

1 Michelle S. Michelson
2 AZ Bar No. 021234
3 ARIZONA CENTER FOR DISABILITY LAW
4 100 N. Stone, Ste. 305
5 Tucson, AZ 85701

6 Attorney for *Amicus Curiae*
7 Arizona Center for Disability Law

8 **IN THE SUPERIOR COURT OF THE STATE OF ARIZONA**
9 **IN AND FOR THE COUNTY OF PIMA**

10 PIMA COUNTY HUMAN RIGHTS
11 COMMITTEE, a State of Arizona
12 appointed committee;

13 Plaintiff,

14 vs.

15 ARIZONA DEPARTMENT OF HEALTH
16 SERVICES, an Arizona Administrative
17 Agency, et al.

18 Defendants.

NO. C20064700

AMICUS CURIAE BRIEF
OF THE ARIZONA CENTER
FOR DISABILITY LAW IN
SUPPORT OF PLAINTIFF

Assigned to: The Hon. Leslie Miller

19 **STATEMENT OF INTEREST OF AMICUS CURIAE**

20 The Arizona Center for Disability Law (“Center”) respectfully submits this *amicus curiae*
21 brief in support of the plaintiff, the Pima County Human Rights Committee (“PCHRC”). The
22 Center is the federally designated Protection and Advocacy system for people with disabilities
23 in the State of Arizona. See Protection and Advocacy for Persons with Mental Illness
24 (“PAIMI”) Act of 1986, 42 U.S.C. § 10801 et seq.; Developmental Disabilities Assistance and
25 Bill of Rights Act of 1975 (“DD Act”) 42 U.S.C. § 6041 et seq.; Protection and Advocacy of
26 Individuals Rights (“PAIR”) Program of the Rehabilitation Act, 29 U.S.C. § 794e. As such,
27 the Center is mandated by federal law to provide certain types of legal representation and
28 advocacy services to individuals with disabilities, including mental illness.

1 The Center has a significant interest in the outcome of this action because it will directly
2 affect the quality of oversight afforded to the deaths of individuals enrolled in the public
3 mental health system. The decision in this case will also help to clarify the roles and authority
4 of the State’s human rights committees for the mentally ill (“HRCs”), which the Center was
5 instrumental in creating as part of the ongoing class action, Arnold v. ADHS, Case No. C-
6 432355 (Maricopa Cnty Super. Ct.)(originally captioned and still commonly known as Arnold
7 v. Sarn). The Center is keenly interested in ensuring that the Arizona Department of Health
8 Services (“ADHS”) does not circumscribe the oversight, protection and advocacy work of the
9 HRCs in violation of state statutes and regulations.

10 SUMMARY OF ARGUMENT

11 **ADHS Should Not Be Allowed to Avoid Confidential, Internal Oversight Intended to** 12 **Assure that Individuals Receiving Mental Health Services Through ADHS Do Not Suffer** **Abuse and Neglect.**

13 In the decision under appeal, ADHS denied the request of the PCHRC for redacted mortality
14 review records and information. In doing so, ADHS has staked out a number of untenable
15 positions. First, ADHS offered a patently illogical reading of A.R.S. § 36-509 which
16 transformed what can only reasonably be understood as a mandate to provide information to
17 the HRCs into a discretionary choice by ADHS. Second, ADHS made the overly broad claim
18 that the reports regarding each death of a client prepared by the Regional Behavioral Health
19 Authorities (“RBHAs”) constitute protected peer review material.¹ Third, ADHS asserted that
20 the PCHRC is not authorized to receive quality assurance documents despite the fact that the
21 HRCs are committees of ADHS which have a quality assurance role.

22 ADHS’ decision demonstrates a fundamental misunderstanding of the role and legal authority
23 of the PCHRC. In this brief, the Center will provide relevant background regarding the history
24 of the development of the statewide HRC system in order to show that, if allowed to stand,
25 ADHS’ decision would undermine the intended purpose and the effectiveness of HRCs

26
27 ¹The issue of whether the requested documents constitute peer review material at all is
28 addressed in Plaintiff’s Opening Brief and will not be revisited here.

1 throughout the State.
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5 **ARGUMENT**

6 **A. The HRCs Have a Strong and Broad Mandate to Protect the Rights of Mentally Ill
7 Individuals.**

8 ADHS has the primary, non-discretionary responsibility for providing mental health services,
9 including a full continuum of care, to individuals in Arizona with serious mental illness. See
10 Arnold v. ADHS, 160 Ariz. 593, 601, 775 P.2d 521, 529 (1989)(*in banc*). The HRCs were
11 established to fulfill a central oversight function for the public mental health system in order to
12 provide an independent layer of protection within ADHS for those enrolled in the system.

13 ADHS adopted the provisions of the Arizona Administrative Code that authorized the creation
14 of Human Rights Committees as a direct result of litigation that the Center brought on behalf
15 of a class of seriously mentally ill individuals in Maricopa County. See A.A.C. R9-21-104,
16 105, 203, and 204.²

17 Arnold v. ADHS was filed in 1981 in response to the chaotic and inadequate nature of the
18 behavioral health system. In the Arizona Supreme Court’s 1989 *in banc* decision, the Court
19 rejected ADHS’ position that it did not have a duty to provide a full continuum of services to
20 seriously mentally ill individuals and upheld the trial court’s finding that ADHS had breached
21 its duty to provide community mental health services to the named plaintiffs. See Arnold v.
22 ADHS, 160 Ariz. 593, 775 P.2d 521 (1989)(*in banc*). The Court noted: “We write today from
23 the bottom rung of the ladder. The record before us demonstrates that Arizona is last among
24 the states of this union in providing care and treatment for its indigent chronically mentally

25
26 ²The case is commonly known as Arnold v. Sarn. At the time of filing, the Center was
27 part of the Arizona Center for Law in the Public Interest (“ACLPI”). In 1995, ACLPI split into
28 two separate entities, with the newly created Arizona Center for Disability Law assuming the
protection and advocacy responsibilities. The Arizona Center for Disability Law currently
serves as co-counsel with the ACLPI and the Center for Public Representation in that matter.

1 ill.” Arnold, 160 Ariz. at 594.

2 On May 6, 1991, the trial court in Arnold v. ADHS entered an Order approving a Stipulation
3 and adopting the terms of the parties’ proposed plan for implementing a comprehensive
4 community mental health system in Maricopa County. The implementation plan, entitled “The
5 Blueprint: Implementing Services to the Seriously Mentally Ill,” required ADHS to promulgate
6 rules that would set forth the rights of seriously mentally ill individuals, create a grievance and
7 appeal procedure, and provide for oversight of the system serving seriously mentally ill
8 individuals. In 1992, ADHS met this requirement by adopting Chapter 21 of Title 9 of the
9 A.A.C. (“Chapter 21”).

10 In the drafting of Chapter 21, the parties to Arnold v. ADHS adopted Human Rights
11 Committees as a key mechanism for improving the broken mental health system and for
12 building accountability and transparency into the ADHS structure. The PCHRC is one of the
13 seven regional Human Rights Committees established by Chapter 21 and codified in state law.
14 By design, all voting members of the HRCs are volunteers who serve because they have
15 expertise in a relevant field (psychology, law, medicine, education, special education, and
16 social work) and/or because they are themselves clients or former clients in the mental health
17 system or parents of clients enrolled in the mental health system. See A.R.S. 41-3803; A.A.C.
18 R9-21-105(B). While ADHS has authority relating to the appointment of HRC members, no
19 ADHS employee can be a voting member on the HRCs. See A.A.C. R9-21-105(C) and (E).
20 Thus, the HRCs are in the unique position of functioning as committees established within
21 ADHS that retain the independence that comes of being comprised of non-employees.

22 The question of independence is of great moment to the oversight role. In the hearing in the
23 instant action, the witness for ADHS, the Division Chief for the Consumer Rights Section
24 within the Division of Behavioral Health Services of ADHS, provided a description of the
25 functions of the Consumer Rights Section that demonstrates the inherent conflict of interests
26 faced by ADHS employees. The staff in the Consumer Rights Section function alternately as
27 advocates for seriously mentally ill complainants within the ADHS complaint system and as
28 representatives of the respondent (ADHS) in a quasi-judicial role issuing legal opinions

1 regarding the rights of complainants. See Supplemental Index of Record on Review (“SIRR”)
2 1 at p. 9 lines 15-23 and p. 10 lines 24-3.

3 The HRCs were designed to mitigate such conflicts of interest. They were created as part of
4 ADHS with the accompanying confidentiality requirements. Yet they are made up of
5 volunteers rather than employees of ADHS and, therefore, less subject to pressure either from
6 sub-contractors or from the ADHS structure itself with respect to providing critical advice and
7 recommendations to those in charge at ADHS.

8 State statute requires that HRCs provide independent oversight in three areas: (1) ensuring
9 that the rights of clients in the mental health system are protected; (2) providing research in the
10 mental health field; and (3) reviewing incidents of possible abuse, neglect or denials of a
11 client’s rights. See A.R.S. 41-3804(E). The HRCs’ duties are set forth in greater detail in state
12 regulations which require each HRC to fulfill six independent oversight and review functions:

13 Each committee shall, within its respective jurisdiction, provide independent oversight and
14 review of:

- 15 1. Allegations of illegal, dangerous, or inhumane treatment of clients and enrolled
16 children;
- 17 2. Reports filed with the committee under R9-21-203 and R9-21-204 concerning the use
18 of seclusion, restraint, abuse, neglect, exploitation, mistreatment, accidents, or injuries;
- 19 3. The provision of services to clients identified under R9-21-301 in need of special
20 assistance;
- 21 4. Violations of rights of clients and enrolled children and conditions requiring
22 investigation under Article 4 of this Chapter;
- 23 5. Research in the field of mental health according to A.R.S. § 41-3804(E)(2); and
- 24 6. Any other issue affecting the human rights of clients and enrolled children.

25 A.A.C. R9-21-105(G).

26 The legitimacy and effectiveness of the HRCs as an oversight mechanism rest on the fact that
27 HRCs are granted access to information or records to the extent necessary to fulfill each of the
28 committee’s duties. See A.R.S. 41-3804(I). See also A.A.C. R9-21-104(G), R9-21-105, R9-
21-203(B)(4), R9-21-204(W) and (X)(setting forth the HRCs’ access to information and
records).

**B. The HRCs Require the Requested Mortality Review Information In Order to
Function Efficiently and Effectively.**

HRCs face a daunting task. They review a high volume of incidents, accidents, uses of

1 restraint and seclusion, and deaths in addition to addressing multiple systemic problems. For
2 illustrative purposes, with regard to the quarter encompassing April through June 2006, the
3 Community Partnership for Southern Arizona (the entity that ADHS contracts with to provide
4 mental health services in Pima County and Southeastern Arizona) reported almost 430 critical
5 incidents and uses of seclusion and restraint, including 52 deaths, for clients within the
6 jurisdiction of the PCHRC. During the period 1996 to 1998, when significantly fewer people
7 were enrolled in the public mental health system than are currently enrolled, more than 200
8 people per year died while receiving behavioral health services through ADHS. See ACDL v.
9 Allen, 197 F.R.D. 689, 691 (D.Ariz. 2000).

10 It is important to recognize that the HRCs receive minimal administrative support and
11 technical assistance from ADHS. HRC members are required to review and weigh the
12 significance of a tremendous number of reports which are often cryptically and incompletely
13 filled out by service providers. One of the great difficulties of such oversight work is that there
14 will always be more deaths (not to mention non-fatal incidents) that raise concerns than can be
15 properly investigated. Without sufficient facts about each death, it can be extremely difficult
16 to identify which of the numerous deaths may implicate issues of inadequate care, abuse or
17 neglect.

18 The step of identifying problematic deaths is key to efficient and effective oversight. At the
19 administrative hearing in this matter, the ADHS witness conceded that it is important for HRCs
20 to obtain information regarding deaths as quickly as possible in order for the HRCs to provide
21 effective independent oversight and that requiring HRCs to request additional information
22 regarding individual deaths in a piecemeal fashion without the benefit of the mortality review
23 information was cumbersome and delayed the oversight process.³ See SIRR 1 at p. 37 lines
24

25 ³The ADHS witness also opined that HRCs should focus on aggregate data instead of
26 case specific information to increase their effectiveness. See SIRR 1 at 34. Certainly aggregate
27 data provides some important information. However, aggregate data shorn of individualized
28 facts does not provide sufficient information for real independent oversight. In the process of
reporting aggregate data, ADHS staff would necessarily make key subjective characterizations of
fact. For example, a chart of aggregate data regarding deaths would likely denote the cause of

1 17-21 and p. 38 lines 22-8.

2 According to the position ADHS would have this Court adopt, the HRCs would get only scant
3 information regarding almost all of these deaths. From that very brief information, the HRC
4 members would need to intuit which deaths they should ask follow up questions about in an
5 attempt to gather the requisite threshold of information that would convince ADHS to open
6 formal investigations. Although ADHS has taken the position that all the PCHRC needs to do
7 is ask for additional information regarding individual deaths, it must be noted that ADHS also
8 takes the position that whether or not ADHS actually provides such additional information is
9 fully within the discretion of ADHS pursuant to the interpretation of A.R.S. § 36-509(A)(11)⁴
10 being forwarded by the defendant.

11 Indeed, the very fact that ADHS misreads A.R.S. § 36-509(A)(11) to find for itself the
12 discretion to deny HRC requests for information demonstrates both the need for true
13 independent oversight and the importance of the judicial system's role in curbing the state
14 agency's tendency toward gatekeeping. ADHS' position here is reminiscent of its past attempt
15 to limit the information it provided to the Center regarding client deaths. In ACDL v. Allen,
16 197 F.R.D. 689 (D.Ariz. 2000), the Center prevailed, pursuant to federal law, in an action that:
17 (1) challenged ADHS' failure to provide Mortality & Morbidity Reports and Addendums to
18 the Center in a timely manner, and (2) confronted ADHS' practice of providing specific client
19 death information to the Center only in those cases where ADHS had determined probable
20 cause existed that abuse or neglect had occurred. In that case, the court held that ADHS cannot
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23 particular deaths as the result of natural causes, suicide, accident, etc. However, for the HRC to
24 independently determine whether a death noted to have resulted from natural causes did or did
25 not relate to inadequacies in the individual's mental health care, the HRC would need the more
26 detailed information contained in the records the HRC is now requesting.

27 ⁴A.R.S. § 36-509(A)(11) clarifies that one exception to the statutory confidentiality of
28 client's health care records is that those records can be released to HRCs (usually in redacted
form). ADHS has taken the untenable position that the wording of this statute places full
discretion in ADHS as to whether it actually releases such records. The flaws in ADHS'
statutory interpretation of this provision are addressed in Plaintiff's Opening Brief.

1 second-guess the Center’s determination regarding whether there is probable cause to believe a
2 death implicates abuse or neglect. The court reasoned that such an interpretation of the law
3 would be unreasonable in that it would severely undermine the oversight role of the Center.
4 ACDL v. Allen, 197 F.R.D. at 693.

5 While the federal statutory authority granting the Center access to information and records is
6 different from the state laws that empower the HRCs, the central point about whether ADHS
7 has the power to second-guess its oversight bodies is instructive. Just as in ACDL v. Allen,
8 allowing ADHS in this case to control the information it provides to an oversight entity would
9 frustrate the purpose of establishing an effective oversight system. Id. ADHS is asking this
10 court to sanction its choice of a gatekeeper role with regard to limiting the HRCs access to
11 information about deaths.

12 Interestingly, in ACDL v. Allen, although ADHS was resisting the disclosure of information
13 relating to deaths, ADHS did not take the position that it was not required to release mortality
14 review records on the ground that they constituted protected peer review information. In a
15 case roughly contemporaneous to ACDL v. Allen, state officials in Pennsylvania tried and
16 ultimately failed to avoid disclosing death-related records to the federal statutory protection
17 and advocacy system in that state on the ground that the records were protected by a state law
18 peer review privilege. See Pennsylvania Protection & Advocacy, Inc. v. Houstoun, 228 F.3d
19 423 (3d Cir. 2000). Following the lead of the Third Circuit in Houston, federal courts have
20 consistently held that the federal PAIMI Act grants federal protection and advocacy systems
21 access to peer review documents. See, e.g., Center for Legal Advocacy v. Hammons, 323 F.3d
22 1262 (10th Cir. 2003); Connecticut Office of Protection and Advocacy for Persons With
23 Disabilities v. Kirk, 354 F.Supp.2d 196 (D.Conn. 2005). In those cases, the courts relied
24 heavily on the fact that the federal protection and advocacy systems are statutorily bound by a
25 duty of confidentiality. See Houstoun, 228 F.3d at 428-429. While the federal statutes at issue
26 in those cases are not applicable here, the same reasoning applies in this case in that the HRCs
27 are also statutorily bound by a duty of confidentiality equal to that which applies to ADHS.
28 This point will be explored more closely in the following section.

1 **D. The State Law Protecting ADHS' Peer Review Material Was Not Intended to Limit**
2 **the HRCs' Statutory Access to Information.**

3 At the hearing before the Office of Administrative Hearings ("OAH") in this matter, ADHS
4 argued that the HRCs were not statutorily entitled to mortality review information and that
5 releasing such information to the HRCs may subject the same information to wider disclosure.
6 See SIRR 1 at p. 43 lines 1-2. This argument does not square with the broad grant of access to
7 information and records contained in A.R.S. § 41-3804(I), the confidentiality requirement
8 contained in A.R.S. § 41-3804(I), or with the protection granted to the information and records
9 supplied to HRCs that is contained in A.R.S. § 41-3804(K).

10 First, A.R.S. § 41-3804(I) establishes that HRCs are to have broad access to confidential
11 information that goes beyond client "records," as that term is defined in A.R.S. § 36-501(40).
12 As A.R.S. § 41-3804(I) states: "Subject to federal law, committee members and consultants
13 have access to client information and records maintained by the appropriate department,
14 provider or regional behavioral health authorities to the extent necessary to conduct committee
15 duties." (Emphasis added).

16 Second, A.R.S. § 41-3804(I) contains its own confidentiality requirement: "Each person who
17 receives information or records pursuant to this subsection shall maintain the information or
18 records as confidential and sign an agreement to comply with all confidentiality requirements."
19 If one accepts ADHS' argument that A.R.S. § 36-509(A)(11) (which addresses the disclosure
20 of client records to HRCs and requires HRCs to keep such records confidential) refers only to
21 client "records" as those are narrowly defined in A.R.S. § 36-501(40), then it follows that the
22 confidentiality requirement contained in A.R.S. § 41-3804(I) encompasses **more** confidential
23 information than is covered by A.R.S. § 36-509(A)(11). Indeed, the plain language of the
24 confidentiality requirement in A.R.S. § 41-3804(I) is broad enough to cover both traditional
25 client records and the confidential client information that is excluded from the formal
26 definition of the term client "records" in A.R.S. § 36-501(40). Moreover, if the confidentiality
27 requirement contained within A.R.S. § 41-3804(I) did not encompass more than the
28 confidentiality requirement which relates specifically to client records in A.R.S. § 36-509, the

1 language would be simply redundant. Such an interpretation would violate the basic tenet of
2 statutory construction that there is a “presumption that the legislature does not include in
3 statutes provisions which are redundant, void, inert, trivial, superfluous, or contradictory.” See
4 Yarbrough v. Montoya-Paez, — P.3d — , 2006 WL 3190320 (Ariz. App. November 6,
5 2006)(quoting State v. Moerman, 182 Ariz. 255, 260, 895 P.2d 1018, 1023).

6 Third, even assuming that the records at issue constitute peer review material, A.R.S. § 41-
7 3804(K) clarifies that the broad grant of access contained in A.R.S. § 41-3804(I) was not
8 intended to be circumscribed by A.R.S. § 36-2403. In A.R.S. § 41-3804(K), rather than
9 keeping quality assurance documents from the HRCs, the legislature made clear that
10 documents provided to the HRCs are covered by the same protection against subpoena,
11 discovery, and use in legal actions as protect the original ADHS documents. That provision
12 states: “Confidential records and information received by the committee or its consultant are
13 subject to the same provisions concerning subpoenas, discovery and use in legal actions as are
14 the original records and information.” This language would be superfluous if the only access
15 to confidential information granted by A.R.S. § 41-3804(I) was to client records as those are
16 more narrowly defined in A.R.S. § 36-501(40). The reference to protection against subpoenas,
17 discovery and use in legal actions shows that the legislature clearly contemplated that the
18 HRCs would have access to quality assurance documents to which such protections apply.

19 As mentioned above, the federal courts that rejected attempts to keep peer review material
20 from federal protection and advocacy systems reasoned that the statutory confidentiality
21 requirement binding those oversight entities supported the disclosure of peer review material to
22 them. See Pennsylvania Protection & Advocacy, Inc. v. Houstoun, 228 F.3d 423 (3d Cir.
23 2000), Center for Legal Advocacy v. Hammons, 323 F.3d 1262 (10th Cir. 2003); Connecticut
24 Office of Protection and Advocacy for Persons With Disabilities v. Kirk, 354 F.Supp.2d 196
25 (D.Conn. 2005). In this case, the confidentiality provision and protection against subpoena,
26 discovery, and use in legal actions that apply to information shared with HRCs provide a
27 strong basis for disclosing the requested information to the PCHRC. In fact, the reference to
28 subpoenas, discovery, and use in legal actions contained in A.R.S. § 41-3804(K) is even more

1 explicit than the confidentiality provision contained in the federal PAIMI Act upon which the
2 federal courts relied.

3 Against this statutory framework, ADHS cannot defend its position that the PCHRC was not
4 entitled to mortality review information under A.R.S. § 41-3804(I) nor can it find any support
5 for the position that A.R.S. § 36-2403 was intended to limit the access to information and
6 records provided to HRCs under A.R.S. § 41-3804(I). Rather, ADHS is attempting to reign in
7 the broad mandate of A.R.S. § 41-3804 by disregarding its clear directive force and relying
8 upon a very narrow interpretation of its own policies. This approach is readily apparent in an
9 interchange between ADHS counsel and the ADHS witness at the OAH hearing in this matter:

10 “[ADHS counsel]: Now, client-related information is a pretty broad category; is it not?”

11 [ADHS witness]: I’m sorry. Can you –

12 [ADHS counsel]: Client-related information.

13 [ADHS witness]: Yeah.

14 [ADHS counsel]: So the department has issued certain policies to try to operationalize that
15 or narrow it down to make it administratively workable?

16 [ADHS witness]: Right....”

17 SIRR 1 at p. 14 lines 23-6 (emphasis added).

18 It is not the place of ADHS to “narrow down” the client-related information available to
19 HRCs. An agency cannot properly “operationalize” a statute by narrowing its scope or
20 mandate. It is one of the first principles of administrative law that statutes control regulations
21 and regulations control policies promulgated by state agencies. When a state agency interprets
22 a policy in a way that conflicts with controlling authority, the policy (or the narrow
23 interpretation of the policy) must fall. Cf. Houstoun, 228 F.3d at 427-428 (holding that a
24 regulation which represents an unreasonable interpretation of a statute must be rejected). In
25 this matter, ADHS has over-stepped its authority by attempting to limit the scope and strength
26 of A.R.S. § 41-3804.

27 **E. The Fact That the Center has Access to Mortality and Morbidity Reports Does Not**
28 **Negate the Need for the HRCs to Receive Mortality Review Records.**

1 The Center and the HRCs work to protect and advocate for individuals with serious mental
2 illness by fulfilling distinct, though complementary, functions. The Center was designated as
3 the protection and advocacy system for Arizona in 1986, prior to the establishment of the
4 HRCs. Thus, the creators of the HRCs were well aware of the Center's role and of the need for
5 additional detailed oversight within ADHS. The Center can only initiate a limited number of
6 cases and full investigations. It cannot provide detailed oversight of the entire mental health
7 system alone due to its limited resources. For example, the Center currently has only two staff
8 attorneys and two staff advocates responsible for covering the entire public mental health
9 system in Arizona. Therefore, a large part of the role of the Center is to advocate for the State
10 to improve its own internal investigations. Consistent with this goal, the HRCs were created
11 within ADHS as an internal check on the State's oversight system to complement the Center's
12 role as a non-state entity.

13 Moreover, while the Center is granted broad authority pursuant to federal law to carry out
14 monitoring activities and to demand information from ADHS once it becomes aware of
15 potential abuse and neglect, the HRCs are, in some respects, privy to more information than the
16 Center on an automatic basis. That is, state regulations and policies mandate that the HRCs
17 receive, as a matter of course, many more incident reports than the Center receives on a day-to-
18 day basis, particularly with regard to incidents involving restraint and seclusion that do not
19 result in injury. Compare, e.g., A.A.C. R9-21-104(G), R9-21-105, R9-21-203(B)(4), R9-21-
20 204(W) and (X)(reports to be provided regularly to HRCs) to A.A.C. R9-20-202(B)(state
21 regulations regarding mandatory automatic reporting to the Center). Thus, with regard to their
22 geographic region of jurisdiction the HRCs are in some ways in a better position than the
23 Center to recognize systemic problems and patterns of abuse and neglect early on. The statutes
24 and regulations creating the HRCs clearly intended that the HRCs have the ability to see the
25 larger picture of systemic problems that comes into focus when viewing both the non-fatal
26 incidents and the deaths together. Therefore, it is especially important that ADHS not constrict
27 the flow of information to the HRCs regarding client deaths.

28 CONCLUSION

1 ADHS' decision to deny the PCHRC's request for mortality review information violates the
2 spirit and letter of the state laws and regulations that mandate the Human Rights Committees to
3 provide independent oversight over ADHS. For the foregoing reasons, and those set forth in
4 the Opening Brief of the Plaintiff, ADHS' decision in this matter should be overruled and the
5 PCHRC should be granted access to the mortality review records it is requesting.

6 RESPECTFULLY SUBMITTED THIS 30th day of November, 2006.

7 ARIZONA CENTER FOR DISABILITY LAW

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Michelle S. Michelson
Attorney for *Amicus Curiae*

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13 Original of the foregoing filed this
14 ___ day of November, 2006, with:

15 Clerk of Pima County Superior Court
16 110 W. Congress
Tucson, AZ 85701

17
18 Copy of the foregoing hand-delivered this
___ day of November, 2006, to:

19 The Honorable Leslie Miller
20 Pima County Superior Court
110 W. Congress
21 Tucson, AZ 85701

22
23 Copy of the foregoing mailed this ___ day of
November, 2006, to:

24 Peter Akmajian
25 Michele G. Thompson
CHANDLER & UDALL, LLP
33 North Stone, Ste. 2100
26 Tucson, AZ 85701
Attorneys for Plaintiff Pima County Human Rights Committee

27
28 Joel Rudd
Assistant Attorney General

1 ARIZONA ATTORNEY GENERAL
1275 West Washington St.
2 Phoenix, AZ 85007-8329
3 *Attorney for Defendant*

4 By _____
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