restraints due to the increased hypercoagulable (risk of blood clots) state of pregnancy and due to the increased risk to the fetus in the event of a fall.

I. Persons who have epilepsy should not be placed in these types of restraints because of potential of injury in the event of a seizure.

29. Front or side restraining will significantly reduce or eliminate the potential for the types of neuro-vascular injuries I described above.

30. For all the foregoing reasons the only effective ways to reduce the risk of harm to prisoners from these restraint procedures are to eliminate the most injurious aspect of them, i.e. prolonged rear cuffing and to minimize the number of people subjected to the restraint procedures to the extent possible.

31. In sum, the manner of restraint is awkward, unnatural, and stresses joints, arteries and nerves in a manner that inevitably will lead to injury, disability and pain in a significant number of persons. The policies adopted regarding medical reviews do not adequately screen out those at risk of severe injury. I would encourage the correctional staff to utilize an alternate, more prudent and safer manner of restraint. Alternatively, if these restraints must be used, I would recommend a much more careful, written and detailed policy of applying these restraints

and would restrict their use as much as possible. In addition, I would require a physician's interview of each Red ID candidate prior to placement in restraints. If risk factors are present, a physical examination should be conducted. Where a prisoner has risk factors, but is nonetheless cleared for Red ID restraints, the prisoner should be examined each month thereafter.

_____

MICHAEL PUISIS, D.O.

Date: May ____ 2002

DOCUMENTS REVIEWED

- 27 Prisoner Declarations submitted with the plaintiffs' motion

- the Notice of Motion

- the Declaration of Dr. Patrick Brown

- the Declaration of Dr. Trevor Parks

- Correctional Health Services Policy and Procedure Subject: Medical Review of Red ID and Enhanced Restraint Status, issued January 3, 2001

- Correctional Health Services Policy and Procedure Subject: Medical Review of Red ID and Enhanced Restraint Status issued April 5, 2002

- the Declaration of Steven Conry

- The abstracts for

1) "Focal Neurological Complications of Handcuff Application," Journal of Forensic Science, 2001, Chariot, Ragot, et al.

2) "A Prospective Study of Handcuff Neuropathies," Muscle & Nerve, June 2000, Grant, A., Cook, A.

3) "Handcuff Neuropathy: Two Unusual Cases," Arch. Physical Medical Rehabilitation, Vol 65, 1984, Levin, Felsenthal.

- The package insert instructions for the use of The Tube (the mitts used for Red ID prisoners)

DOCUMENTS REVIEWED SINCE MY REPORT

- CHS individual facility monthly "Enhanced Restraint Status/Red ID Medical Reviews" tracking forms

- Red ID tracking forms for the month of April 2002 in the Bronx Supreme and Criminal Courts

- the full text of the above noted neurology articles

- the medical record of David Gray and of Robert Hall

- modifications requests for David Gray, Dexter Hemmings, Ronald Herron, and Jose Pizzaro, which appear to have been denied by security personnel

- A letter by Dr. Harold Appel, neurologist in the New York City jail system, published in Neurology, June1991

- the New York State Commission on Correction Chairman's Memorandum No. 19-2001

- Some abstracts on pulmonary embolism in upper extremities

- the deposition transcript of Dr. Patrick Brown

- the deposition transcript of Dr. Trevor Parks

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

JAMES BENJAMIN, et al.,

Plaintiffs,

-against-

WILLIAM J. FRASER, et al.,

Defendants.

DEPOSITION OF MICHAEL PUISIS, a non-party witness, taken by Defendant, pursuant to Order, at the offices of Corporation Counsel, 100 Church Street, New York, New York, on Saturday, May 18, 2002, at 9:50 a.m., before Jacklyn Lisi, a Shorthand Reporter and notary public, within and for the State of New York.

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A P P E A R A N C E S :

PRISONERS RIGHTS PROJECT
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BY: FLORENCE A. HUTNER, ESQ.
IRENE R. BUCH, ESQ.
Control No.: III-02015

* * *

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto, that the filing, sealing and certification be, and the same are hereby waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the questions, shall be reserved to the time of the trial;

IT IS FURTHER STIPULATED AND AGREED that the within examination may be subscribed and sworn to before any notary public with the same force and effect as though subscribed and sworn to before this court.

I N D E X

EXHIBITS

Whereupon,

MICHAEL PUISIS,

after having been first duly sworn, was examined and testified as follows:

EXAMINATION BY

MS. HUTNER:

Q. Please state your name and address for the record.

A. Michael Puisis, 932 Wesley, Evanston, Illinois 60202.

Q. Good morning.

A. Good morning.

Q. Thank you for coming out here on a Saturday.

Have you been deposed before?

A. Yes.

Q. How many times?

A. Several, I don't know the number.

Q. You know that this is an opportunity for me to ask you questions, you answer the questions.

You know you are under oath and if there is any question that you don't understand, ask me to clarify it, I will be happy to do that.

If you don't ask me to clarify it, I will

assume you've understood the question.

All right?

A. Yes.

Q. Just before this deposition began, Ms. Freeman handed me certain documents.

Did you review these documents -- we'll mark them as exhibits in the deposition later, but are these documents that you reviewed in preparation for this deposition?

A. Yes.

Q. Do you want to take a look at them or do they look familiar from that side of the table?

A. They look familiar.

Q. Did you review any other documents in preparation for this deposition?

A. Dr. Park's deposition, the declarations of, I believe, Dr. Brown and Dr. Park, the declaration of Mr. Curry.

Q. Whose declaration?

A. I think it was -- I don't remember the name, but it was a correctional official.

Q. Could it be Conry?

A. Conry, that's correct.

Q. Anything else that you can think of?

A. Off the top of my head, no.

Q. Did you review any articles or other medical literature other than the ones that you have cited in your expert report?

A. I reviewed the section on reflex sympathetic dystrophy and Harrison Textbook of Medicine.

I did a literature search and reviewed a couple of abstracts, that I don't recollect the names of, on upper extremity thrombo embolism, and I also reviewed some abstracts on restraints.

I'm sorry, I just don't remember the number or the exact titles of the abstracts I looked at.

Q. Did you review these on the Internet?

A. I did the lit searches on the Internet med line.

Q. How did you review the abstracts?

A. Digitally.

Q. Did you print them out?

A. I think I did for a couple on thrombo embolism, that's correct, and I think I printed the FDA guidelines on restricts.

Q. FDA?

M. Puisis

A. Food and Drug Administration.

Q. Did you bring them with you?

A. I did not. I can probably find them again, if I remember where I went for them, but if you need them, I will try to look and produce them for you.

** MS. HUTNER: Yes, I would like to have copies of those.

If it's possible to do it today, of course that would be lovely. We can provide you with Internet access. If it isn't, then I'd like to have them as soon as possible.

Q. What is reflex sympathetic dystrophy?

A. It's a condition that is of uncertain etiology, which means we don't know exactly why people get it, but it is thought to occur as a result of trauma or injury to a limb or nerve, and results in a chronic pain condition that is a result of a reflex action that involves the spinal cord.

So that there is an injury in a distal extremity and impulses goes to the spinal cord and a resultant pain syndrome occurs. And it is often evidenced in orthopedic injuries or injuries to an extremity.

Q. Can you just define distal extremity for me?

A. Arms, legs, the distal part probably below the elbow, I would consider distal.

Q. When you say chronic pain, what do you mean?

A. I think chronic is undefined in general.

Q. Would you say that it lasts for a certain period of time?

A. Yes.

Q. Approximately how long?

I understand that there is a range. I'm just trying to figure out at what point does it stop being intermittent, if that is not chronic and becomes chronic, and becomes a one-time brief event and then becomes chronic?

A. To be honest, the term is not explicitly defined, to my understanding, in the medical literature.

Q. What does it mean to you?

A. It occasionally is applied to certain illnesses.

For example, chronic may mean in some instances more than three months. It may mean more

than a week. But I think that it's not explicitly defined in the medical literature.

Q. Can you give me examples of the sort of trauma injury that have caused this reflex sympathetic dystrophy?

A. I think there is a wide variety of injuries that can result in it. I looked it up because I had been talking to a colleague who works at the Cook County Jail, who told me of an inmate that he examined who had sympathetic dystrophy from an injury to a limb, and the injury was, I think, neurological in nature.

Q. Do you know anything more specific about it?

A. No. It was a casual conversation, but I had been talking to him about the handcuff issue, and he brought up this item as a possible consequence of it.

Q. What's the name of this colleague?

A. Dr. Roger Benson.

Q. What's his position?

A. He is a senior physician at the Cook County Jail.

Q. Who is he employed by?

A. The County of Cook.

Q. You said the injury to this inmate you were discussing was neurological.

Do you know anything more about it?

A. No, I don't.

Q. So you have no idea what actually caused the injury; is that right?

A. No.

Q. Let me reask the question.

Do you have any idea what caused the injury?

A. No.

Q. In the section in the medical texts that you read on this condition, what sort of trauma or injury was described as possibly leading to sympathetic dystrophy?

A. It appears any type of injury can lead to this.

Q. Could breaking a finger lead to this?

A. I believe so.

Q. Why do you think so?

A. Because I've seen this condition myself in people who have fractured legs, specifically the tibia, and as a result of that type of injury they

developed a reflex sympathetic dystrophy.

Q. Can you define sympathetic dystrophy, please?

A. The sympathetic nervous system is a complex of neuro connections that in part resides in the spinal cord and in other areas of the body that mediate certain types of neural impulses.

These types of neural impulses innervate smooth muscle. They innervate sensory discharge. They innervate sweat glands. They may innervate increase in heart rate, and dystrophy is an abnormality of that neural interaction with the body.

That's about the best description I can give to you.

Q. Was this section of the Harrison text relevant, in your opinion, to the rear-cuffing issue that we are dealing with in this litigation?

A. I think it has some relevance.

Q. What's that?

A. Insofar as if someone is injured in a handcuff -- by the use of handcuffs, that there may be a possibility of development of this condition.

I don't think it's highly likely, but it

is a possibility.

Q. You said you had encountered the condition in your experience; is that right?

A. I have.

Q. Approximately how many times?

A. I'm going to guess about four or five times.

Q. That's over how many years?

A. I'm thinking of a period while I was at Cermak Health Services, which is a Cook County jail, 11 years.

Q. What were the causes of the condition in those four or five cases?

A. Usually musculo-skeletal injuries.

Q. For example?

A. I told you one, fracture. And the second was a blunt trauma, as I remember, and I don't remember more than that.

Q. Were any as a result of injuries relating to handcuffing?

A. Not in my experience.

Q. What do you think is the likelihood that any injury from the type of restraints that we are talking about in this litigation would lead to this

sort of sympathetic dystrophy?

A. I would say it's possible. More than that, I would be speculating. And I don't have a good basis at this juncture to give you a probability.

Q. Do you have any specific basis to believe that handcuffing injuries would lead to sympathetic dystrophy?

A. I think it could, and it's something I probably would look closer at.

Q. What do you mean you'll look closer at it?

A. It's something that I investigated just prior to coming out here and did not have the time to review any literature on it or investigate whether there is a causal relationship or there might be.

Q. Do you expect to change your testimony in any way from your declaration or your expert report on the basis of this issue?

A. I should ask if it's appropriate that at this juncture if I am permitted to do any further review of anything prior to trial. And if I am, I will. If I am not, then I will not.

M. Puisis

Q. Actually, I think it's not appropriate, and Ms. Freeman and I just agreed that there would not be further research and review between now and the time of your trial.

MS. FREEMAN: I think we agreed I would not show him anything else. Obviously, if you raise a question that he chooses to investigate because of a question that you've raised, that's within his purview.

MS. HUTNER: I think it's highly problematic if there is additional independent work done between now and the trial.

I think there was a fairly clear understanding between our offices that that would not happen. I do think it is problematic.

On the other hand, if you are planning to do that anyway, then I would appreciate having a prompt as possible notice of that.

THE WITNESS: I will do that.

MS. HUTNER: Given that we are supposed to have your direct testimony by Tuesday, it will have to be soon.

THE WITNESS: As a matter of fact, probably I will not because of a time constraint. I

really have no time to do it. As a matter of practical fact.

MS. HUTNER: I know how that goes.

Q. Do you have any specialties in your practice?

A. I'm an internal medicine physician.

Q. Do you have any specialties in infectious diseases?

A. Insofar that I've worked a fair number of years caring for people with infectious diseases and have been considered an expert in several areas of infectious disease, particularly tuberculosis, I would say I have experience in that field.

Q. When were you considered an expert in any infectious diseases?

A. I've been on panels for the CDC, Center for Disease Control, to review their guidelines on tuberculosis, screening for jails.

And I'm currently a consultant to them in evaluating whether those guidelines are being applied in jails.

I've also been asked to participate in meetings that they have had related to sexually transmitted diseases.

M. Puisis

Q. When you say "they," you mean -- are you still referring to CDC?

A. Center for Disease Control. I've also had fairly extensive experience working with the Chicago Board of Health on tuberculosis and sexually transmitted disease issues, and have written an article and co-authored chapters in a book on contagious and infectious diseases.

Q. When were you on the CDC panel on tuberculosis screening?

A. It's in my curriculum vitae, but I can find the dates for you if you need that provided.

MS. HUTNER: Can we mark this exhibit as Puisis Exhibit 1?

(Puisis Exhibit Number 1 was marked for identification.)

Q. I'm showing you what has been marked as Puisis Exhibit Number 1.

Do you recognize that?

A. I do.

Q. What is it?

A. It's a declaration I wrote.

Q. In this litigation?

A. That's correct.

M. Puisis

Q. There is a curriculum vitae attached to this declaration.

Would you take a look at it?

MS. HUTNER: Off the record.

(Discussion off the record.)

A. It's incomplete.

Q. It is incomplete?

A. Yes -- or maybe it's out of order, wait a minute.

Q. If you want, we can unstamp the exhibit and reshuffle the pages and see if it's complete.

A. I believe it is complete, it's out of order.

Q. Is this your current and up-to-date curriculum vitae?

A. It is.

Q. In looking at that, can you tell when you participated in a CDC panel or panels on guidelines concerning tuberculosis screening in the jails?

A. 1995.

Q. Was that a singular or plural panel, one or more panels?

A. It wasn't really a panel. It was a group of people that the CDC utilized to review the

document that then became the standard.

They E-mailed the draft as for comments of a select group of people. We made comments, sent them back, they revised it, sent it back.

Q. I see.

A. That process continued until they had a final document.

Q. When did you consult with CDC about evaluating the application of these guidelines?

A. That's actually ongoing. There was a meeting in Atlanta in 1999 that resulted in a questionnaire and a process.

That questionnaire was recently completed; in fact, if you want to see a draft of it, I can show you the front cover of the draft that we were asked to review, make comments on, send back and they were going to produce a final document.

Q. Did you participate in any other advisory groups or panels, whatever you want to call them, with the CDC?

You mentioned the ones concerning tuberculosis and sexually transmitted diseases.

A. I was a reviewer of grants. In 1999, I was asked to sit on a panel in which grant proposals

to the CDC were presented.

The group of reviewers reviewed each grant in an abstract and gave an opinion as to whether this was something the CDC should or should not participate or fund.

Q. What sort of programs were seeking these grants?

A. Proposal to screen for sexually transmitted disease in a high school, proposal to screen juveniles in correctional facility for chlamydia or gonorrhea, et cetera.

Q. So these were still all related to infectious diseases; is that correct?

A. That's correct.

Q. Do you have any special training in neurology?

A. As part of my internal medicine study we rotated through neurology.

Q. But that was the same as everybody else who focused on internal medicine?

A. That's correct.

Q. What about vascular surgery?

A. No.

Q. Do you have any special training in

correctional security?

A. No.

Q. Do you have any special training in establishing risks in transportation in vehicles?

MS. FREEMAN: Objection. Is this medical training?

MS. HUTNER: Any training at all.

A. I don't even think there is a subset of training for physicians for transportation in medical vehicles. I've never heard of such a specialty.

If you are saying is there a specialty of physicians who train in transportation, I don't know that that exists.

Q. No. That's not what I'm asking.

What I'm asking is whether you personally have any training in establishing risks concerning transportation in vehicles?

A. I don't, and I don't think such training exists.

Q. But you don't have any, right?

A. No.

Q. Do you have any special training as a public sanitarian?

M. Puisis

A. Only insofar as I followed sanitarians around doing inspections.

Q. That would make me an expert, too.

A. But I do not.

Q. Do you have any special training as a building engineer?

A. I was a carpenter, if that counts.

Q. When is the last time that you had direct patient care?

A. A couple of months ago.

Q. Where was that?

A. I believe it was at the Joliet correctional facility. I still see patients -- approximately 15 percent of my time is clinically seeing patients and I work at a variety of facilities in Illinois.

Q. Approximately how many patients a week do you see?

A. I think it's a hard question. I don't have an exact answer for you, but when I see patients, I probably -- 15 patients a day, so if you took 20, 40 hours, divided it or multiplied it by 15 percent -- multiplied that by 15 is probably the number I see on average.

M. Puisis

Q. Have you ever treated any patients who are in restraint status?

MS. FREEMAN: Objection. I don't think the words "restraint status" is clear.

MS. HUTNER: We'll see if the witness understands it.

A. Right, I was going to say I'm not -- I prefer to use a term more in line with what I'm familiar with.

Q. What term would you use?

A. Well, I'd rather that you ask the kind of question you want and I'll try to provide the answer I think is appropriate.

Q. Have you ever treated inmates in the sort of restraints that you observed Red ID inmates in your tour of the New York City Department of Corrections court pen facilities?

A. No.

Q. Is all of your current direct patient care in correctional facilities?

A. Yes, it is.

Q. You worked as a physician assigned to Cermak Health Services; is that right?

A. That's correct.

Q. What were your responsibilities as a physician?

A. They changed over time. When I first started, I was a staff physician. I started in 1985.

At some point, I became an assistant medical director and then the medical director.

Q. What were your responsibilities as a staff physician?

A. To see patients and a variety of other administrative tasks.

Q. What were your responsibilities as assistant medical director?

A. Pretty much the same, with the exception that there was more supervisory requirements and a bit more administrative work.

Q. How about as medical director?

A. More administrative work.

Q. Does that mean less seeing patients?

A. A little bit, more development of policy, procedure, interacting with governmental agencies, designing programs, setting guidelines, supervising physicians, that sort of thing.

Q. At Cermak Health Services, you worked in

the Cook County Jail; is that right?

A. That's correct.

Q. Do you know whether that's a jail as the name indicates as opposed to a prison?

A. It is.

Q. What is Addus Health Care?

A. It's a comprehensive health care company.

Q. What does that mean?

A. They provide home health care, scheduled nursing, comprehensive correctional medical services, durable medical equipment.

There may be some other endeavors that are in that that I'm unaware of.

Q. You are working for them now?

A. As a consultant, that's true.

Q. So you are no longer corporate medical director of their correctional division?

A. I am, but as a consultant.

Q. What does the correctional division do?

A. It provides comprehensive medical services in correctional facilities.

Q. What correctional facilities?

A. Currently, there are six correctional facilities where we provide direct care. That would

be Joliet, Stateville, Illinois River, Decatur and the treatment and detention facility and Dwight.

Q. What was the last one?

A. D-W-I-G-H-T.

All these facilities are in Illinois. Five of them are related to the Illinois Department of Corrections. The TDF facility is a facility that's connected to the Illinois Department of Mental Health.

Q. Are you familiar at all with Prison Health Services?

A. You mean the company?

Q. Yes.

A. Yes, I am.

Q. So is the function of Addus Health Care or at least the correctional division similar to what Prison Health Services does?

A. It is.

Q. Do you know whether Addus Health Care sought the position of providing health care in the New York City jails recently?

A. I think they did before -- I was not working with them at the time, but they did.

Can I interject?

Q. Sure.

A. In my work in this endeavor that we are engaged in here.

Q. You mean the litigation?

A. That's true. I am not acting as a representative of Addus Health Care, and I am acting independently and my superiors in fact do not know that I do this. Or they know that I do this kind of thing but they don't know specifically that I engage in specific assignments that I choose.

Q. That's fine.

A. Okay.

Q. In the time that you have been providing direct medical care in a correctional facility, have you received any specific complaints secondary to handcuffing?

A. Yes.

Q. What kinds of complaints?

A. In the normal course of work I've seen people who have had handcuff injuries.

I should add that Cermak is not a booking jail.

Q. What does that mean?

A. There are certain jails that are booking

jails. A booking jail is a jail to which an inmate who is arrested is immediately brought.

A referral jail is then a jail that persons who are detained in a booking jail are sent after a bail has been set.

For example, in Chicago, Chicago police may arrest someone, incarcerate them in a local lock-up that's run by the Chicago Police Department.

That person would have a hearing. The judge would determine that the person had no bond or whatever, as a result of which the person would be incarcerated and then remanded to the Cook County Jail.

So the Cook County jail was a facility that saw people after an initial incarceration and in that sense it was a referral jail.

Q. Thanks.

We were talking about complaints that you've received about handcuff injuries.

Can you describe the sort of injuries that you've seen in your experience?

A. I've seen people who complained of loss of sensation, bruising, that sort of thing.

Q. Anything else?

A. No.

Q. Were those complaints from inmates who had been front-cuffed, rear-cuffed or both?

A. My recollection, people were not rear-cuffed in the Chicago system. I can't vouch for that, but I have not seen it.

Q. When is the most recent one of these complaints that you've heard?

A. It would have been when I was working at the jail, but I have not seen episodes of this in the prison system.

Q. So when you say working at the jail, you mean during the time you were at Cermak working in Cook County Jail?

A. That's true.

Q. You stopped working at Cermak in 1991; is that right?

A. No, '96.

Q. '96?

A. Yes.

Q. Sorry.

What's the Society of Correctional Physicians?

A. It's a group of physicians that have

organized themselves into a society, who all work in correctional facilities for the purpose of collegiality in an attempt to develop a society of physicians that is organized.

Q. Is this a national society?

A. It is.

Q. How large is it approximately?

A. Approximately 500 individual physicians, 4 or 500.

Q. How long has this society been in existence, to your knowledge?

A. I'm not sure, I think six or seven years.

Q. Does it hold regular meetings of any sort?

A. It does.

Q. How often?

A. I believe twice a year, and the meetings are connected to the National Commission and Correctional Health Care meetings. There may be a third, I'm not certain.

Q. Are there presentations at these meetings?

A. Yes.

Q. Have any of those presentations involved

medical effects of restraints?

A. Well, I haven't been at all the meetings so it's difficult for me to say.

Q. At any of the ones that you've been at?

A. I don't believe, most of the talks have been on topics such as HIV and other related topics.

Q. How long have you been a member of this society?

A. I can't tell exactly -- I don't remember, I think for about five years.

Q. What's the American college Of Physicians?

A. It's a society of physicians who are specialists in internal medicine.

Q. Does this group have regular meetings?

A. They do.

Q. Do you go to those meetings?

A. I have in the past, but not frequently.

Q. Are you aware of any presentations or discussions in connection with this organization that concern medical effects of correctional restraints?

A. I believe -- you know, I don't know the answer to that.

Actually, you asked me if I know. I don't know, but there may be -- because I believe that they have a position on -- they may have a position on restraints.

I know there was a lot of discussion in the past several years about medical restraints, and I don't know if they have a position on that or not, but I am not aware of it.

Q. You were a consultant to the U.S. Department of Justice in 1989, or you have been to the present, I'm sorry -- it's a little hard to read on your curriculum vitae here -- on conditions in a variety of jails throughout the United States. That's what your curriculum vitae says.

Can you describe what that work is?

A. They call me to be an expert medical witness in the evaluation of medical programs at prisons and jails.

Q. Can you be more specific?

A. In what way? I mean, where would you like me to go?

Q. What are you evaluating?

A. I evaluate their policy, procedures, death records, practices. I evaluate medical

records. I evaluate quality of care. I evaluate physicians. I evaluate the comprehensive medical program and give them a report on that program.

Q. In the course of this consultation, have you ever evaluated anything relating to correctional restraints?

A. I have insofar -- I think there were a couple of situations where an excessive restraint was used in restraining a patient and that resulted in a morbid event.

Q. Does that mean death?

A. In one case it did. Let me think of the second one.

In one case it did, and in the other case I gave a recommendation on the manner of the restraint, and I'm sorry, I can't be more specific, because I would have to ask their permission, but I can tell you the details, but not the cites or the names.

Q. That's fine.

Can you tell me what was the restraint that you considered excessive?

A. In one facility, an asthmatic patient was questioned as to whether he had asthma or not. And

it was determined by a nurse not to have asthma and the correctional folks took the inmate and, and I guess, restrained him in a take-down posture and may have used excessive force. And shortly after that episode the inmate died.

A second episode I remember evaluating a manner in which patients who were mentally ill were restrained in a jail holding area pending evaluation, and I made a recommendation about that.

Q. What was your recommendation?

A. That a person who is deemed psychotic by a nurse or by a correctional officer should not be restrained unattended in a chair without evaluation for an extended period of time.

Something like that, this was years ago, and this is to the best of my recollection.

Q. Can you define psychotic, as you just used it?

A. A person with disorganized thinking and -- I'm sorry.

Q. Go ahead.

A. A person with disorganized thinking who is acting in a bizarre manner.

MS. HUTNER: Off the record.

(Recess taken.).

Q. You mentioned before that you believe that the American Society of Physicians has a position on medical restraints.

Did I understand that correctly?

A. No, I have no idea whether they do or don't. I suspect that they may have a position on restraints because a number of organizations made comments on it, but I don't have any idea whether they do or do not.

Q. You also don't know whether its correctional restraints or medical restraints?

A. I would doubt they had a position on correctional restraints.

Q. The first patient that you were describing by whom you spoke in your consultation for DOJ, the one who died, did he die of asthma?

A. He did.

Q. You said that he had been restrained in a take-down posture.

Can you describe what that is?

A. I don't remember the exact details, but I believe it was, you know, a prone posture, but I couldn't definitively tell you.

My recollection was just that he was taken down and roughed up.

Q. And this is what you were talking about when you discussed the possibility of the use of excessive force?

There was some interaction between the correctional staff and this asthmatic inmate where they -- the correctional staff ended up using force that you believe might have been excessive; is that right?

A. I was not responsible for reviewing that part, but that had occurred and that was being investigated by the DOJ.

Q. Do you remember how long afterwards the inmate died?

A. It was a short period of time. It was less than a couple of hours, an hour.

Q. What's your basis for saying that asthma was the cause of death?

A. I saw the autopsy, I think. As I remember, I saw the autopsy.

Q. Those are the only examples that you recall in the time that you've been consulting with DOJ where an issue of correctional restraints came

up?

A. I don't recollect. I could spend some time thinking through the cases that I've been involved in, whether there were restraint issues.

Q. These are the only ones that you remember at this point?

A. No. There were things like Angola. Maybe I shouldn't mention that. I shouldn't talk about cases.

Q. You don't have to mention the names of cases.

A. There were people who were detained in conditions that I thought were inappropriate, and I think that has occurred throughout the time I've been with them.

Q. What do you mean, or can you give some examples of conditions of detention that you believe are inappropriate?

A. For example, I remember one facility where people were brought for emergency evaluation and required to sit in a cage that was, as I recall, about 4-1/2, 5 feet high, and they had arm and leg chains on, and would be required to wait in these cages for hours at a time to be seen by a physician.

So that these were people who were sick, vomiting, in pain, undiagnosed conditions who were in a cage where they couldn't actually stand up.

Q. They weren't given any breaks?

A. Not until they saw the doctor. I mean, whether they gave them a break to go to the restroom, I don't recollect, but I don't think they did, as I remember. That was years ago, but I think it still occurs.

So there were situations like that, that I think if I really sat down and tried to write them all out, there would be a number of situations like that.

And I would give a medical opinion to the Justice Department as to whether that was something that I thought would be acceptable.

Q. Do you consider the situation that you just described comparable to what you have seen in the New York City Department of Correctional Facility for Red ID?

MS. FREEMAN: Objection. Comparable in what respect?

MS. HUTNER: Well, I think that's really for the witness to say.

A. I agree. I'm not sure I know exactly what you mean.

Q. Let me ask you --

MS. HUTNER: First I'm going to ask counsel not to make speaking objections that clue the witness in to what to say.

Q. Did you think that this situation that you just described about the sick inmate sitting in a cage was medically appropriate?

A. No, I did not.

Q. For what reasons?

A. Because someone who had an unknown diagnosis but had a medical complaint was forced into a position that was inappropriate for their condition.

They couldn't stand up, and furthermore, they may have had a condition that could have been exacerbated or made worse by virtue of the position that they were required to be in.

Q. Do you have any other objections that you recall to this practice?

A. Medically?

Q. Yes.

A. I think that, as I said, I think it could

have caused harm to the patient.

Q. Do you know of any instances where harm was actually caused to a patient in that circumstance?

A. As I recall, I did not have an opportunity in that situation to review records relative to that.

Q. Do you have any of the same objections that you just described to that other situation?

Do any of those objections apply to the manner in which you saw the Red ID inmates being held in the City's court pens?

A. I'm not sure I really want to go there. I think it's a different situation, and I remember you asked my opinion independently about that.

I mean, I think in one situation the -- you know, they have handcuffs behind, and another situation they have leg irons in a cage, and they are a little different, and it's a different scenario. And I think to draw conclusions from that would be confusing.

Q. That's fine.

Can you describe the work that you did for the ACLU in Indiana in 1988?

A. The Westville facility is located in central Indiana, and there was a TD outbreak that resulted in an investigation of the facility, and I was asked to review medical care, not just TD care, but medical care relevant to conditions of confinement.

Q. Did any of your review concern the medical effects of correctional restraints?

A. It did concern medical restraints and what I thought was -- can I ask my attorney a question off the record?

MS. HUTNER: Well, you are supposed to finish answering the question. Then if you want to consult with your attorney, you can do that.

A. Well, maybe I can ask both of you since you are both attorneys.

The cases I'm involved in reviewing for the ACLU or for the Justice Department are -- include confidential information that I don't know if I'm privileged to disclose to you all.

And while there may be situations where there have been instances where I have seen or have reviewed something, I don't know if it's something I can disclose or not disclose appropriately.

Q. Let me ask you a question that might eliminate the problem.

A. Because you can understand if someone asked me about a death review that I did at Rikers Island, you would be very concerned if I was giving that to an attorney in Seattle.

Q. I might be. It depends if it's public record or not. I certainly appreciate your concern about confidentiality.

Did anything that you saw in the course of your consulting for DOJ or for the ACLU inform or effect the opinions that you are giving in this case?

A. Yes, but let me put it to you a different way.

I have reviewed, and not actually for the DOJ or the ACLU, I have reviewed as a consultant, cases where mental health patients died as a result of restraints over a 16-hour period.

And I have seen that -- I have seen death result from restraints on three occasions. These were restraints of mental health patients in four-point restraints and they all died of pulmonary embolism.

The embolism in all cases did not occur immediately after restraint, but in all cases occurred some time after.

Q. What do you mean by "some time"?

A. A week, ten days.

Q. Is it your opinion that in each of those cases the pulmonary embolism was caused by the restraint?

A. Very much so.

Q. What's the basis for that opinion?

A. Because the restraint was a risk factor for deep vein thrombosis. Persons, all of them have deep vein thrombosis that resulted in pulmonary embolisms and they died. There were no other risk factors for the DVT.

Q. So you mean none of the three had any other risk factor; is that right?

A. No, none.

Q. Are you familiar with four-point restraints?

A. I am.

Q. Is it your opinion that four-point restraints are similar to the restraints that the City uses for Red ID inmates?

A. Insofar that a limb is immobilized, there is a similarity.

MS. FREEMAN: Do you need to take a break?

THE WITNESS: I'm sorry, I need to take a break to answer this page.

(Recess taken.)

Q. I'm going to ask the reporter to read back my question and the beginning of your answer and then you can complete your answer.

(Record read.)

A. That is the answer.

Q. That is your answer?

A. Yes.

Q. In four-point restraints, all four limbs are completely immobilized; is that right?

A. That's true.

Q. In what I will call the Red ID restraints, the inmates can walk around; is that correct?

A. That's true.

Q. They can stand up or sit down?

A. That's true.

Q. They can turn around?

A. Yes. Not easily, but they can.

Q. They can move their arms to a very limited degree; can't they?

A. I didn't appreciate that they could move very much at all.

Q. But they can move at all; is that right?

A. When I tried them on, I couldn't move very much. You have this black box that holds the wrists together in a fairly rigid manner, and it wasn't easy to move the arm.

Q. But you couldn't move your arms apart from each other, but you can move them up and down a little bit, right?

A. Very little.

Q. You can move your elbows a little bit?

A. I certainly couldn't flex the elbows.

Q. Okay, but that's not what I asked.

A. What did you ask? I'm sorry.

Q. Whether you could move them at all.

A. A small amount.

Q. In four-point restraints, can the arms be moved at all?

A. Sure. I mean, as much as you can.

Q. So you think that the level of restraint

of the arms is the same in the Red ID restraints and in four-point restraints?

A. I think the degree of restriction is similar.

Q. Doesn't it matter whether there is any movement at all?

A. Well, there is movement in both situations, but very, very little.

Q. You said that the degree of restriction was similar.

Would you say that the degree of restriction is the same?

A. It's not identical, because they are different types of restraints.

Q. But it's your opinion that the amount that you can move your arms is the same in four-point restraints and in Red ID restraints?

MS. FREEMAN: Objection. Asked and answered.

MS. HUTNER: I don't think so.

A. I would say it closely approximates one to the other.

Q. Do you think that there is a greater degree of mobility, granted very limited, all the

same, but we are talking comparisons here in either four-point restraints or the Red ID restraints?

A. For which limb?

Q. Upper.

A. Are you speaking about the whole arm?

Q. Any portion of the arm, shoulder to fingertips.

A. I think it's a hard question to answer. I'll take a stab at it.

Q. Thank you.

A. I think people in four-point restraints can -- in fact, I know they can move their shoulder up off the bed. And in that sense I think there is a lot less mobility in the Red ID restraints from the shoulder to the elbow and arm.

You can move the arms together a little bit in the Red ID restraint, but only as a unit. And you certainly can't flex or extend the arm very much.

I think you can flex and extend more in a four-point restraint, but to tell you the truth, I'm speculating exactly, it's not been measured, but that's the best answer I can give you.

Q. You've testified in previous litigation

as an expert only once; is that correct?

A. Can you repeat that question, please?

Q. You've testified as an expert in litigation only once previously, is that right?

A. I think more than once.

Q. At least one of those instances, if there was more than once, was in Marshall versus Whisante in the Northern District of Alabama in 2001?

A. That's correct.

Q. What was that case about?

A. The Southern Center for Civil Rights was acting on behalf of inmates to address conditions of medical care in a jail in Alabama.

Q. Were you retained by the Southern Center for Civil Rights?

A. I was.

Q. What medical care issues came up in that case?

A. There were a variety of issues; access to care, some mental health issues, staffing issues, intake screening issues. I can't remember everything.

Q. Is that all the issues that you remember?

A. If you want to sit here a little bit I

can go through my mind and try to pick all of them out.

If you have a specific question, it might be easier for me to address whether that was considered.

Q. Do you remember any issues concerning the medical effects of correctional restraints?

A. There was an issue regarding restraining of the suspected people with mental illness.

Q. What was that issue?

A. My recollection is that the practice for patients who were deemed by the correctional staff to be out of control and possibly mentally ill was to address the issue with a nurse, and a decision was made often without medical supervision, to restrain or otherwise confine people, and that this was occasionally done without medical participation.

So the correctional staff would, for example, use pepper spray in order to disable a patient who may have had a psychotic episode. And patients were put in either quiet rooms or restrained with or without medical supervision.

Q. Did you testify at a trial in that case?

A. I did.

M. Puisis

Q. Did you also testify at a deposition?

A. I'm sorry, I do not believe where I testified was in a trial, it was a hearing.

Q. Okay.

A. In front of a judge, and I do not believe I was deposed, but I'm not sure about that.

Q. You said that you've been an expert witness in other litigation?

A. In Michigan City, Indiana, I was deposed on a condition of confinement case, I believe in 1985, and I'm not sure of the date, 1985, 1986.

MS. HUTNER: I want to note for the record I don't believe that was disclosed to us.

Q. Was there anything in that case that concerned the medical effects of correctional restraints?

A. No, there wasn't.

Q. Did you work with Gene Miller before this litigation?

A. I have, but I don't remember exactly where. He was a consultant for the Justice Department on one or two cases that I participated in. And I'm sorry, I can't remember the case.

Q. Do you remember approximately when?

A. I don't. It was years ago.

Q. It was years ago; more than two, more than five, more than ten?

A. I'm guessing five. I think that would be a good guess.

Q. You've published articles and you have done presentations about tuberculosis and hepatitis B; is that right?

A. Yes.

Q. You've also had publications about sexually transmitted diseases in correctional facilities; is that right?

A. Yes.

Q. Have you had any publications on the medical effects of correctional restraints?

A. No.

Q. Do you believe that the issue of medical effects of restraint practices is an important health issue, correctional health issue?

A. In reviewing this case, I've come to believe that it is.

Q. You edited a book on correctional health; isn't that right?

A. That's true.

Q. As editor-in-chief, did you determine the contents of the book?

A. I did.

Q. So that means you decided what to include?

A. I did.

Q. You picked which articles you would write?

A. It wasn't quite like that.

Q. How did it work?

A. I'm sorry?

Q. Did you write the articles nobody else would write? How did it work?

A. Sort of. The problem with the production of that text was that, it was hard to get people to commit to the work that was required.

And the schedule of the publisher was such that we just couldn't do everything that we wanted to do, and I had to help with a significant piece of the writing, assist people in the editing of different chapters.

Q. What did you want to do in that book that you couldn't do because of those restraints?

A. Emergency care, and there were just some

topics.

Q. What other topics?

A. I don't remember off the top of my head, but I know there was one on an electronic record that the person just couldn't get done in time.

As I mentioned, emergency care. Off the top of my head, I can't remember more than that.

MS. HUTNER: Could you mark this as Puisis 2, please.

(Puisis Exhibit Number 2 was marked for identification.)

Q. Can you take a look at this document that has been marked Exhibit 2 in this deposition and tell me whether this is selected pages from the book that you edited?

A. Yes.

Q. I have a copy of the book here in case there is something that you need to refer to. I just thought it was unnecessary to copy the whole thing.

At any rate, this book focuses on -- the main sections of this book focuses on interaction with patients, general correctional medical issues, infectious diseases, women's health care, mental health and public health issues; is that right?

A. Yes.

Q. The two articles that you wrote are on chronic disease management and on sexually transmitted diseases in correctional facilities; is that right?

A. That's correct.

Q. There is only one reference in this entire book to restraints; is that right?

MS. HUTNER: Off the record.

(Discussion off the record.)

Q. This reference is on page 91 of the book; isn't that right?

A. You are referring to what?

Q. Page 91?

A. Page 91 is here, that's correct.

Q. Do you know of any other reference in the book to any issue concerning restraints?

You are welcome to look through the book if you want.

A. I'm not sure. I think to look at the entire text and tell you whether there is or isn't a reference, I can't do it here.

I don't think there is a reference. There may be a reference in the section on

pregnancy, and there probably is a reference to restraints in the mental health section.

I don't recollect if there is or isn't anywhere else.

Q. This reference on page 91 concerns shackling and hospital correctional units; is that correct?

A. That's correct.

Q. It doesn't mention rear-cuffing in particular; does it?

A. No.

Q. So these concerns apply to front-cuffing as well as to rear-cuffing; don't they?

A. This is a different context than I think what you are speaking about. You are speaking about cuffing, handcuffing, and the transportation of people, et cetera.

This is, I believe, in the section on the hospital secure unit and references the practice of correctional people shackling inmates to a bed with a single-point restraint under certain conditions.

For example, officers may consider pregnant women in labor a security risk and they may shackle them to the gurney, in labor or otherwise.

Or someone who is in an acute care hospital for a medical condition may be in bed and shackled to the bed while on a secure unit.

And that's what this refers to.

Q. When you say "this," you are referring to page 91?

A. To page 91.

It does not refer to the cuffing of patients or inmates in a transportation setting.

Q. Is there a reason that you didn't include anything about the medical effects of handcuffs or other restraints other than the shackling and what you've described in the book?

A. I'm just thinking now, I mean, at the time I did not intentionally by design include or exclude shackling as an issue.

Now that I think about it, I have to admit that the situation at Cermak was one where there was not the use of chains or other devices to restrain people in transport, as I recall.

Therefore, it was not a major issue in my mind. And when I conceived the text, it was just something that I probably did not appreciate as much because it hadn't occurred as a practice.

Q. Do you have any personal experience with side-cuffing?

A. I've never been side-cuffed myself, if that's what you are asking.

Q. I meant more as an observer?

A. No.

Q. Have you ever conducted or participated in any studies of the medical effects of restraint practices?

A. Could you repeat the question?

Q. Sure.

Have you ever conducted or participated in any studies of the medical effects of restraint practices?

A. Not studies.

Q. What, if not studies, then something else?

A. I've written policies on restraints on mental health units. And I've done that at least a couple of times, and I've done that in conjunction with psychiatrists and with experienced psychiatric nurses.

Q. Did your policies concern the use of correctional restraints for mental health inmates?

A. There was that correctional officials or correctional officers, would utilize devices that were similar to medical restraints.

We were involved in commenting that that was not something that medical persons should be involved with in terms of approving or denying on a routine basis.

For example, it's not appropriate for a correctional officer to place a mental health patient in physical restraints for medical purposes.

Q. When you say devices like medical restraints, what sort of devices are you referring to?

A. A restraint.

Q. What kind of restraint?

A. Well, any restraint that's used on a medical unit.

Q. Does that include handcuffs?

A. Let me go back to what you were asking two questions ago, because I think I've lost the train of thought of where you are going.

Q. Okay.

A. If that's okay.

Q. Sure.

Does that mean you want me to go back two questions?

A. Or ask me what you want me to answer.

Q. I thought I understood you to say that correction officers use devices like medical restraints.

What did you mean by that?

A. There are times when correctional officers on a mental health unit will place people on their own, without medical supervision, in medical restraints.

Q. What's a medical restraint? Is that like a straight jacket?

A. Four-point restraint, whatever device is used, or even handcuffs, for example, if an officer were to handcuff a patient to a bed.

Q. But the policies that you wrote concerned the use by correctional staff of devices intended to be medical restraints; is that what you are saying?

A. Yes.

Q. So the policies didn't concern the medical effects of devices used for security restraints; is that right?

A. With the exception that I was involved in

the development of one policy at Cook County Hospital, with Dr. Raba, in developing a policy regarding guidance on the application of shackling in the hospital.

Q. What do you mean in this case by "shackling"?

A. Specific examples would be cuffing a woman in labor to a gurney.

Q. So is it like the issues that we were talking about in connection with page 91 of your book?

A. That's true.

Q. Do you agree that the effects of handcuffing depend on an individual's physical characteristics and condition?

A. Somewhat.

Q. What's the qualification?

A. I think there are conditions that predispose an individual to a higher risk of serious consequences, and I think that there are probably individuals, who because of their body shape or size, may have higher risk of injury or harm due to shackling.

You are asking about shackling per se?

Q. No, I'm asking about handcuffing.

A. Okay.

Q. Is your answer still correct?

A. Yes.

Q. Do you agree that front-cuffing can also cause injury?

A. Yes.

Q. Do you believe that some level of discomfort from the use of handcuffs is acceptable?

MS. FREEMAN: Objection.

A. As a person or as a physician -- actually, they are both equal. I'd prefer that no one be harmed personally. As a physician, obviously we should not take a position that harm is appropriate.

I mean, we all take an oath that we will help patients, and it's not my business to tell the correctional people what they can and can't do, but to give them advice.

Q. Do you think that handcuffs are comfortable?

A. No.

Q. Do you think that the use of handcuffs in correctional facilities can be appropriate from a

physician's point of view?

A. I don't think that's a question I have an answer to.

Q. Okay, well, let me ask you a different question then.

Do you believe that correctional facilities should stop using handcuffs?

A. Not necessarily, no.

Q. Given that handcuffs can be uncomfortable, as you just said, do you think that there is some level of discomfort that is acceptable in the use of handcuffs?

A. I don't like the word acceptable, and I don't really want to answer in that term.

I think correctional people have a very difficult job, and I appreciate what they do. And my role is not to tell them how to do their job, but to take care of the patients in situations where I have been an administrator. My role has been to give them advice on how best not to harm people doing what they have to do.

Q. Do you have an alternative to rear-cuffing that you recommend?

A. Are you asking me to give you an opinion

about how a policy should be or what security should do?

Q. I'm asking you -- I should have tied it specifically to this litigation, because it is really specifically with regard to this litigation.

Do you believe that there is an alternative to the rear-cuffing that is used for Red ID inmates that is a preferable alternative?

MS. FREEMAN: Again, I'm going to object. Are you asking for a preferable alternative from a medical standpoint?

MS. HUTNER: Well, I think that's what Dr. Puisis is, that's what his standpoint is, so I guess so.

A. I guess I would feel comfortable doing that if I had a little more time to develop a position on what proactively they could do.

But I do believe that there are things that can be done to reduce the incidents of harm.

Q. What could be done?

A. I want to start by saying that I don't want to pin myself into a corner because to develop a policy for them, I would do a little bit more work in trying to understand the operations of what they

have to do and talk to security.

But I do believe that harm that occurs due to these devices is in part due to the length of time in which individuals are restrained.

So duration of restraint is one issue that needs to be addressed.

The second issue is selectivity on the part of both corrections and medical staff in eliminating those individuals who either do not have a need for restraint, or may be harmed by restraints medically.

Let me be a little bit more specific.

I'm not a correctional expert and I don't pretend to be. But it would be my advice to the correctional authority to review their practice of selection of inmates for these devices, so that selection is considered very seriously.

Q. Can you be more specific about that?

A. I believe these are very high level restraints. It's not trivial. And I think that -- and it may already be done, I don't know what corrections does, but my advice to them would be to ensure that the process of selecting who is put in restraints is very carefully done, and with

sufficient safeguards so that someone who is put in these restraints indeed is a -- a person who can cause harm.

Now, that's saying that without being a correctional expert, and I have no basis to make that other than I think this is a problematic type of restraint, that they would be best advised to be careful of.

The second advice I would give them would be medical advice relative to what I believe would be the potential for harm to persons who are put in these restraints, and to give them my best advice as to how to modify their practice for the safety of the patients and the inmates.

Q. Do you have an opinion either way about whether the New York City Department of Corrections' selection procedures are appropriate?

A. No, I have no information to make that evaluation, and I don't think I would even want to be in that position to make that decision.

Q. You said duration was an issue.

How long do you think is an acceptable amount of time for the restraints to be on a person continuously?

A. I don't think I can give you a complete answer for all patients under all circumstances. I think there are two general areas of concern that I would have.

One is the potential neuropathies that can occur, nerve damage. And the second is the potential for pain. A third would be the potential for thromboembolic events.

And the fourth would be the adverse effects of complications due to a person's underlying conditions. And there may be others that I could think of, but off the top of my head, that is what I would say.

Q. Would you agree then that depending on a particular person's condition or tendencies, to the extent that those can be determined, there is some amount of time for which they can appropriately remain in Red ID restraints?

A. That's not quite the way I approach it. I take a different perspective. Let me make an analogy and then I'll come back to your question.

The analogy is to full leather restraints utilized for patients who are mentally ill. My understanding of current recommendations by experts

is that restraining mentally ill patients should not be done at all if it is possible not to do it.

I believe that practitioners across the United States, particularly in nursing homes and in institutions for the mentally ill, are reducing significantly the utilization of restraints because of the harm that has ensued to patients.

So, you know, when you apply this to corrections, I'm not a correctional expert, but it would make sense to me that prudent people, or officials, would look at that and for liability purposes and for safety purposes would consider the use of a more severe restraint in the context of their need.

I can't tell security officers how they should restrain people. That's their business to know what is the best way to restrain people, but I think there probably are other ways that they could do this that may not lead them to the -- to safety and to health issues for the inmates.

Q. What if those other ways resulted in an increase in violence which causes a different kind of harm, what would you think about that?

A. I don't have an opinion for you, because

it's not an area that I feel capable of giving you an opinion on.

These are correctional matters. I'm not a correctional official. And if there were a warden and a facility I was working in, I would tell them can't you find any other way to do this, but I don't tell people how to restrain people. I don't get into that business, it's not my field.

Q. From a medical point of view, do you think that there is some amount of time that persons for whom there are not medical contraindications can remain continuously in Red ID restraints?

A. It is my opinion that, I don't think anyone has an exact answer for you. I don't.

I would reference the model for restraint of the mentally ill, because restraints are restraints and a restraint is an immobilization of a limb in this case, or a part of the body, so that movement is reduced.

And using full leather restraints as an analogy, the general standard in the community is that every two hours persons in leather restraints are let up or nurses or caregivers will actively and passively move all limbs, all four limbs, allow the

patient to take a bathroom break, and then reapply their restraint.

MS. FREEMAN: Off the record.

(Discussion off the record.)

Q. Are you suggesting that the full leather restraints for mentally ill patients are analogous to the Red ID restraints in their effect?

A. No, I don't think I'm quite saying that, but I think that we can learn from the experience of using these devices over the years.

Q. I'm sorry, were you finished?

A. No, that's about what I was going to say.

Q. Do you agree that Red ID inmates get bathroom breaks and other breaks during the course of the day?

A. When we took the tour, I was told that they get a bathroom break at lunch.

Q. If I told you that they get bathroom breaks on request, would that change your opinion?

A. What opinion?

Q. About the adequacy of these breaks?

A. For bathroom? I mean, I think people should be able to go to the bathroom when they need to go to the bathroom.

Q. Right.

A. But --

MS. HUTNER: Off the record.

(Discussion off the record.)

A. But if you are asking -- but if you are generalizing from saying is it appropriate to let them go to the bathroom more than once and that's considered appropriate relief from the restraint, I think they are just different questions.

So if you can ask the question, I'll answer it. But I'm not sure I get it.

Q. When the inmates, the Red ID inmates go to the bathroom, in addition to whatever other needs they are fulfilling, don't they also get relief from the restraints?

A. I'm not sure. When I was on tour, I was told they get a bathroom break. When they get lunch, they are taken out of restraints. If there are other circumstances, I'm unaware of those.

Q. I'm telling you for the purposes of this deposition, and for the questions that we are discussing right now, that to please assume that the inmates get breaks more than just at lunchtime.

Whether you call them bathroom breaks or

you don't, I'm asking you to assume that they get breaks during which time they are removed from the restraints, and that they have those breaks any time. If, for example, they request to go to the bathroom, in addition to the meal time.

And I'm asking you whether that effects your opinion of the adequacy of the breaks, assuming that that is true, whether that effects your opinion of the adequacy of breaks of the restraint from the Red ID inmates?

A. No.

Q. Why not?

A. Because it's selective, and not routine and not codified.

Q. Can you please clarify what you just said?

A. It would be one thing if the policy said every two hours persons are to be released from restraints for 10 minutes or 15 minutes for the purposes of going to the bathroom, stretching, whatever they wanted to do, versus an inmate at the discretion of the officers permitted to let an inmate go to the bathroom upon request.

Q. In terms of the medical effect on the

inmates, if even without having such a policy written down that is the regular practice, does that change your opinion about the medical effects of these restrains or the medical advisability of the restraints?

A. No.

Q. Why is the medical effect different if the practice is the same regardless of what the policy says?

A. Well, from my experience working with corrections, and this is no slur to my colleagues in corrections, but many jails, the ones I've worked in and some of the ones I've seen, are busy institutions that are crowded and often with short staff, and not always pleasant officers. Some are pleasant and some are not. It's variable.

To depend on an arbitrary decision that is not codified in the security rules is to expect an exception, it's what it is. It's not something that must or must not be done, and I believe that the behavior of officers towards inmates is best regulated by rules.

It's a rule-based group, and I think that officers will respond to orders that are written and

directive that give them guidelines.

After all, these are high risk, I'm assuming high risk individuals, and I think officers are probably reluctant to let them out, I would think.

Q. I understand what you are saying. I am asking you to assume, and I don't think you've done that yet for the purpose of my question, that in fact the officers are giving regular breaks to the inmates?

A. Yes.

Q. Does that affect your opinion, I mean assuming that that's happening, just putting aside your concerns about whether it could really happen, does that affect your opinion about the medical effect of these Red ID restraints?

A. No, and I think I understand what you are saying.

As an administrator, I understand that you cannot give advice or guidance to the correctional staff by assuming that someone will or will not be released from restraints in an arbitrary fashion to relieve themselves.

I think that you have to consider the

general condition that they are in restraints and that the rules of security are XYZ. And in this situation, my understanding is, is that inmates are not permitted out of restraints upon request.

For example, if someone is numb, and I was with Mr. Conry, who I believe is a very high-ranking official, and in front of Mr. Conry an inmate said, "I can't feel my fingers, can someone see me?"

He may not remember that. I did, I was standing there, and I looked at him, and he looked at me. I'm speaking of Mr. Conry now.

That inmate was not released from restraints. So my point is, is that these are devices from which inmates are not released upon request if they have complaints that may be harmful.

Q. Would your opinion of the validity of the Department of Corrections policy be affected if there were specific guidelines in the applicable policies that dictated the frequency and duration of breaks from the restraints?

A. I think it would help. As I said before, my position is that I'm not a correctional expert, and my advice to the correctional people is

if you can avoid these restraints, do so.

If they were to say there is no way to avoid it, I would, as a medical person, do my best to give them advice on what problems it would get into and, therefore, in that situation, I think frequent breaks would help to reduce the morbidity.

Q. Can you just define morbidity as you use it?

A. Harm to the patient.

MS. HUTNER: Off the record.

(Recess taken.)

Q. All right, let's get going.

Do you contend that any of the enhanced restraint equipment used by the New York City Department of Correction is not properly used?

When I say "enhanced restraint equipment," I mean the same as Red ID restraints.

A. I'm sorry, repeat the question.

(Record read.)

A. I think the mitts are not being used in accordance with product guidelines. I don't know if there are product guidelines for the restraints or the little black box they use to secure the wrists together. So I can't speak about whether devices

are used appropriately.

I just think the manner of restraints is improperly applied.

Q. If I told you that the Department of Correction is now using latex gloves inside the mitts or non-latex gloves for persons who are allergic to latex and using a spray sanitizer between inmate uses, do you think that's appropriate?

A. I think it's appropriate to use it. I think that -- because of the length of time they are in, I think you can get some, you know, conditions, rashes, et cetera, that are related to sweating, similar to dishpan hands or long exposure of the skin to water, and you know, these are minor skin conditions, but they probably could occur, but I think in terms of the sanitary aspect of these devices, I think it is an improvement to wear latex gloves and sanitize the mitts.

Q. Do you think it's a sufficient improvement just in terms of the sanitary use of the devices?

A. I think it's an improvement to sanitize it, yes.

Q. What else do you think would need to be done, if anything?

A. In terms of the sanitary aspect of the mitts?

Q. That's correct.

A. I think the length of time in the mitts is a problem because of the fact that people will sweat for a long period of time, and if it's a situation where an inmate will be in these restraints for consecutive days for a long period of time, they may develop a rash or other minor skin conditions.

So I think it would help if they weren't in for a consecutive long period of time, but in terms of the sanitary issue, I think that there has been an adequate response.

Q. Is it your understanding that inmates are given only one bathroom break, at 11:00 a.m.?

A. That is my understanding, yes.

Q. Is your opinion affected by that understanding?

A. In part, yes.

Q. If they had more bathroom breaks, would you have a different opinion about the practice?

A. It depends what the rules were.

Q. You didn't conduct a physical examination of any of the Red ID inmates that you observed; is that right?

A. No, I did not.

Q. You visited the court pens only in the Bronx, right?

A. There were two areas we visited, the Supreme Court and the --

Q. The Criminal Court; is that right?

A. That's correct.

Q. Did you ask to see court pens in any other boroughs or in any other locations?

A. No, I didn't, no.

Q. You don't know what the conditions are like in those other boroughs; is that right?

A. I do not.

Q. On your tour of the Bronx Court facilities, you saw Red ID inmates going from the bus to the courthouse, right?

A. They were in the courthouse when the bus came to a Sallyport. The Sallyport was in the courthouse. That is what I saw.

Q. You saw them going from the bus into the

building; correct?

A. Yes, they were already in the building. They went from the bus up the stairs and somewhere, elevators, I guess, and then into pens.

Q. In order to get out of the bus, they had to go down a couple of steps, right?

A. They climbed off the bus, they -- right.

Q. In order to get from the Sallyport to the rest of the building, they had to climb a flight of stairs; is that right?

A. That's correct.

Q. Nobody tripped or fell; did they?

A. No.

Q. You didn't observe anybody lose their balance; did you?

A. No.

Q. You've stated that you believe inmates should be escorted out of the bus; is that right?

A. I believe that, yes.

Q. Only in a situation where there are stairs or at any time?

A. Certainly with stairs. It depends what you mean by an escort, and it depends on the person, but in general I'm not sure that an escort would be

necessarily required on a flat surface, but I think it would kind of depend.

Q. What would it depend on?

A. Well, there is probably infinite hypothetical here, but let's assume that the correctional people do not change or modify the group of patients who are appropriate for designation of Red ID.

In that case, I think many people should be escorted.

Q. Could you be more specific?

A. Well, I guess old people should be escorted. People with neurological impairments, ataxias, movement disorders. I suppose I could include a significant number of other conditions that --

Q. Do you have a basis for believing that anybody with any of the conditions that you just described is in fact in unmodified Red ID status -- let me rephrase the end of that -- are they not in modified restraints?

MS. FREEMAN: I'm going to object as to form.

A. Well, it's a really hard question for me

to answer because I'm not sure of the actual practice.

Q. That is what I'm asking.

Do you know about the actual practice at the facilities?

A. I understand about what is supposed to happen, but I don't understand what people actually do in all circumstances.

My suspicion, based on what I have reviewed, is that there is imperfect screening, that there are overrides by correctional staff of medical decisions.

There are screeners who are not physicians, and there may be other issues there, but that system is imperfect and, therefore, I would suspect that people who should not be in these restraints are in restraints, and there are people for whom modification has been requested for whom modification does not occur.

So in that sense, I would respond that that probably does occur.

Q. What is the basis for this suspicion that you just articulated?

A. I think in the medical records that --

the two records that you have, there was a denial of a request by a medical person to modify the restraint, or to have the person not placed in restraints. So that answers that piece.

Q. In both of the records that you reviewed or just one of the two?

A. I don't remember, I think it's both.

Q. Do you know how many Red ID inmates there are in the department on any given day?

A. I believe Mr. Conry told me there were 500.

Q. Based on your review of two medical records, do you believe that there is a widespread --

MS. FREEMAN: Objection. You are mischaracterizing the witness' testimony.

MS. HUTNER: Hard to do since I haven't gotten halfway through the question.

MS. FREEMAN: Go ahead.

Q. Based on your review of these two medical records, do you believe that there is a systemic problem of overrides by correctional staff?

MS. FREEMAN: I will object as to mischaracterizing the witness' testimony.

MS. HUTNER: If I said something wrong, I don't think I characterized the testimony, but if he doesn't believe that, he can say so.

A. Well, I think that no one knows the answer to that, because I don't think there is any evidence presented to me that this process is actually reviewed in any organized fashion beyond, you know, beginning to count how many people are in restraints.

Or I think there was an attempt, at least to try to count how long people were in restraints while they were in court, but not the full length of time they were in restraints, but beyond that I don't think there is an organized study of what happens to these people.

So no, I don't have any evidence that leads me to believe that there is or isn't, beyond what I just said.

Q. Are these two medical records also the basis for your belief that there is imperfect screening?

MS. FREEMAN: Again, I'm going to object. I don't believe the two medical records were the only basis for his opinion.

MS. HUTNER: Oh, well, if you have another basis, then please tell me.

A. Why don't you ask the question again and then I'll answer it.

Q. You told me about a suspicion that you have about problems that are occurring, or that you believe are occurring, and you told me that the two medical records that you reviewed were the basis for that suspicion.

Is there anything else that's the basis for that suspicion?

A. Dr. Park in his deposition said that -- agrees that there were records where physicians were to screen, and it was a physician assistant, that he had not given specific guidance to physicians on screening, that he himself did not understand until very recently the nature of the restraint.

Q. What's the relevance of that last factor?

A. I'm just saying that there seems to be a general lack of focused examination.

Q. By whom? Of what?

A. By Dr. Park, by physicians as described by Dr. Park. And I just think that when I hear those kinds of comments, it makes me suspicious that

there is a lack of review of the process.

In fact, the protocol is very general. And when I see that, as an administrator, and based upon my experience in corrections, I believe that that kind of execution of a plan leads to deficiencies.

Q. Other than your assumption that a general protocol leads to deficiencies in execution, do you have a basis for believing that there are problems with the screening?

A. You are going to have to be more specific by what you mean by "screening."

Q. When you said that based upon what you reviewed you believed there is imperfect screening, I'm just referring to whatever you meant.

A. Then let's be clear about what both of us are talking about.

I prefer you would ask a question about screening and specify what kind of screening you want.

Q. That's not what I'm trying to find out here.

A. What are you trying to find out here?

MS. HUTNER: Could you read the last

question back?

(Record read.)

A. So my question would be what kind of screening do you mean?

Q. That's what I just said, whatever you meant when you said the screening was imperfect.

What did you mean when you said that?

A. You are going to have to read back what I said.

(Record read.)

A. There are two issues there. One is the --

Q. Let me make sure we are both in the same place here.

You are telling me what you mean by imperfect screening in that answer that you gave that was just read back?

A. Right. And there is an intake process where people are asked questions about their medical conditions. That is currently used as a screening device for whether someone is acceptable or not acceptable to use ID restraints. And the second part of that screening is the review of the record.

At times, my understanding is people are

examined, but this is a very small percent, and it looks to me like less than 2 or 3 percent are actually evaluated.

So that's what I was referring to.

Q. What do you think is imperfect about that?

A. Well, first of all, the persons who are doing the screening are screening as an intake process. They are not screening for Red ID. So the information they collect is then subsequently used to screen for Red ID, but the intent of the screening is not to screen for Red ID.

So the kinds of questions and the focus of the history is not specifically meant to screen for Red ID.

Secondly, the persons who perform that screening evaluation, who are, I believe physicians and physician assistants, I'm not sure if physician assistants do intake examinations, but I believe they do, those individuals, to my understanding, based on Dr. Park's deposition that they are not specifically trained or knowledgeable about the Red ID status, have not seen the device, and are not provided any guidance as to what questions might be

relevant to ask.

As a corollary, the chart reviews that occur of those, I believe imperfect screening histories are then evaluated by people who may or may not understand the medical consequences of Red ID restraints by virtue of the fact that some of them may not even know what the process is and may be uninformed as to the potential consequences.

Q. You keep calling this screening imperfect.

Are you suggesting that it should be perfect, or do you actually mean inadequate or something else?

A. "Inadequate" is an okay word.

Q. Is that what you mean?

A. Yes. It's -- less than adequate is a good term.

Q. You observed rear-cuffed Red ID inmates in the Bronx Court pens asleep on benches; didn't you?

A. There was one inmate who was asleep, or he looked like he was asleep.

Q. Did that inmate look precarious to you?

A. He did.

Q. Did he fall off during the time that you were there?

A. I only watched him for less than a few seconds, but he didn't.

Q. But you were in the area for more than a few seconds, right?

A. Yes.

Q. And you might have noticed if an inmate fell off a bench in a cell, right?

A. True.

Q. You don't know what provisions are made for the medical care of inmates in court pens; do you?

A. I was told that anyone who has a complaint would have their complaint addressed by a medical person.

Q. Did you sit down in any of the Red ID compartments in the buses?

A. I did not.

Q. So you really don't know whether you could brace yourself with your knees; do you?

A. Well --

Q. From personal experience?

A. I was in a van that -- it's not

identical, but somewhat similar to the situation, and it was tough to brace even with free hands.

Q. In fact, the van didn't have any separate compartments; did it?

A. I don't understand what you mean.

Q. The van did not have individual compartments for a single person to ride in; isn't that right?

A. No, but the arrangement was similar.

Q. Did you measure the distance between the back of the seat and the front of the partition in front of it, in the van?

A. No, I haven't.

I mean, I can guess for you.

Q. I don't need a guess.

A. Okay.

Q. You don't believe that Red ID inmates are transported in those vans; do you?

A. I have no idea.

Q. You said that inmates complained to you during the tour; is that right?

A. They did.

Q. How many inmates complained to you?

A. My recollection is every inmate offered

complaints.

Q. Did you start a conversation with every inmate?

A. No.

Q. What did you ask them?

A. You know, I don't remember.

Q. Do you remember exactly what they said to you?

A. Well, I don't remember what they asked, and I don't remember what they said relative to the question I may have asked.

I think I did ask a couple of inmates questions, but I honestly don't remember, but I do remember the inmates complaining about the cuffs.

Q. You don't remember any specific complaints; is that right?

A. Yes, I remember one inmate was struggling against the cuffs, and was trying to get them off. And he said his hands were numb.

And he -- he said he was in pain and his hands were numb. He couldn't feel his hands.

Q. Were you concerned about secondary gain in any of your responses, that is in the responses that you received?

A. In terms of what?

Q. Did you think it was possible that any of those inmates had a non-medical motive to get out of the restraints?

A. I think that's a possibility in any of these situations.

Q. You were personally placed in Red ID restraints; is that right?

A. Yes.

Q. You stayed in those restraints for less than five minutes?

A. Probably less than two minutes.

Q. Part of that time you were front-cuffed; isn't that right?

A. I don't think so.

Q. You didn't experience any loss of balance while you were in the restraints; did you?

A. I had a strange feeling that -- I'm not sure how to explain it. It's a feeling of being in a very awkward position.

Q. Is that the same thing as having a loss of balance?

A. Well, I didn't stumble, if that's what you mean, but when you say feeling of imbalance, I

mean, I don't have vertigo so the restraints themselves didn't make me feel like I was falling, but it didn't feel very comfortable.

Q. Do you think in order to experience a sense of loss of balance in the restraints someone would have to have vertigo?

A. No, and I think a sense of a loss of balance doesn't have anything to do with an opinion. It's not that someone feels like they are going to lose balance, but it's the real potential that they could lose their balance and fall.

Q. You said that you had pain and slight bruising from the restraints; isn't that right?

A. Yes.

Q. An impression on your wrist?

A. Yes.

Q. What do you think that impression was from?

A. The compression of the cuff.

Q. That would have been the same if you were front-cuffed; wouldn't it?

A. I can't answer that.

Q. Have you ever been front-cuffed?

A. I have never been front-cuffed.

Q. Other than if perhaps you were front-cuffed on that occasion, I'm not talking about that.

A. No, I have never been front-cuffed.

Q. Did you examine Gene after he was removed from the restraints?

A. I looked at him. I wouldn't call it an examination, but I looked at his hands.

Q. What did you look at?

A. I look at his wrists and his hands.

Q. What did you conclude?

A. Gene had edema and whether he has an underlying condition, I don't know, but he had edema and he had probably a quarter-inch impression where the cuff was circling the wrist, and in that area he had kind of a red bruise or an impression.

Q. Edema is swelling, right?

A. That's correct.

Q. Did you look at his wrists or hands before he was placed in the restraints?

A. No, I didn't.

Q. So he could have had the exact same edema beforehand; is that right?

A. He could have, I don't know.

Q. And the quarter-inch impression where the cuff was circling his wrist could also have occurred if he had been front-cuffed; isn't that right?

A. Sure, it's possible.

Q. He mentioned to you that he felt pressure or tension in his upper arms; isn't that right?

A. I think he did.

Q. What was the explanation that you gave him for that pressure or tension?

A. I don't recall that I gave him an explanation. If you remember that I said something to him, maybe you could refresh my recollection, but I don't remember that conversation.

Q. I can tell you that in his deposition he said that you had given him a medical explanation for that sensation and he didn't remember what it was, so I thought maybe you remembered.

A. I'm sorry, I don't.

Q. Do you remember telling Mr. Miller that if he had remained cuffed he would have experienced swelling?

A. I don't remember that, but I believe it's true.

Q. Is that based on your observation and the

edema after he was removed from the restraints?

A. That's true.

Q. Do you remember telling Mr. Miller that there was a good likelihood in a cohort of 100 people that there would be a sizable number of injuries from those restraints?

A. Not specifically.

Q. Do you believe that that's true?

A. Yes.

Q. What do you mean by "good likelihood"?

A. Well, I would feel better if you asked a question related to that we were responding to a comment that was made by Gene that I couldn't evaluate and I need a clearer question.

Q. What do you think is the likelihood in a cohort of 100 people that there would be a sizable number of injuries?

A. From?

Q. From the Red ID restraints.

A. I am assuming that an average time in restraint is eight hours.

It's hard to give that answer unless I know exactly what cohort is, but I think in general, to answer your question, I believe that a sizable

number, 80 percent or higher would have pain and maybe even 100 percent would have pain.

I believe that in the range of somewhere between 15 and 50 percent would have some type of neuropathy, whether temporary or transitory or permanent, and the rest of the conditions would really be variable, depending on the prevalence of the condition and the population.

Q. Depending on what?

A. The prevalence of conditions in the population and in this area.

I don't think anybody has a lot of experience with studying Red ID type restraints, because I don't believe in my experience a lot of people do it.

I've been in an awful lot of jails, and I've not seen this type of restraint used commonly, and therefore, I'm not sure that there has been a lot of experience in studying it medically. And the inmate population tends to be an understudied population, so it's hard to give you statistical information for which there is very little study.

Q. What's your basis for the percentages that you just gave me?

A. I'm basing it on my own personal experience of experiencing of what these things felt like, and the fact that it is an unnatural posture.

And when people assume an unnatural posture for a long period of time, they tend to have pain.

Q. Did you read Mr. Bogart's report?

A. I'm not sure.

Q. David Bogart was retained by the defendants in this action as an expert.

A. I don't believe I did, no.

Q. Does it affect your opinion at all to hear that he did write a report, he was in rear restraints, he was in restraints for about an hour and said that he experienced some discomfort at the beginning, but less as the time wore on, and nothing that he would describe as pain?

A. It's possible, sure.

MS. HUTNER: Let's mark this as Puisis Exhibit 3.

(Puisis Exhibit Number 3 was marked for identification.)

* * *

M. Puisis

AFTERNOON SESSION

(Time Noted: 1:19 p.m.)

BY MS. HUTNER:

Q. The declaration that is marked as Puisis Exhibit Number 1 is the declaration submitted in this litigation, right?

A. That's correct.

Q. You signed that declaration under penalty of perjury?

A. That's correct.

Q. In your declaration, you stated in paragraph 2 that rear-cuffing would inevitably result in a variety of musculo-skeletal and neurovascular injuries; is that right?

A. Yes.

Q. What was your basis for that statement?

A. My basis was the fact that this position stretches the joints and may compress the nerves in a manner that will lead to injury.

Q. Do you know any studies to support this claim?

A. I think I cited several studies in my report, and those are the studies that I used in

part in forming my opinion.

Q. Had you read those studies when you wrote your declaration?

A. No.

Q. What was the basis of the statement in your declaration when you wrote it?

A. I read the abstracts, but not the studies. I read the studies at a later date.

Q. In your experience, are the abstracts always a good substitute for the studies themselves?

A. I think they reflect the general idea of the study. I think that's the purpose of it.

Q. How long is a study abstract?

A. I'm not sure I understand the question.

Q. How long is the abstract?

A. It's a paragraph.

Q. Is that a paragraph that's commonly reprinted at the beginning of the article itself?

A. Sometimes it's identical or it's taken from it. Sometimes it's not. But it's very similar.

Q. When you say "inevitably" in your declaration, do you mean that every rear-cuffed person will incur those injuries?

A. No.

Q. What does inevitably mean to you?

A. Inevitably means if you assess the population of inmates that are cuffed, some will sustain injury.

Q. Is the proportion of those that will sustain injury the proportions we were talking about just before lunch?

A. Without asking you to -- I'm not sure exactly what you are referring to what we talked about before lunch.

Q. I'll describe it. You shouldn't be guessing here.

A. Sure.

Q. You said that you believe that 80 percent of those in a cohort of 100 would have pain -- I'm sorry, 80 percent or more and maybe 100 percent, I'm doing my best to quote you from my notes, I don't mean to misrepresent you, and somewhere between 15 and 50 percent would have some type of neuropathy?

A. That's a guess, and I would agree with that.

Q. So when you say that in your declaration that rear-cuffing will inevitably result in a

variety of injuries, and you just explained to me that means some inmates will sustain those injuries, are those the proportions that you are talking about, the ones I just stated to you?

A. Yes.

Q. Do you still agree with that statement?

A. Yes.

Q. Do you believe that temporary numbness and permanent nerve damage are of equal concern?

A. No.

Q. In your report which we marked just before lunch as Exhibit 3, which is also in front of you, you disagree with Dr. Park's statement that prolonged cuffing primarily causes temporary numbness?

MS. FREEMAN: Can you tell us where you are?

MS. HUTNER: Sure. At the top of page 4, in the middle of that carryover paragraph at the top of the page.

MS. FREEMAN: Okay. Why don't we refer directly to the document, because I think the way you characterized the statement was not correct.

Q. Your report says, "Dr. Park also mentions

that prolonged cuffing primarily causes numbness that occurs equally with front or rear-cuffing. I disagree."

What do you disagree with?

A. The word -- that occurs equally with front or rear certainly, and temporary I just think there is not -- because there is no studies on rear-cuffing, and because the medical staff at Rikers do not study the effects of rear-cuffing here, there is no basis to compare front and rear-cuffing, with the exception of our opinion as medical people as to the effects of rear-cuffing.

So it is my opinion that the rear-cuffing is more of a joint stress and may precipitate greater neuropathy than front-cuffing.

And in that respect, I disagree with Dr. Park.

Q. You say it may precipitate greater neuropathy.

Is that right, is that what you just said?

A. I think I did, yes.

Q. That means you are not sure that it will?

A. Well, it is my opinion that it will, but

because it's not been studied, I have to qualify that.

Q. What's the basis of your opinion?

A. The basis of my opinion is that the studies on neuropathy that I cited identified -- or at least one of them identified that some of the risks for neuropathy may be struggling against the cuffs.

And in my opinion, rear-cuffing and in certainly one individual that I watched while there, inmates are not comfortable in this position, and they attempt to relieve themselves of the position, so they are at times struggling against the cuffs. And I think that that increases the risk of neuropathy.

And one more thing. In addition to that, the torsion of the wrists may exacerbate the problem.

Q. You observed one inmate struggling as you said with the rear cuffs; is that correct?

A. That's correct.

Q. What is your basis for saying that the torsion of the wrists may exacerbate the problem?

A. Well, if you think about it, putting

palms in is not a very comfortable position.

Q. Do you mean in or out?

A. Palms out. Did I say in?

Q. Yes.

A. I'm sorry, putting palms out, hands behind your back is not a very comfortable position.

It is my opinion that people would try to find relief from the position, and in trying to find that relief, they would attempt to move, and in attempting to move, they would come up against the restraint, and in doing so they would incur a higher possibility of impression.

Q. So the basis for your statement that it is well established in medical literature that front-cuffing can cause neuropathy is those three studies that you cited in your report?

MS. FREEMAN: I'm sorry, are you referring to the document again?

MS. HUTNER: Yes, we are in the same paragraph on the top of page 4 of the report.

A. Yes.

Q. Have you read any other studies to that effect?

A. It's not a well-studied problem.

Q. What do you mean by it is well established then?

A. That there is evidence that it occurs and it has been documented by neurophysiological studies, specifically I believe electromyograms.

Q. When you say torsion of the wrists, are you referring to the turning of the wrists so that the palms are facing out?

A. Yes.

Q. What's your definition of neuropathy?

A. Nerve damage.

Q. In your opinion, is temporary numbness an example of neuropathy?

A. Yes.

Q. Does temporary numbness cause permanent nerve damage?

A. It's not a logical question, because temporary is not permanent. That would be like saying is temporary equal to permanent, and it is not.

Temporary doesn't cause permanent. It's just a question that doesn't make sense, so I'm not sure how to answer it, and I'm not trying to be smart or anything.

Q. You said neuropathy was nerve damage, right?

A. Yes.

Q. Do you think that damage could be temporary?

A. Yes.

Q. So then when somebody, for instance, falls asleep with their arm under their pillow and wakes up with their hand feeling what we call "asleep," at least over here in the world of lay people, then that's an example of temporary nerve damage?

A. No.

Q. What's the damage?

A. In the case you just stated, it would -- it's a compression effect of the nerve.

Q. Can front-cuffing cause neuropathy as well?

A. Yes.

Q. Given that, do you have an opinion on the appropriate correctional response to the fact that cuffing can cause neuropathy?

A. I think I've already addressed this, but I believe that the correctional folks, in my

opinion, should worry about selection of who should be cuffed and worry about the circumstances under which they should be cuffed so that they only use a higher level of restraint as absolutely necessary.

Q. That doesn't address the issue of front-cuffing causing neuropathy; does it?

A. I'm not sure I get the context of the question.

Q. If front-cuffing can cause neuropathy, then are you suggesting there are some individuals who should not be cuffed at all?

A. I think that probably would be true, yes.

Q. How would you identify those individuals?

A. The most obvious example is somebody who is quadriplegic. Why would you cuff someone who is quadriplegic?

Just as an example, off the top of my head, but -- and that's a most extreme example.

Q. A quadriplegic is somebody whose four limbs are paralyzed?

A. That's correct.

Q. This would limit the individual's likelihood of being an escape risk or a violence risk; wouldn't you say?

A. Yes.

Q. Let's stick to people then who might be escape or violence risks.

A. Well, I have to tell you I've seen quadriplegics shackled, and it's just strange things happen in corrections, it's a fact of the matter that it happens, so I think there is a continuum of people that maybe shouldn't be shackled.

I don't think pregnant women should be shackled.

Q. Do you think that's true throughout their pregnancy?

A. Yes.

Q. Including the first trimester?

A. Yes. I don't think first trimester has anything to do with the situation.

Q. Why is that?

A. I just don't.

Q. Do you have a basis for that?

A. Well, let me back up. And I'd rather that you rephrase the question about shackling.

We've been talking about shackling in terms of putting a restraint on someone, and shackling, about putting a handcuff on someone. So

I'd prefer if you are talking about Red ID restraints, I can go forward.

If you are talking about other shackling, I'd prefer you ask me which kind of shackling, because it may make a difference.

Q. Just now we were talking about individuals who should not be front-cuffed, and you identified quadriplegics as one, and then you said pregnant women shouldn't be.

Were you talking about front-cuffing or something else?

A. If you are saying front-cuffed in the Red ID manner, my recommendation to corrections is, I would be very much against it.

And if they did it, I would tell them that they had better take every precaution to ensure the safety of the person. And that includes any stage of pregnancy.

Q. So I take it that you are opposed to rear-cuffing in the Red ID manner for women in any stage of pregnancy; is that right?

A. That's correct.

Q. Why is that?

A. Well, for a couple of reasons. From an

administrative reason, I think the liability is extremely high, that if there were an injury, that there would be litigation.

My advice to correctional officials that I would work with, if I were making the recommendation, would be it would be not prudent to put pregnant women in restraints because in the event of a fall, which I believe is quite possible, an injury to the fetus, they would be potentially liable.

Q. What about from a medical point of view?

A. From a medical point of view, I still believe for -- that you could injure the fetus for the same reasons that I recommended.

On a liability basis, there is a medical reason. The medical reason is if there is a fall and an injury, the fetus could be harmed. So there is an additional entity, fetus that would be harmed.

In addition to that, if there is immobilization, then there are two problems with women who are pregnant. There is the question of edema, because women are more prone to have edema, and the issue of clotting, because women are in a hypercoagulable state during pregnancy.

M. Puisis

I read Dr. Park's comments about that, and I will double-check, but my opinion, and my current belief, is that that state of hypercoagulability occurs because there is increased estrogen in the woman's system and that estrogen is of a result of the conception of the ova, and those changes occur shortly after fertilization. And that is what makes women more prone to increased clotting. And I think that occurs shortly after fertilization.

Q. What is it that you believe Dr. Park said that you are responding to?

A. I believe he said in his deposition that his only concern for pregnant women was in the second and third trimesters, but he didn't say or clarify what his concern was during that time.

He just said that he would not advise to put women in restraints who were in the second or third trimester, but didn't give a basis as to why they shouldn't be placed in restraints.

Q. In your declaration in paragraph 3, you indicated that subclavian steal was a likely consequence of rear-cuffing.

At the time that you wrote this

declaration, had you ever observed subclavian steal in any circumstances?

A. Just to go back, did I say it was likely? I don't think I thought it was likely.

Q. You said that the restraint is tantamount to an exaggerated stretching of the subclavian artery of both arms in a manner that is likely to cause vascular compression, especially with deep breaths or turning of the head side to side?

A. I didn't quite say that. I said the posture of restraint is an exaggeration of the Adson test, which is a test physicians use to stretch the subclavian artery to test for compressions of subclavian artery.

Q. Right. The sentence I read was taken from paragraph three of your declaration; wasn't it?

A. It wasn't exactly what I said, but it was paraphrased.

Q. I don't believe that's the case.

Can you please read the sentence that starts, "So the restraint is tantamount"?

A. "So the restraint is tantamount to an exaggerated stretching of the subclavian artery of both arms in a manner that is likely to cause

vascular compression."

Q. Can you finish?

A. "Especially with deep breaths or turning the head side to side."

Q. Do you still agree with that statement?

A. I do, but I do not want to, or I hope we wouldn't spend a lot of time -- I think this is a very unlikely scenario.

I think it's a possibility. I agree with what I said, but I don't think it's going to affect a large number of individuals at all, and I would not want to make my opinion sound as if this is a major portion of my opinion relative to why or why not these restraints should or shouldn't be used.

Q. I don't plan to ask you a lot of questions about it, but I do have a few questions, and given you put it in a sworn declaration, I want to explore it.

Had you ever observed subclavian steal in any circumstances when you wrote that?

A. Not personally, no.

Q. Why did you believe that a person with respiratory disease would be likely to have this condition?

A. It was based on the physical diagnosis test that is used to diagnosis this condition.

Q. Do you know of any studies that support that conclusion?

A. Not off the top of my head, no.

Q. When you had originally included this statement in your declaration, did you investigate the likelihood of its occurrence from rear-cuffing?

A. There is very little literature on rear-cuffing period. There is obviously no literature in an unusual occurrence of rear-cuffing.

Q. Did you check?

A. Yes, I did.

Q. You found nothing?

A. No.

Q. In your report, in the footnote that's on page 3, you state that you believe that the possibility of this occurring, and I assume you mean subclavian steal syndrome, is remote; is that right?

A. Yes.

Q. Does this mean that you changed your mind about the position that you took in your declaration?

A. No.

Q. What was --

A. I just don't want to move it to front center.

I'd like to say that it is a remote possibility. It's something that I thought about. I think it's a real possibility, but it is such an unlikely event and it is an uncommon position that it would be, as I said in the footnote, it's a distraction from the real issue, which I think that neuropathies and pain and the other things I'm talking about are the real issue here, and that I just think this would be a distraction.

Q. What caused you to put that footnote in your report?

A. You know, I thought about it a lot and I read Dr. Park's comments and I thought, you know, this is not going to lead to a productive and practical discussion of the real issue surrounding these restraints.

Q. In paragraph 4 of your declaration, you state that "stretching the brachial nerve is also likely to lead to neuritis or neuralgia in some individuals"; is that right?

A. Yes.

Q. Do you still agree with that statement?

A. I read Dr. Park's comments about the brachial plexus and, you know, I agree that in terms of the terminology that what I'm talking about there is the brachial plexus. And if that is what you are getting at, I still agree with it, though I think that the position does stretch, the arm stretches at the shoulder, and the nerves and those structures that are within the neck entering the arm are stretched.

Q. Can you define neuritis?

A. It is an inflammation of nerves.

Q. What's neuralgia?

A. It's pain in the nerves, or pain that occurs because of an inflammation of the nerve.

Q. When you say it's likely to lead to neuritis or neuralgia, what do you mean by "likely"?

A. I think that if you look at the population of people that are restrained in this manner, some individuals will eventually develop neuritis or neuralgia.

Q. But "likely" doesn't mean most of them will develop one of these conditions?

A. Well, I think I gave you what I thought

were some statistics on what people would get.

Q. This goes back to the 15 to 50 percent?

A. Yes.

Q. That to you is --

A. Well, actually, yes, it's -- I would answer in the same way.

Q. Do you think this statement is more accurate if you substitute the word plexus for the word nerve?

A. Yes.

Q. Have you reviewed any cases of brachial plexus stretching, leading to neuritis or to neuralgia?

A. I have personally seen people with brachial plexus injuries from trauma, and I cannot recall exact details, but I do recall in several, more than one, where people had injuries to their neck or shoulder area and had brachial plexus injuries.

Q. Did you ever see a case where a restraint caused either neuritis or neuralgia?

A. As I said, I have witnessed people with neuropathy.

Q. You've witnessed what people with

neuropathy?

A. Prisoners.

Q. Okay, well, you just mentioned that you had personally seen neuritis or neuropathy or neuralgia, and I don't know whether you are using those terms interchangeably or not in persons who had been injured in a traumatic way. I'm asking whether you've ever seen any of these conditions in somebody in whom the conditions were caused by the manner of restraint?

A. You were speaking of brachial plexus injuries, and then you switched, I believe, to handcuffing and neuropathy.

Yes, I have seen people with handcuff neuropathy. Neuropathy is nerve damage. Neuritis is inflammation of nerves, and neuralgia is pain of nerves. So neuritis and neuralgia are subsets of neuropathy. So, therefore, if I seen neuropathy, it may have been caused by neuritis, and it probably included neuralgia. It may have included neuralgia.

Q. What you are saying in your declaration is that the Red ID restraints can cause neuritis or neuralgia in the brachial plexus?

A. From nerves that come from the brachial

plexus, correct. Brachial plexus is a group of nerves that form out of the spinal cord and then reform into individual nerves that then enter the arm and shoulder, et cetera.

Q. So I don't think at this point we were talking about handcuffed neuropathy.

I think I was just exploring this statement in paragraph 4 of your declaration and I was asking you whether you had ever seen any cases of brachial plexus --

A. Neuritis from handcuffing?

Q. Neuritis from correctional restraints.

A. No, no.

Q. Have you ever personally seen an instance of carpal tunnel syndrome or other neuro injury resulting from rear-cuffing?

A. As I said before, rear-cuffing is not used in jurisdictions where I've worked to the best of my knowledge, so -- but I have not seen a case of carpal tunnel syndrome from that, but I've seen it.

Q. Have you seen carpal tunnel syndrome from handcuffing at all?

A. I've seen people with carpal tunnel syndrome, and whether it was caused from handcuffing

is something I don't know.

I am sure, because I'm dealing with prisoners, that the people I have seen have been handcuffed. Whether that contributed to their carpal tunnel, that's something I can't answer because I don't know.

Q. You have no way of knowing either way; is that correct?

A. No, I don't think I do.

Q. You said that repeat visits to court could lead to permanent damage, right?

We are still in paragraph 4 of your declaration.

A. Yes.

Q. How often do you think the visits would have to be for the permanent damage to occur?

A. As I said before, the duration of time in restraints is a factor in the development of risk for injury, so the longer and more frequent a person is in restraints, the greater the risk and the greater the possibility that injury will occur.

And I can't quantify for you an exact number. It may be geometric. It may be linear, I don't have an exact answer for you.

Q. So you don't have any basis for telling whether it would be linear or geometric?

A. The one study that I cited when the average duration of time in restraints increased from, I think it was an hour to three hours, or 1-1/2 hours to three hours, the number of neuropathies doubled.

Whether that relationship would hold for every doubling of time is not clear to me, but, in any case, the duration of time I think does have an effect.

Q. Do you agree that numbness generally resolves in time?

A. I think that's an overly broad question that I'd like clarification of.

Q. Have you had experience with patients who have experienced numbness?

A. Yes.

Q. In what proportion of those cases has the numbness eventually resolved by itself?

A. I really would not know how to answer that. I mean, I've seen people with strokes who have permanent numbness, and I've seen people with permanent injuries and I've seen people in transit.

M. Puisis

Usually when people come to me with a complaint of numbness it's something more permanent or lasting.

Q. And the complaints of numbness that seem more permanent and lasting have causes like strokes or injury, is that what you are saying?

A. Trauma.

Q. What kind of trauma?

A. Blunt trauma, I believe that in the past, unfortunately, it's in terms of time period, I can't remember a single individual, but I have heard complaints of inmates telling me they can't feel after being handcuffed, but in terms of that being permanent, it's hard to assess, because I have no way to recollect what the time frame was from the time they complained to me to when they had handcuffs on, but it is something that's common enough I think with physicians working in jails, in particular that I feel fairly comfortable saying that to you.

Q. Saying what specifically?

A. That inmates have complained of long-lasting numbness.

Q. What does "long-lasting" mean?

A. Well, from the time that I'm talking to them to the prior time of application of cuffs.

Q. How long was that?

A. Like I say, I don't remember, but I worked in a jail where from the time people would have had handcuffs on to the time they see me, maybe anywhere from several hours to a week or two.

Q. You don't know which of those inmates were coming to you with complaints?

A. No.

Q. You didn't follow-up with any of them?

A. Follow-up is very difficult. People get discharged from jail and you lose contact.

Q. So you didn't follow-up with those inmates?

A. They were discharged. There is no way to follow-up. That's correct.

Q. How often have you personally observed cases of pulmonary embolisms?

A. I think probably a couple of dozen, maybe more.

Q. What were the causes of those embolisms?

A. I mean, I don't have written case reports for you on each one of these, so....

Q. Do you remember any of them?

A. I know several. I mean, I've already cited several for you on deep vein thrombosis.

Q. How many subclavian embolisms have you ever seen?

A. I think I've seen one, but, you know it was back when I was at County as a resident, and I don't have a good recollection of that. It would have been years ago.

Q. Have you read about any cases of subclavian embolism in your review of the literature?

A. It's reported, yes.

Q. In the literature, what are the causes that are given for that?

A. Currently the causes are placement of a central catheter or malignancy.

Q. I'm sorry?

A. Central venous catheter malignancy, and in fact, I hate to bring it up, but subclavian steal is mentioned.

MS. HUTNER: Can we take a break for just a moment?

(Recess taken.)

M. Puisis

Q. When we were talking earlier in this deposition about embolisms, I believe we were talking about pulmonary embolisms; is that right?

I can elaborate a little for you. According to my notes, you were talking about pulmonary embolisms that were caused by restraints which were a risk factor for deep vein thrombosis?

A. Right. For the most part a thromboemboli in that context refers to pulmonary emboli. That's only because that's where the clot goes.

Q. So it could have started anywhere?

A. No. In other words, the clot starts from somewhere but travels. Once it travels, it's a thromboemboli. It usually travels to the lung because that's where blood is returning. Theoretically it could go anyplace.

Q. Are you aware of cases where pulmonary embolisms were caused by thrombosis of veins in the arms?

A. As I said, it's described, it's considered a more common problem than is generally thought, but --

Q. What does that mean, more common than generally thought?

A. When I mentioned to you that I did a little research on this, and one of the abstracts said that, so all I'm doing is kind of citing what I read. But in my experience, I have never seen an upper extremity thromboembolia.

Q. In your opinion, what are risk factors for increased clotting?

A. There is a long list, I probably can't remember the entire list. The list can be found in a textbook of medicine.

I wouldn't want to be held to any list I gave you, but I will take a stab at it.

There are a number of clotting factors that when they are present they are to increase clots, Protein C, Leiden factor, cardiolipin, lupusanticoagulant.

Those clotting factors, when they are present, may result in increased or do result in increased risk of clotting.

In addition, certain malignancies result in increase risk of clotting, certain states. For example, pregnancy results in increased risk of clotting due to the estrogen compounds. Using oral contraceptives or estrogen compounds is a risk for

clotting, which incidentally is why smoking and taking oral contraceptives is not a good idea, particularly over the age of 35, because there is an increased risk of clotting.

Prolonged immobilization or immobilization of a limb is a risk for clotting.

Do you want me to go on?

Q. No.

A. There is a fairly large number of conditions.

Q. Do you believe that any of these risks can be tested so that the likelihood of being at risk for clotting is predictable?

A. Some you can and some you can't. For example, doing blood tests to determine if someone has lupus antibody is not a very practical thing to do, and I don't believe that a screening test for that would be cost effective or practical.

Q. If there were regular breaks and the inmates could move their wings around regularly for some period of time, do you think that would reduce the risk of clotting?

A. Substantially.

Q. Can you say how long you think those

breaks should be?

A. I think a five to ten minute break.

Q. How often?

A. Two hours.

Q. In your report at page 5, you say that prolonged ischemia may potentially harm some individuals.

What do you mean by "prolonged"?

A. I didn't have a specific time frame in mind, I just -- I think.

Q. Do you know?

A. No, not particularly, but for example, I think anything more than a half hour, 15 minutes cutting off circulation is a problem.

I will say this. I did a rotation orthopedic surgery. And orthopedic surgeons, when they operate on a limb and they want to reduce the bleeding during surgery, will put a tourniquet on the proximal part of the extremity, and by "proximal," I mean the area closest to the trunk of the body.

So for example, if they are operating on a hand, they will put a tourniquet on the upper arm and they will constrict the blood flow to the arm,

and when they do that, they have a time factor where they have to release the tourniquet in order not to lead to damage.

I believe that that time frame was derived by either experience or their opinion as to whether harm could come to the person they were operating on.

That was about two and a half hours for an arm, and I think the leg there is an equal time period. Granted, this was years ago that I did that, but whether that still holds is something I'm not aware of, but at that time, it was kind of a definite time frame that you could put a tourniquet on for sewing.

You didn't want to do it more than that because tissue damage may result in the lack of blood flow from the body to the extremity.

Q. What's your basis for saying half hour to 15 minutes? You just said that a moment ago.

A. Well, let me say that there are individuals who may have conditions for which any ischemia is not a good idea.

For example, persons who have underlying arterial disease, for example, cholesterol deposits

or narrowing of the arteries, whether congenital or acquired, and those individuals would have a potential, that would mean that less duration of time could harm them.

For most people, I think they can tolerate the longer period of time if they were healthy.

Q. Which longer period?

A. The period I described.

Q. Half an hour to 50 minutes?

A. No, the 2-1/2 hour period.

But with people for underlying disease, I think a shorter period of time could cause harm.

Q. Do you have any knowledge that the tourniquet the orthopedist used in surgery caused the same decrease in blood flow as handcuffs might?

A. No. It's obviously different, and I don't mean to imply that it is, it's a different tourniquet. It has a different purpose. And it in no way restricts blood flow in the same way.

I only bring it up as an example of what I do know in general about this.

The handcuffs are very superficial. It has nothing to do with the deep arteries. It is not

constricting blood flow. It's the posture even more than the constriction of the handcuffs, that if there is an anatomical problem, and subclavian steal is one of those where someone has a variant, an anatomical variant or an artery that's not normal and they are put in this posture, they could have a severe diminishment. And as I said before, this is an unlikely situation, but it can occur.

Q. Ischemia is what happens when you cross your legs for too long, right?

A. Partly, but that's also kind of a temporary neuropathy.

Q. How can you tell which it is?

A. I'm not sure you can tell exactly. The lack of sensation is probably a neuritis, but the nerve artery veins run in bundles. They are usually together, so if you are compressing one you are usually compressing the whole bunch, and I'm not sure it's always possible to tell which is which.

Q. In paragraph 6 of your declaration, you mentioned cases that you've reviewed of incarcerated individuals in four-point restraints who suffered pulmonary emboli and died.

Are those the cases that you were

referring to at the beginning of this deposition?

A. Right.

Q. Do you agree that musculo-skeletal problems are likelier to exist in persons with preexisting back, neck and shoulder injuries than in persons without?

A. Yes.

Q. Do you still agree with everything you said in this declaration?

A. I'm not going to read it right now, but I -- as I recollect I do. I just think that this was written kind of on a very quick notice, you know, give me a letter to describe this, and I did that. And I gave them some of the things that were going on in my head about it.

I still agree with it, though these conditions are all possible. I just would not like to emphasize some at the expense of practical considerations.

Q. Did you review any transportation records relating to Red ID inmates?

A. I believe I was shown a group of papers where they documented the time frames that people were -- arrived in court, when people left court and

the duration while they were in the court building that they had restraints on.

Q. Who showed you those documents?

A. Lisa did.

Q. That's Ms. Freeman?

A. Ms. Freeman, I'm sorry.

Q. Did you draw any conclusions from your review of those transportation records?

A. I looked at a small sample. Two things struck me. One was that they were not all in the same form, so that there was not consistency on how it reported specifically.

Some forms did not include the initial time that the inmate was placed in restraints. Some forms had a space to identify what time the inmate was placed in restraints at the facility, but it was not filled out in all cases. So there was a combination of ways of reporting it.

And in no case, and I didn't look at a lot of records, I looked at maybe -- leafed through very briefly a couple of dozen, and in no cases did I see the total time in restraints from the facility to when they arrived at the facility and the restraints were taken off.

Q. Is that because it hadn't been totaled up on the form, or because you didn't have the information on the form necessary to calculate that?

A. Both. In some it just didn't have that information down there, and on some it had the time they arrived in court and the time they left court, and nothing else.

In others, it had the time they left the facility and the time they arrived at the facility, but it didn't indicate that is when they had the restraints put on.

In other words, I have no reason to believe they are being deceptive, but that wasn't clear, but it looked like it took about an hour, an hour and 15 minutes to get back and forth from the court, from the group of facilities I looked at, so I was under the assumption you add two hours to that time.

Q. I am sorry, two hours to what?

A. To the total time they listed -- in other words, I looked at maybe six or seven of these forms and on each of them it was about an hour, hour and 15 minutes transportation time, more or less.

Q. So why are you suggesting adding two

hours?

A. Because it's an hour one-way and an hour back. That's what they wrote.

Q. From the time that they arrived at the court facility?

A. From leaving the facility to arriving at court.

Q. So the time that they left the facility was not included? You are saying you would add an hour to that?

A. I was making an assumption that maybe that was it.

Q. Did you review any courthouse logbooks relating to Red ID inmates, either on your tour or subsequently?

A. I don't believe I did. I know Gene Miller reviewed some kind of log when we were on tour, but I did not, to the best of my recollection.

Q. On page 2 of your report, you state that you traveled in a van that was designed for inmate transportation.

We talked about the van a little bit earlier -- I'm sorry, I'm going to withdraw that.

When you were talking about these vans ,

you say in your report that you do not believe that these transportation arrangements are safe; is that correct, at the very end of that carryover paragraph on the top of page 2?

A. Right, that's exactly what I said.

Q. Specifically what do you believe is unsafe?

A. When inmates ride in a vehicle, they are starting and stopping, they are accelerating decelerating, so there is movement.

When Red ID restraints are used, the inmates have their arms behind them, they have no means to protect themselves in the event of an acceleration or deceleration movement that causes them to move. So these are free weight, and they could potentially fall against or fly against the front of the cages they are in and hit themselves.

Q. If an inmate were front-cuffed with the cuffs attached to a waist chain, wouldn't that be the same?

A. Almost, I think it's a little more protective to have your arms in front of you, but, mainly because it could protect you from hitting your face.

Q. Even if your wrists were fixed at about waist level?

A. Yes, there is not a lot of difference. I just think that it's a proven fact that seat belts save lives, and the reason is that it restrains people in the event of an accident or in the event of, you know, some type of movement of the vehicle where people might lose control. And it saves lives, it just does.

Q. Are you aware that New York State law does not require seat belts on buses like the inmate buses?

A. With Red ID restraints?

Q. That New York State law does not require seat belts on any New York State buses?

A. I just think Red ID restraints were not considered when the legislators wrote the law, and that the legislators probably assumed that people had the free use of their limbs to protect themselves.

Q. You think the legislators assumed that prisoners were travelling without handcuffs?

A. I don't know that they considered the prisoners at all when they wrote the legislation.

Q. You don't know either way; is that right?

A. I don't.

Q. You recommend putting padding in the cages; is that right?

A. I think that's one alternative.

Q. Are you aware of any security concerns relating to doing that?

A. It's not for me to say, I don't know. There may be.

Q. If it turned out that there were serious security concerns, would that change your mind about padding the Red ID inmates on the buses?

A. Let me put it this way, I think that the security people and the medical people could discuss this issue and make some accommodation to more safely transport people, but I agree that there are probably security concerns and they should be taken into consideration. I don't disagree with that.

Q. Do you agree that any resulting solution will likely be a compromise between security and medical concerns?

A. That's the way life is.

Q. Are you aware of any security concerns about having seat belts on the inmate buses?

A. I imagine there are. I just think that if people are in Red ID restraints, some of the security concerns are -- have less merit, because people are so restrained that they literally can't take advantage of the opportunity to use the restraint, but then again I am not a security person and I don't pretend to even want to tackle that problem, but I can imagine.

MS. FREEMAN: Off the record.

(Discussion off the record.)

Q. On page 3 of your report, you say that the correctional health services policy does not give medical staff sufficient guidance; is that right?

A. Yes.

Q. What guidance should be applied for who should or should not be placed in these restraints?

A. I wouldn't want to be held to a limitation on what guidance exactly I would give, but I will give you how I would proceed with providing the guidance.

Q. That's fine.

A. Because I think I have done this in other situations at the Cook County Jail on a number of

occasions.

When a situation like this occurs, I would, for one, think about it for a fair amount of time and I generally would, you know, look at what was occurring.

For example, we did the restraint policy where people were shackled, and we actually went and looked at the women who were shackled who were in labor while it was happening.

And then what I do is I discuss the process with colleagues who I trust, who I think have prudent judgment, and are good physicians and have no agenda one way or another to, you know, either, you know, in any prejudice against any party.

Then I would review medical literature that I thought was important. I would come up with a group of recommendations, and in my case, at Cermak, I would present it to the physicians at a meeting for a discussion, because I believe that no one person can really, you know, develop these policies, and I think the people who actually practice have a lot of say about what they encounter.

For example, the physicians who are seeing patients at intake or the physicians who are examining the Red ID patients for clearance or reviewing the charts unquestionably have questions and comments that they make, and they will let the senior physician know that there may be problems in certain areas that the senior physician never contemplated. These things happen all the time.

So I'd absorb all that information and sit down with a group of people I trusted and make a decision and discuss it with the correctional folks, get some comments, do a couple of revisions like that and --

Q. Understanding that you haven't sat down and thought about this policy --

A. Right.

Q. -- what categories of guidance would you include in such a policy?

A. Let me cut to the chase for you in terms of trying to think -- help you with what you are getting at.

Off the top of my head, I think that my opinion about this process is the duration of time people are in restraints, and the kind of screening

and elimination of people who are at higher risk.

I would hope, and I don't want to get too far into this, but my advice to the correction folks would be, be more selective who they put in.

In other words, is someone really violent and is it imperative that this character be put in. That individual may need to be restrained in a serious type of restraint, and I don't have any problem with that, but I would hope they were doing that because there are 4 percent of people who are in these types of restraints.

Having said that, my recommendation would be to include in the intake form that they currently use, a direction as to what type of persons should not be screened and ask those questions at the intake exam.

Q. What types of persons should not be screened?

A. Should not be included -- given Red ID restraints, I'm sorry.

In other words, I am assuming that you are going to use the chart reviews of the intake exam, history and exam to make the determination that they should or should not be in Red ID

restraints.

There are different ways to do that, one of which is require every inmate receive an examination before going into restraints. That's one option.

If the facility finds that it is better to use the intake exam sheet, then they should ask questions that specifically address the risk factors for Red ID restraints. And I'll give you a quick digression and example.

When the HIV epidemic began, at that time history and physical examination focused on the risk factors for HIV, and at that time into the intake screening examination questions appeared in many jurisdictions. In fact, now in almost all jurisdictions about risk factors for HIV, because this is the popular we care for.

Those included did you have a transfusion? Do you share needles? Have you had sex with men? So the practitioners can identify those individuals who are at risk who may be at a higher risk for HIV.

In a similar vein, in whatever format you would choose to screen people, whether that is via

the intake chart with a follow-up examination or by examination, you ought to ask more focused questions that determine if someone has a risk for injury.

And that would include, for example, prior surgery on upper extremity joints, histories of carpal tunnel syndrome, you know what I mean, you know that Dr. Park or whoever could determine what appropriate risk factors exist and include those questions in the format.

MS. HUTNER: Off the record.

(Discussion off the record.)

A. I want to complete my idea there that the current method is to use the intake history as the screening device.

You could equally and perhaps in a better fashion decide that anyone who is going to be put in Red ID have a separate history taken, because if that were done, the practitioners would understand that the entire focus of the history is to eliminate those at risk for Red ID.

When people are doing intake exams, their focus is not specifically on Red ID; in fact, I think it's probably the last thing on their mind, so therefore a stronger recommendation would be to have

a screening device, an instrument and a series of questions that they would ask that would identify those who may need an examination.

I'm not saying everyone should be examined. I'm saying it wouldn't be a bad idea, there would be a triage mechanism that at a minimum would start with a questionnaire, and for those with some risks would result in examination and identification of those who are likely, and then physician judgment could be applied.

Q. Do you believe that this screen device that you are suggesting would provide sufficient guidance to the physicians who are making the initial and monthly medical reviews of Red ID placements?

A. It could, yes, I think it could.

Q. Do you believe that in-service training could provide the necessary guidance?

A. I think it would be mandatory to have some type of explanation to the staff about what they were required to do. I don't think it's entirely difficult, but I think it could be and should be done.

Q. What would you do in the event that you

have a hypothetical inmate who security determines legitimately is a high security risk, and medical staff determined has some risk factor associated with Red ID restraints?

A. Hypothetically speaking, I don't run -- physicians don't run correctional institutions. Security people do. Medical people give them advice and medical people provide medical care.

If a security imperative is determined by security officials to be paramount they do what they do regardless of what anyone says or with guidance of what people say, but they still do it.

I'm sure they take into consideration their own liability in that manner, and I think that's about what I want to say.

I don't think we could -- medical people ever force corrections to do anything. I think they take our recommendations under advisement. And what else are we going to do?

Q. Do you believe that someone who claims to have asthma but doesn't use an asthma pump can be rear-cuffed?

A. I think the determination of who has asthma and who doesn't have asthma should be a

physician decision, but I believe that some inmates will say they have asthma and do not, simply for the purpose of getting in or out of restraints, let's face it, that will occur in I think some cases, but I believe that decision should be made by a physician.

Q. Do you believe it would be reasonable for a physician to take into account whether or not the inmate has ever requested or used an asthma pump?

A. I think that's a reasonable consideration in order to determine whether someone has asthma.

And moreover, some people with asthma have asthma but it is not current, it may not be continuous, and it may have been something that affected them intermittently in the past and so yes, it's physician's judgment based on circumstances that exist.

Q. You state in your report on page 3, "In a jail setting, there is always pressure, implicit or explicit, on medical staff to go along with security staffs' inclinations and not raise potential medical contraindications."

What's your basis for that statement?

A. Personal experience and having

interviewed and talked to multiple health care practitioners in many jurisdictions, in many jails and prisons in the whole country.

Q. Do you have any specific knowledge about such pressures in the New York City Department of Correction?

A. No. I mean, as a matter of fact, this was the first visit to Rikers Island I've ever made.

Q. When you say personal experience, do you mean that you have experienced that pressure from security staff?

A. Yes.

Q. Are you aware of the possibility of pressure from inmates on medical staff to provide diagnoses?

A. Yes.

Q. Do you have any experience with that?

A. Yes.

Q. Is that personal experiences as well?

A. Yes.

Q. Do you know of any skin disorders that have actually been transmitted through the use of security mitts, either at New York City DOC or elsewhere?

A. You know, I've never seen them used at all, but I can tell you that I've seen impetigo transmitted inmate to inmate from contact, and it wasn't clear whether it was transmitted by contact via an object or whether it was transmitted directly from skin to skin.

Q. What is impetigo?

A. It's a staff skin infection and it's commonly transmitted by contact. Children get it. Wrestlers get it. And whether the bacteria can live inside the mitt is something I don't know, but it is, you know, likely.

And so, I think, that's why the manufacturer probably recommends sanitizing it.

Plus, you know, there are other bacteria that could be transmitted.

Q. Is there a reason that you didn't mention in your report the possibility of inmate pressure on medical staff?

A. In what context?

Q. Well, in the same context that you mentioned security staff pressure on medical staff.

A. No, there is no particular reason.

Q. Do you think age is a factor in whether

someone should be placed in Red ID restraints?

A. Yes.

Q. Why?

A. With age, people lose agility. It is well-known, for example, that at extreme ages people fall more.

Q. You mean elderly people?

A. Elderly people, right. I would hope they don't put elderly people in restraints.

I don't know -- well, I would assume that you are not going to have an 80-year-old who is going to be in Red ID restraints, but I don't know that, so I bring up elderly in the event that situation does come up, because I think to me it's an obvious problem.

I don't know what the city would do, and if the city doesn't intend to put people in who are extremely elderly, some of this is moot, but I do believe people over 45, I'll pick that as a benchmark, will probably have more problems because after that age people are at higher risk for myocardial infarction.

I think that any stresses that may occur due to anxiety or anything that could raise the

pulse rate, for instance, being in these restraints, I'd be anxious to tell you the truth, and it raises the heart rate, I think that it's not a stretch to believe that it would be more of a problem over 45.

I tend to think in the back of my mind that most of the indications for putting people in restraints are relating to violence, and it just seems more common in the younger population, so I'm suspecting you are not going to see very many people over that age.

For example, if I were doing a policy, I'd ask a different series of questions of people over 45. I don't even believe you are going to see very many people over that age, but I bring it up because of the possibility and because I don't know the exact demographics we are talking about.

Q. Would you say that 45 then is a cutoff age that you would suggest to either prohibit Red ID restraints or limit them?

A. The way I would do it is anyone over 45 should have a physical examination encounter with a physician, and that that examination would appropriately address questions of risk factor assessment.

An examination that would assist in that determination, and I think you could make a cutoff over a certain age, I'm guessing here 55, somewhere between 55 and 60 where you just wouldn't put people in that type of restraint.

Once again, that's very arbitrary because some people at the age of 65 are in great shape and very agile.

Q. Is edema of the upper extremities a common clinical finding?

A. Edema is a condition that occurs in liver disease, heart disease and kidney disease and other diseases, but those are the three commonest ones and is manifested in dependent parts of the body, or parts that are immobile or parts that suffer constriction.

What I mean by that is that edema is gravity-related, or the manifestations of it are gravity-related. For example, edema most often manifests in the feet because it's the lowest part of the body and the fluid goes to the lowest part of the body.

But in people who are lying flat, for example, they become edematous in their back, and

when people who have edema wear stockings, you can see the constriction or you can literally see the edema in the area where the elastic in the stocking has compressed the skin.

So edema will be manifested in areas that become dependent or constricted.

And it is most commonly seen in the feet because that's the area that is dependent, but it will occur in any part of the body where these conditions occur.

Q. Do you believe that all epileptics in Red ID status should have cuffing modifications so they are not rear-cuffed?

A. I think so. I believe that people who have epilepsy or alcohol withdrawal seizures are at much higher risk of injury if they are placed in these restraints, principally because if they have a seizure while they are restrained, there is a greater likelihood of harm --

Q. What about --

A. -- and the harm is a result of either a fall and an injury to their head or other body part.

Or in the -- in an actual seizure, there is both a tonic phase and a clonic phase.

A tonic phase is a phase where the muscles are contracted continually, and the clonic phase is where they are repetitively jerking.

These phases result in extreme contraction and a jerking of the muscles. And if those events recur while someone is in an unnatural position, that is with their arms behind your back, I would suspect that some of them can even break bones.

And I think it would be dangerous to do that, so unfortunately, the whole area of epilepsy is one where there is some amount of gaming and also it is an area that physicians typically do not take very good histories of, so it's a tough one, but I believe that an attempt should be made to identify those people who have true epilepsy.

Q. When you say "true epilepsy, "do you mean grand mal epilepsy?

A. Yes, but any type of epilepsy.

Q. Petty mal seizures do not involve any physical movement of the limbs, right?

A. It has to also do with the level of consciousness. If someone becomes unconscious, whether they sustain a tonic clonic phase is

immaterial if they are walking up the stairs and they become unconscious, they can fall.

So the fall part I think is related to the, you know, to all seizures, and the tonic clonic phase is related to the injury, you know, that could occur, you know, against a fixed restraint.

Q. What about if the epilepsy is controlled by medication?

A. It's a little dicey. I think what you are dealing with is a risk benefit ratio, and the absolute necessity of security of putting these people in a restraint. And I don't have a good answer to that.

I suppose you can have a policy where if they haven't had a restraint in a year or so --

Q. You mean a seizure?

A. I mean a seizure, you could say that they would be cleared, but there is a risk benefit that I think security would have to take the liability for.

Q. If the intake process were changed as you recommended, do you believe that a chart review would be sufficient to determine in most cases whether there was a medical contraindication to Red ID restraints and in some cases whether a physical

examination was warranted?

A. Under the circumstances that exist, I would probably recommend a unique form that they did a history and a brief face-on-face encounter with each individual and be done with it. I think that's the best.

Q. At the time of initial placement in Red ID status?

A. Right.

In other words, you don't do it for everybody at intake, but people who have Red ID you have a form, and the doctor sees them and goes through a questionnaire, knows what it's about, does it, and you are done with it.

If the requirement is, however, to do the screening based on the intake chart, I think it's a little more complicated. I think you would need to place a series of questions in the form and then educate the staff about the meaning of those questions.

The problem with that approach is that you have people, I mean physicians coming and going, people are fired and they leave, they resign, new physicians come, there is turnover in staff, and the

process of reorienting them to that particular thing is a little tougher than it is if they have a unique form.

Because even if someone is a new physician, they are given a unique form that says here, evaluate this person for Red ID status. They would then obviously ask what is Red ID status.

Whereas if they were doing it on an intake form, they wouldn't ask that question. They would just do the histories as a matter of course and they would lose the perspective of equating that person specifically for that event.

And from an administrative point of view, I think it would be a little bit of a hassle either way, but I think in the long run you would be better served by getting this form done and just doing it.

Q. On page 7 of your report at the very end you say you would require a physical examination prior to restraining and each month thereafter.

Why do you recommend a physical examination every month or do you still agree with that?

A. I'm not sure if an actual physical exam is necessary each month, but I think in some cases

it is.

For example, those individuals who have possible risk factors assuming a physician evaluates them, determines they are clear for Red ID, and at a monthly basis it would be incumbent upon a physician to reassess to determine whether in fact some harm had ensued because of these risk factors.

Q. Don't you think if some harm had ensued, it would have been brought to the attention of the medical staff and been a notation in the chart?

A. I honestly don't think that happens. Sometimes it does, but these are large facilities and stuff happens. And I think it's hard to get seen sometimes, and I just don't think it's a reliable way to follow up.

Q. So you would recommend physical examinations for inmates with risk factors who have nonetheless been cleared for rear-cuffing; is that what you are saying?

A. I think at a minimum, yes. I think it wouldn't hurt to redo people monthly, but it would be, I admit, difficult administratively and I think you can make an argument that you know it may not be practical.

Q. When you say at a minimum, do you think that would be adequate?

A. At a minimum for what?

Q. At a minimum, the individuals who had risk factors were nonetheless cleared --

A. Yes, yes, I do.

MS. HUTNER: Let's take a break.

(Recess taken.)

MS. HUTNER: Let's mark these as exhibits.

(Puisis Exhibit Numbers 4, 5 and 6 were marked for identification.)

Q. You wanted to clarify something?

A. I wanted to clarify some points I made about policy recommendations for Red ID restraints in terms of the two-hour interval I mentioned out of restraint.

I would also recommend that during times when individuals are held in pens in which they are the only occupant, that the restraints be removed.

Once again, if there is a security imperative that they be in restraints in those pens, that may be a different story, but provided that there is not, I think that would be extremely

helpful in reducing the possible risk.

Q. Do you believe that having a control group is an important component of scientific studies?

A. Yes.

Q. Do you agree also that correlation does not necessarily imply causality?

A. I do.

Q. You cited three articles in your report which have now been placed before you as Exhibits 4, 5 and 6 respectively to this deposition.

Do you believe that these articles are instructive in assessing the medical impacts of the Red ID restraints?

A. Yes.

Q. Let's look at Exhibit 4 first, which is the French study. This study discusses the possible neurological effects of handcuffs, right?

A. Yes.

Q. It doesn't conclude absolutely that the neurological symptoms are related to handcuffing; isn't that right?

A. Well, it's so highly suggestive as to -- it would be difficult to draw the conclusions.

I mean, there were some people who may have had prior injuries, but for the most part, these were a group of people who had antecedent cuffing and had neuropathies that were likely caused by cuffing and -- so in that sense, it's highly suggestive.

Q. When it says -- the first sentence says, "The application of handcuffs may result in compression neuropathies at the wrist."

You read that to be highly suggestive, is that your term, that the application of handcuffs does result in these neuropathies?

A. Yes.

Q. Incidentally, the portion at the top of the article in smaller font that says "abstract," is that the sort of abstract that you read before writing your declaration?

A. Yes, I suppose, unless there is a different -- I mean, I don't have what I read in front of me.

Q. But it would have looked something like that?

A. Yes, sure.

Q. There were limitations in this study,

right, for instance, the authors said they could not estimate the tightness of the restraints, right?

A. Yes.

Q. You didn't mention that in your report; did you?

A. I don't believe I did.

Q. The tightness of the restraint could have been a significant factor in whether or not there was a resulting neuropathy from the handcuffs; don't you think so?

A. Yes, I think it is, yes, absolutely.

Q. There were no electrophysiological studies in this report, right?

A. That's correct.

Q. There was no clinical follow-up, either, right?

A. That's correct.

Q. So it's possible that the instances of numbness, which were in half of the subjects with symptoms at all, might all have resolved by themselves with time?

A. That's correct.

Q. You didn't mention any of those things in your report; did you?

A. No.

Q. In your report at page 4, in case you want to look at it, you compare the 6.3 percent of prisoners with symptoms in this article, Exhibit 4, the chariot study, to 100 percent of prisoners with neurological symptoms that you say you observed on your tour. Is that right?

A. They are consecutive sentences, yes.

Q. What do you mean by this compares to 100 percent of prisoners?

A. Let me be more specific. The French study takes a subset of patients who were incarcerated. It takes all those people and it questions for symptoms and then it evaluates, and in a clinical exam find that 6.3 percent have findings that indicate neuropathy.

Now, it's not an apples-to-apples comparison, so I'm talking to inmates who are in a pen in restraints. They are telling me they have symptoms. If they were examined, what percentage would have neuropathy. And I frankly don't know the answer to that.

But 100 percent had symptoms, and the group --

Q. I just want to clarify when you say 100 percent had symptoms, you mean 100 percent reported some symptom to you?

A. I think that means the same thing.

Q. I just want to check.

A. And so it's not an apples-to-apples comparison, and I want to be clear about that.

I'm not trying to fool you in any way. It's not an identical study.

I think it would be interesting to study a large group of people who are in Red ID and find out what percent from an unbiased observer had actual findings.

The question that I think none of us can answer is whether this study has applicability in terms of this situation, in terms of, you know, using the same statistics, but it's the only evidence that we have.

Q. If the only evidence we had hypothetically were not applicable, then we wouldn't have any evidence; isn't that right?

A. We would have opinion of experts, that's correct.

Q. But we wouldn't have evidence from the

literature?

A. Right.

Q. You didn't ask any of the inmates whom you saw on your tour whether they had preexisting conditions that may have affected their reaction to the restraints; did you?

A. No, I didn't.

Q. Whether they had taken psychotropic substances?

A. No, I didn't.

Q. Did you ask them whether the restraints hurt?

A. I believe I did.

Q. What answer did you expect to that question?

A. I don't think I had an expectation, but they said yes.

Q. Let's look at Exhibit 5, which is the study by Grant N. Cook.

You call this the Emory study, right?

A. Where is your reference?

Q. Two-thirds of the way down the full paragraph on page 4?

A. Yes, I believe that's true.

M. Puisis

Q. You cited as reporting that handcuff-related nerve injuries can be severe and permanent; is that correct?

A. That's correct.

Q. This study particularly concerns overtightened handcuffs; isn't that right?

A. Correct.

Q. You are not claiming that the problems that you say might result from Red ID restraints are caused by overtightening cuffs; are you?

A. No, but I would keep in mind that the prolonged duration of cuffing, I believe, will result in people attempting to find a more comfortable position and will result in people in some fashion struggling or attempting to move their extremity, and that that movement, that struggle, that attempt to get the cuff off -- and in fact Mr. Conry said people are continually trying to get these things off, and they get the mitts off and they are moving, et cetera, that that movement will be the equivalent of -- in terms of its ability to put pressure on the nerve, an excessively tightened cuff.

Q. Have you seen any studies or articles

that said that?

A. The study we just talked about said that.

Q. Where?

A. Let me look.

Q. Sure.

A. Can I read the section that I'm thinking about?

Q. Sure, if you can tell me where you are.

A. It's on the second page of the article by Patrick Chariot.

Second page, second column, beginning second sentence, "It has been suggested that handcuffed individuals taking alcohol or other psychotropic substances fail to realize that their handcuffs have been applied too tightly and may continue to struggle with consequent nerve injury."

My reading of that is that it's not necessarily the alcohol or psychotropic use. It's the struggle against the cuff that is additive to the overtightening. And I think that has an effect, yes.

Q. Don't you think that this sentence that you just read from the Chariot article talks about a situation where the handcuffs have, in fact, been

applied too tightly?

A. My interpretation of that sentence is that the struggle results in an additive effect.

Q. Can you answer my question?

A. Your question is?

Q. This sentence says that, "These individuals failed to realize that their handcuffs have been applied too tightly."

Doesn't that mean to you that the handcuffs have been apply too tightly?

A. That's what the author says.

Q. So if the handcuffs have not been applied too tightly, then we have a different situation than the one described here by Chariot?

A. I think not. I think the struggle itself is a factor.

Q. You think that Chariot says that?

A. I think it does. I think the struggle leads to people putting pressure on the nerve through trying to move the hand. I'll give you an example.

If I'm in Red ID restraints and trying to move my hand against a fixed restraint, I will put pressure on the area against which the cuff is

hitting the hand. And I think that's equivalent of an overtightened situation. And to the extent that that struggle is continuous, it puts pressure on whatever structures it puts pressure against.

Q. Wouldn't that be the same, whether the cuffs were in front or back if they are struggling?

A. Yes, I think it would, but I think that the rear cuff is more comfortable, if you ask me, and I think that there is more struggling.

In fact, Mr. Conry indicated to me he said people are always trying to get out of these things, and in fact they do. He mentioned they try to take the mitts off and they do, and in fact one of the inmates we watched was continuously struggling to get the mitt off as we were talking to him.

Q. How many inmates did you observe on your tour approximately?

A. Six, eight, ten in the pens, and there were a whole busload getting off. I don't know how many were getting off the bus. I think you were there a dozen, half dozen, two dozen, I don't remember.

Q. You saw one who was struggling, right?

A. I did, yes.

Q. In fact, in the Grant article, isn't there --

MS. FREEMAN: Can you refer to these by exhibit number?

MS. HUTNER: Sure, Exhibit 5.

Q. Isn't there particular concern expressed about the use of handcuffs that continue to tighten after being placed on the prisoner?

A. Yes.

Q. Are you aware that the New York City Department of Correction uses double-locking handcuffs that do not tighten when the inmates struggle?

A. I wasn't aware.

Q. Let's say that they do.

Wouldn't that eliminate the concern about handcuffs that tighten more as a prisoner struggles?

A. I don't think it changes my opinion. I think that if you were to tell me that they use a ratcheted cuff it would be worse, but I still think that the fact that every inmate I talked to complained of numbness and the fact that overtightened handcuffs can cause neuropathy and the

struggling against them can cause neuropathy, that there is sufficient basis to support my opinion.

Q. Are you suggesting that if an inmate injures himself because he is struggling against the cuffs, that the cuffs should be removed because he is injured?

A. You are going to have to repeat that. I'm sorry.

Q. Sure.

Would you say that an inmate whose injury is caused by the inmate's struggle against the handcuffs should have the handcuffs removed or his restraints modified?

A. You are supposing that there is an injury that is identified, and I'm not sure, does that pertain to a preexisting injury that the doctors know about?

Q. No. I'm asking whether in a case where the inmate's only injury is caused by the inmate's struggle against the cuffs.

A. How would you know that?

Q. How would you know whether it isn't?

A. Well, you don't, but I don't understand what the difference is and I'm not sure what the --

therefore what the question means.

Q. Okay.

A. I'm not sure where we are going.

Q. That's all right, I'll move on.

In the Grant study, which is Exhibit 5, the authors of that article did not consider a nerve abnormal based solely on an inmate complaint; isn't that right? I believe this is at 934.

A. I don't recall. If you tell me that that's true, I would agree for the purpose of moving on.

Q. Actually, they considered a nerve abnormal only if they had electrophysiological data to support the conclusion, or if the patient complained of numbness, weakness or paresthesia were supported by the result of a physical examination?

A. I think they had two groups. They had -- of the people who were evaluated, they did electrodiagnostic studies on a certain percent of them and they had symptomatic evidence in another group, and then they had electrophysiological evidence in another.

Q. Paraesthesia is a sensation of pricking, tingling or creeping on the skin, right?

A. More or less.

Q. Isn't that kind of what again we lay persons refer to as pins and needles?

A. I think that's one. I have not had pins and needles sensations as you are describing, but I don't believe I've had all the kinds of paresthesias that inmates complain about, because there are some that's just continual pain. There is some that are loss of sensation. There are some that's altered sensation, and in talking to a large number of patients about these things, it appears there is a wide variety of sensations that come under the rubric of paresthesias, but pins and needles is ones we understand.

Q. Let's look at Exhibit 6. This deals with just two particular cases; isn't that right?

A. Yes.

Q. It describes those cases as unusual; correct?

A. That's correct.

Q. And the focus of this article is really on identifying which nerve is identified when there is neuropathy from handcuffing?

A. Right.

Q. It doesn't draw conclusions about the likelihood of neuropathy?

A. I don't believe it did.

Q. In fact, it states that compression of the sensory branch of the radial nerve may be harmless, right?

A. I think it does say that, yes.

Q. It recommends not overtightening cuffs; correct?

A. It does.

MS. HUTNER: Let's mark this as Exhibit 7.

(Puisis Exhibit Number 7 was marked for identification.)

Q. Could you look at Exhibit 7, which is a document that was provided to me by Ms. Freeman this morning. Tell me what that is.

It was represented to me that you reviewed this between the time of your report and the time of this deposition.

A. It's a letter to the editor in Neurology Magazine, it's a medical journal, and the letter is by Harold Apple, who is a neurologist, and I believe at the time he was working here at Rikers Island.

Q. When was the letter written?

A. 1991.

Q. You've reviewed this between the time you wrote your report and today?

A. Yes, I did.

Q. Did you learn anything from it?

A. Well, he worked here in the New York prison system, and he thought that handcuff neuropathy, as he said, is a common occurrence and -- can I just make a comment?

Q. Yes.

A. You know, I think what this meant to me relative to your last question about two unusual cases, let me relate an antidote that I think is a pro quo.

I was a resident at Cook County Hospital where we saw a lot of TB cases, and I went across the street to rush Presbyterian Medical Center for clinical rounds on infectious disease when I was a resident, and they presented a case of a person that had an unusual presentation, and in the middle of the presentation, I said to myself, this person has TB.

I've seen dozens of these at County, and

there is no question that this guy has TB. And I'm sitting there listening, and the case went on and on and the professor at the Department of Medicine, Stu Levin was talking.

The end result is the person had tuberculosis, and they said this is an extremely unusual case. And it was portrayed as being highly unusual and unique. And the fact of the matter was this was very common. Everyone at County had seen dozens of these, because we treat the population that has it.

And the term two unusual cases for people who work at the hospital is reflective, I think, of two important issues.

Number one, prisoners are not studied well at all. And there is a lack of investigation into problems that prisoners have, and that's related to the way society perceives prisoners.

In addition, physicians who do studies generally do not care for prisoners and so prisoners are not studied.

So Dr. Apple is saying that he works at Rikers and this is a fairly common occurrence. And he is writing about people reporting a case of

neuropathy, because in the literature it's not described. So somebody reports a case and there is -- we found only three articles, the fact of the matter is is that people who really work in institutions see this on a fairly regular basis and this is a neurologist, and he is saying this is a fairly common occurrence, so I want to make that comment, because I think this is important.

Q. You think this letter to the editor from Dr. Apple adds weight to what we've marked as 6?

A. I think it adds weight to my entire opinion. I think it speaks to the fact that the condition of neuropathy is something that is not studied and is not evaluated.

In fact, here at Rikers, I am sure -- well, let me rephrase that. I suspect that the inmate who complained to myself and to Mr. Conry about having numb hands was not evaluated as an example.

Q. But you don't know that; do you?

A. I don't know that at all.

Q. This letter to the editor concerns front-cuffed inmates, right?

A. I believe it does, but yes, he refers to

the Stone article, and I don't have that, so he is referring to an article that I do not have, so I'm not sure what the method of evaluation was.

Perhaps if you are willing, I can research the Stone article and review it for you.

Q. I suppose it's too late, but I appreciate it.

MS. HUTNER: Can we mark this as Exhibit 8?

(Puisis Exhibit Number 8 was marked for identification.)

Q. You have in front of you Exhibit 8 in this deposition, which is a chairman's memorandum from the New York State Commission on Correction.

You reviewed this?

A. Yes.

Q. For what purpose?

A. Because it might be pertinent to this matter.

Q. Do you believe it's pertinent to your medical opinion?

A. Yes, yes --

Q. How?

A. -- I do.

Q. How?

A. Well, it's a policy -- it's a memorandum on mechanical restraints.

Q. How does it inform your medical opinion?

A. Well, it's from the New York State Commission on Corrections, and it's to the sheriffs and jail administrators regarding mechanical restraints, so I think that's right in the ballpark.

Q. How does it inform your medical opinion?

A. Well, it makes me aware that there is awareness on the New York State Commission on Corrections' part that there needs to be some degree of prudence and caution in the application of mechanical restraints, and it gives guidelines on the use of restraints.

Q. Are you aware that the State Commission has specifically exempted New York City's transportation of Red ID inmates from that memorandum?

A. I don't --

MS. FREEMAN: Objection.

A. I don't know that.

Q. Does it alter the medical opinion that you've given?

A. No.

MS. HUTNER: Let's just mark these as Exhibits 9 and 10.

(Puisis Exhibit Numbers 9 and 10 were marked for identification.)

Q. Exhibits 9 and 10 in this deposition, which have just been marked, are medical charts that were provided to me this morning by Ms. Freeman with the representation that you had reviewed these charts.

Exhibit 9 is a medical record for David Gray.

Exhibit 10 is a medical file for Robert Hall.

Did you review those documents?

A. Briefly, yes.

MS. FREEMAN: I just want the record to reflect that these documents have previously been provided to you in discovery.

MS. HUTNER: That's fine.

Q. What, if anything, did you learn from either of these medical charts?

A. Well, I think it was interesting to review the charts, because I was able to see the

actual forms that are used for intake histories and the recording of physical examinations, but in addition to that, I believe on both records there were issues with the inmate either requesting modification Red ID status or physicians approving or giving recommendation for Red ID modification, and I think they were denied by security or stamped as such, and I thought that was important.

Q. You hadn't seen any intake forms or physical examination notation forms when you wrote either your declaration or your report?

A. You know, I can't remember, I don't believe I did. I do not believe I did. The report maybe, but not the declaration, the declaration I had not. The report -- I can't remember.

Q. If you had reviewed it before the time that you wrote your report, would you have noted that in your report?

A. I may have. I don't think I can give you a good answer to that.

Q. How long did you spend reviewing these records?

A. Briefly, maybe 15 minutes.

Q. In total?

A. 15 minutes, half hour, something like that, each.

MS. HUTNER: I'd like to take a couple of minutes' break at this point.

(Recess taken.)

MS. HUTNER: I have no further questions.

(Time noted: 3:47 p.m.)

_____

Subscribed and sworn to
before me this_____ day
of _____, 2002.

_____
Notary Public

CERTIFICATION

I, JACKLYN LISI, a Shorthand Reporter and notary public, within and for the State of New York, do hereby certify:

That MICHAEL PUISIS, the witness whose examination is hereinbefore set forth, was first duly sworn by me, and that transcript of said testimony is a true record of the testimony given by said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 22ND day of May, 2002.

Jacklyn Lisi

JACKLYN LISI

ERRATA SHEET

WITNESS: _____

TESTIMONY DATE: _____

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