UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

JAY F. VERMILLION, Plaintiff,	)	
v.	)	Civil Action No. 1:15-cv-605-RLY-TAB
MARK E. LEVENHAGEN, Superintendent, *et al*.,	)	
Defendants.	)	

BRIEF IN SUPPORT OF PLAINTIFF'S MOTION TO EXCLUDE EXPERT WITNESS ROBERT MORGAN FROM TESTIFYING

Plaintiff Jay Vermillion is seeking justice for four years of forced, isolated confinement in the Indiana Department of Corrections. Supporting his case is planned expert testimony from two highly respected authorities on solitary confinement. These experts, Terry Kupers, M.D., and Dan Pacholke, will opine as to the mental and physical toll solitary conditions exact on prisoners and the more humane alternatives Defendants ought to have employed.

Defendants tender Robert Morgan, Ph.D., to rebut this testimony. *See* Morgan Report (Ex. 1). Dr. Morgan did not evaluate Mr. Vermillion. He has never stepped foot in an Indiana prison. He espouses an outlier view that minimizes the harms of solitary confinement and relies on a thoroughly discredited "meta-analysis" ignoring decades of research. His methods interpreting the meta-analysis are fatally unsound. Dr. Morgan's testimony will serve only to mislead the jury with a false veneer of objectivity. Accordingly, Mr. Vermillion asks the court to bar the testimony in its entirety.

I. BACKGROUND

A. Dr. Morgan's Limited Experience Studying and Assessing the Effects of Solitary Confinement

Dr. Morgan holds a doctoral degree in counseling psychology from Oklahoma State University. Morgan Dep. (Ex. 4) at 11:12–15. He is a professor at Texas Tech University and supervises students providing substance use and mental health services to probationers. *Id.* at 10:22–25; 36:23–17. Dr. Morgan also directs the Forensic Science Institute at Texas Tech. *Id.* at 121:16–19. Much of his forensic practice is evaluating the competency of criminal defendants to stand trial and assessing criminal responsibility. *Id.* at 41:16–42:23; Ex. 1 at 4.

Dr. Morgan cites "20 years of providing correctional and forensic services to inmates and criminal defendants," Ex. 1 at 3, but very little experience assessing the risk of solitary confinement on prisoners. The "20 years" includes a 10-year stint at the Lubbock Mental Health Retardation Center, where he developed a jail-based competency restoration program, as well as approximately 1000 forensic examinations related to criminal responsibility and competency to stand trial. *Id.* at 4; Ex. 4 at 42:15–43:12. It also includes work with a school district on jail reentry programs. Ex. 1 at 4.

Dr. Morgan's experience providing mental health services in segregation units is minimal and temporally remote. In the early 1990's, he completed a ten-week internship under the supervision of a psychologist at the US Penitentiary in Leavenworth. Ex. 1 at 3; Ex. 4 at 44:1–11. He did not serve prisoners in segregation. Ex. 4 at 44:12–15. He then worked as an unlicensed mental health professional at one maximum-security prison in Kansas for approximately 18 months. Ex. 1 at 3; Ex. 4 at 44:16–46:11. There his duties extended to a segregation unit with an average length of stay of 30–60 days for disciplinary segregation and one year for administrative segregation. Ex. 4 at 46:12–17; 49:3–17; 50:19–22. He sometimes

provided back-up coverage to a segregation unit with an average length of stay of two to three years. *Id.* at 49:18–20; 50:19–51:4. He spent six months at a minimum-security facility, where the average length of stay in segregation was two-to-three days. *Id.* at 51:5–14. He completed a pre-doctoral internship at a federal prison from 1998–1999. Ex. 1 at 2; Ex. 4 at 51:15–25. Exposure to solitary confinement during his internship was limited to a four-month rotation during which he performed mental health rounds in a segregation unit one day a week. Ex. 4 at 52:1–53:13.

Dr. Morgan's other correctional experience is his work consulting for a private company that contracts to provide mental health services to prisons, and consulting on litigation. *Id.* at 54:18–55:7; 57:18–58:1. He cites involvement (for the defense) on cases challenging the practice of solitary confinement in California, Canada, and Alabama. *Id.* at 57:18–58:1. In Alabama, Dr. Morgan toured prisons but did not assess any prisoners. *Id.* at 57:24. No federal court has qualified Dr. Morgan to testify as an expert witness. And as will be discussed, courts have been sharply critical of Dr. Morgan's work.[1] Despite Dr. Morgan's involvement in the Canada litigation, a Canada Court of Appeals deemed solitary confinement unconstitutional and barred it after 15 days. *Canadian Civil Liberties Association v. Canada (Attorney General)*, 2019 ONCA 243 (2019) (excerpts attached as Ex. 7) at ¶ 150.

Dr. Morgan's scholarly work only recently has turned to the topic of solitary confinement. His curriculum vitae categorizes 82 publications as peer-reviewed, of which three pertain to solitary confinement. Morgan CV (Ex. 2) at 2–9; Ex. 4 at 13:13–14:2. The most

[1] *See Brazeau v. Attorney General (Canada)*, 2019 ONSC 1888 (2019) ("I do not give much weight to Dr. Morgan's meta-analysis conclusions") (excerpts attached as Ex. 5) ¶ 182; *Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491 (2017) (excerpts attached as Ex. 6) ¶¶ 94–95 ("I do not accept Dr. Morgan's evidence that some [prisoners] will be harmed, and a significant number will not."; "I specifically do not accept his evidence for concluding that some inmates will experience no serious permanent negative mental health effects from prolonged administrative segregation.").

recent of the three, a 2018 study in Kansas prisons, was a student project that he supervised. Ex. 4 at 14:6–13; 191:19–18. Dr. Morgan is listed fourth out of the four authors on that study. Ex. 2 at 3. The second, entitled, "Questioning solitary confinement: Is administrative segregation as bad as alleged?" appeared in *Corrections Today*. Ex. 4 at 14:14–19; Robert D. Morgan et al., *Questioning Solitary Confinement: Is Administrative Segregation As Bad As Alleged?*, CORRECTIONS TODAY (September/ October 2017) (attached as Ex. 8). *Corrections Today* is the magazine for the American Correctional Association. Ex. 4 at 14:20–22. Although Dr. Morgan categorized this article as "peer-reviewed," publication in *Corrections Today* is not decided by research psychologists and psychiatrists, but by those in the corrections industry. Ex. 4 at 14:23–15:6. Moreover, Dr. Morgan's article appeared in a section of the magazine called "Speak Out," which is an opinion column. *See Questioning Solitary* (Ex. 8) at 1; *Corrections Today*, AMERICAN CORRECTIONAL ASSOCIATION (attached as Ex. 9) at 4.[2]

Dr. Morgan's signature research on solitary confinement is a 2016 meta-analysis purporting to quantify the harms of solitary confinement. *See* Ex. 1 at 9–10; Ex. 4 at 19:11–17. The meta-analytic study includes two meta-analyses, Research Synthesis 1, directed by a Canadian researcher, and Research Synthesis 2, directed by Dr. Morgan. Ex. 4 at 156:8–23; *see generally* Robert D. Morgan et al., *Quantitative Syntheses of the Effects of Administrative Segregation on Inmates' Well-Being*, PSYCHOL., PUB. POL'Y & L. (Aug. 2016) (attached as Ex. 10) at 4. The meta-analytic study disregarded decades of respected research in favor of a small number of studies that do not represent the body of work on this topic. The reliability of Dr. Morgan's meta-analysis has been heavily criticized, and at least one court has rejected it. *See Brazeau v. Attorney General (Canada)*, 2019 ONSC 1888 (2019) (excerpts attached as Ex. 5) at

[2] Available at http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Publications/Corrections_Today_Magazine/ACA_Member/Publications/CT_Magazine/CorrectionsToday_Home.aspx (last visited June 20, 2019).

¶ 182 ("I do not give much weight to Dr. Morgan's meta-analysis conclusions."); Craig Haney, *The Psychological Effects of Solitary Confinement: A Systematic Critique*, 47 CRIME AND JUSTICE 365 (Jan. 2018) (attached as Ex. 11) at 398 *et seq.*

Dr. Morgan also cites his receipt of funding to conduct research in the field of corrections as evidence of his qualifications. Ex. 1 at 2–3. But he has received no funding to research the effects of solitary confinement. Ex. 4 at 34:7–16. In fact, the National Institute of Justice rejected his grant proposal to perform a longitudinal study of the consequences of solitary confinement after a peer-review committee identified methodological concerns with his proposed study. *Id.* at 34:13–36:22.

B. Dr. Morgan's Methods in this Case

The bulk of Mr. Vermillion's 1,513 days of isolation occurred on Department-Wide Administrative Segregation status in the Westville Control Unit (WCU). Both Dr. Kupers and Mr. Pacholke toured the WCU to study its layout, operations, and atmosphere. The WCU is a stand-alone facility within the Westville Correctional Complex of 224 solitary beds divided among four separate pods. Its features breed solitude. A Human Rights Watch Report described the WCU's solid steel, boxcar doors as "effectively cut[ting] inmates off from the world outside the cell, muffling sound and severely restricting visual stimulus." Human Rights Watch, *Cold Storage: Super-Maximum Security Confinement in Indiana* at 15 (Oct. 1997). The sole area for "outdoor" recreation in the WCU is a small, walled-in enclosure with a patch of sky. Human Rights Watch described the sensation of standing within it as "akin to being at the bottom of a well." *Id.* at 17.

Dr. Morgan did not join the view scheduled for the Plaintiff's experts, nor did he visit the WCU (or *any* Indiana facility) to inform his opinions. Ex. 4 at 81:13–19. In his deposition, Dr.

Morgan was not even able to provide the name of the facility where Mr. Vermillion was in solitary confinement, *id.* at 85:15–18, much less ground his opinion in knowledge of that facility's unique characteristics, *id.* at 85:20–86:23.

Nor did Dr. Morgan examine Mr. Vermillion. *Id.* at 83:14–15. Dr. Morgan had no explanation for why he did not examine Mr. Vermillion, other than that there was insufficient time. *Id.* at 83:19–20. Defense counsel never reached out to Plaintiff's counsel to ask whether Mr. Vermillion could be made available for an in-person evaluation by Dr. Morgan. Instead, Dr. Morgan limited his investigation in this case to document review. *Id.* at 81:6–12.

C. Dr. Morgan's Proposed Testimony

Dr. Morgan offers three overarching opinions.

First, Dr. Morgan seeks to criticize Dr. Kupers' findings regarding the effects of solitary confinement on Mr. Vermillion. Ex. 1 at 5.

Second, Dr. Morgan plans to opine that the serious risks of psychological harm from solitary confinement, as described by Dr. Kupers and Mr. Pacholke, are not universally experienced. He intends to tell the jury that on average, solitary confinement produces mild to moderate health effects as compared to the general population, with some people experiencing negative effects, some experiencing no negative effects, and some improving. *Id.*

Third, Dr. Morgan intends to testify that Mr. Pacholke's discussion of correctional industry standards is incorrect. *Id.*

II. LEGAL STANDARD

Rule 702 of the Federal Rules of Evidence, which governs the admissibility of expert opinions, provides that:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an

> opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

The district court plays the role of gatekeeper by examining: (1) the proposed expert's qualifications; (2) the reliability of her methodology; and (3) the relevance of her testimony. *Gopalratnam v. Hewlett-Packard Co.*, 877 F.3d 771, 779 (7th Cir. 2017).

Rule 702 requires the Court to ensure that expert evidence "is not only relevant, but reliable." *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 589 (1993). The reliability requirement serves to distinguish a well-grounded expert opinion, which is admissible, from "subjective belief," which is not. *Id.* at 590. The purpose of this gatekeeping is "to make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. at 157, 137 (1999). "[N]othing . . . requires a district court to admit opinion evidence" that rests solely on "the *ipse dixit* of the expert." *Id.* at 157.

The Court has "considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable." *Id.* at 152. Courts consider the proposed expert's full range of experience and training in the subject area, as well as the methodology used to arrive at a particular conclusion. *Smith v. Ford Motor Co.*, 215 F.3d 713, 718 (7th Cir. 2000).

In addition to being reliable, expert testimony must "assist the trier of fact to understand the evidence or determine a fact at issue." *Lewis v. CITGO Petroleum Corp.*, 561 F.3d 698, 705 (7th Cir. 2009). The burden of admission rests with the proponent of the expert testimony. *Id.*

III. ARGUMENT

A. Dr. Morgan Is Not An Appropriately Qualified Expert.

Dr. Morgan's published and peer-reviewed scholarship on solitary confinement consists of one meta-analytic study summarizing research performed by others, and one student project he supervised.[3] Ex. 2 at 2–9; Ex. 4 at 13:13–14:2; 14:6–13; 19:11–20; 191:19–93:2. When he applied to the National Institute of Justice to fund his own research into the effects of solitary confinement, peer reviewers rejected it for methodological concerns, the specifics of which he claimed not to remember at his deposition. Ex. 4 at 34:13–36:22. His clinical experience in prison is more than 20 years old and consists primarily of two years working in segregation units with prisoners there for periods far shorter than is relevant here. *Id.* at 44:16–51:14. Since receiving his doctorate degree, Dr. Morgan's principal activities as a practicing psychologist have not involved prisoners in solitary confinement. He worked for a decade at the Lubbock Regional Mental Health Mental Retardation Center, and he now supervises students working with probationers. *Id.* at 43:5–12; 36:23–37:17. He has a significant practice performing competency examinations in criminal justice matters, and he at times consults for a private prison contractor. *Id.* at 41:16–42:3; 39:13–17. He has also consulted for a private company providing psychological services for the Dallas Cowboys at the NFL Combine. *Id.* at 43:12–17. He has not examined Mr. Vermillion, has not toured the WCU, and has no familiarity with the

[3] Dr. Morgan could not recall basic details of the 2018 Chadick study, i.e., whether it included the segregation units he worked at in the early 1990s:

> Q: And did the study evaluate prisoners in some of the same segregation units that you yourself had worked in when you were a mental health professional in Kansas?
>
> **A: That I don't know. That's a—I never thought of that. That's a—I don't know. I'd have to ask the lead author.**

Ex. 4 at 192:22–93:2.

Indiana Department of Corrections. *Id.* at 81:13–82:7. He could not even recall the name of the segregation unit where Mr. Vermillion was held. *Id.* at 85:15–19. He is not an expert on solitary confinement and should not be qualified as one.

B. Without Examining Mr. Vermillion, Dr. Morgan's Opinions Regarding His Mental Health Are Fatally Unsupported.

Like any expert, mental health professionals must root their opinions in adequate knowledge of the subject as to which they will testify. *See, e.g., Ancho v. Pentek Corp.*, 157 F.3d 512, 519 (7th Cir. 1998) (holding that a district court properly excluded an expert witness because, among other reasons, "he did not even see fit to visit the accident scene"); *O'Conner v. Commonwealth Edison Co.*, 13 F.3d 1090, 1107 (7th Cir. 1994) (adopting view that a medical expert should have reviewed relevant medical literature, reviewed Plaintiff's medical records, and done a thorough work-up of the Plaintiff); *but see Walker v. Soo Line R. Co.*, 208 F.3d 581, 591 (7th Cir. 2000) (lack of medical examination did not render expert's testimony on effects of electrical current on the body inadmissible) (citation omitted). Moreover, expert mental health witnesses must use methodology that "adhere[s] to the same standards of intellectual rigor that are demanded in [their] professional work in order to be reliable." *State Farm Fire & Cas. Co. v. Electrolux Home Products*, 980 F. Supp. 2d 1031, 1047 (N.D. Ind. 2013) (second alteration in original, citations omitted).

Dr. Morgan's specific field is forensic psychology. Individual evaluation is the foundation of forensic psychology and its primary method. Practice guidelines for forensic psychology require that "[f]orensic practitioners . . . only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings." *Specialty Guidelines for Forensic Psychology*, AMERICAN PSYCHOLOGICAL ASSOCIATION

(excerpt attached as Ex. 12) § 9.03 (Opinions Regarding Persons Not Examined).[4] "When it is not possible or feasible to examine individuals about whom they are offering an opinion," the ethical guidelines require that they "make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony." *Id.*

Dr. Morgan acknowledges that in his forensic practice, he would only testify as to a criminal defendant's competency after having evaluated them in person. Ex. 4 at 83:10–13. Under cross-examination, he agreed with the proposition that "a mental health professional has to evaluate someone to reach a conclusion as to their mental health." *Id.* at 83:5–9. Yet he never sought to evaluate Mr. Vermillion. *Id.* at 83:14–15. When asked why he chose not to examine Mr. Vermillion, Dr. Morgan indicated that he felt he did not have the time. *Id.* at 83:19–20; *cf. Fuesting v. Zimmer, Inc.*, 421 F.3d 528, 534–35 (7th Cir. 2005), *vacated in part on other grounds*, 448 F.3d 936 (suggesting that courts weighing an expert's reliability consider whether "the expert is being as careful as he would be in his regular professional work outside his paid litigation consulting") (quoting Fed. R. Evid. 702 advisory committee's note (2000)).

Dr. Morgan admits that, due to lack of familiarity with Mr. Vermillion, he cannot testify to Mr. Vermillion's mental health or the effects of solitary confinement on Mr. Vermillion. Ex. 4 at 82:22–24. *See Castrillon v. St. Vincent Hosp. & Health Care Ctr., Inc.*, 2015 WL 3448947, at *4 (S.D. Ind. May 29, 2015) (barring a psychology expert from diagnosing the defendant because, even though it would be in his expertise to do so, the expert "conceded in his deposition that he cannot make such a diagnosis, having never met [the defendant]."). Dr. Morgan therefore selects a roundabout approach, commenting on his mental health indirectly through critique of

[4] Available at https://www.apa.org/practice/guidelines/forensic-psychology (last visited June 20, 2019).

Dr. Kupers. But this limitation renders his conclusions questioning Dr. Kupers' findings totally lacking in foundation and inadmissible, as will be explained.

1. Dr. Morgan's Opinions Regarding the Need For Psychological Testing to Rule Out Malingering Should be Excluded.

Dr. Morgan opines that Dr. Kupers did not adequately rule out the possibility that Mr. Vermillion was malingering. Ex. 1 at 12. This opinion relies on prejudicial and offensive speculation as to Mr. Vermillion's alleged propensity for deceit. Dr. Morgan's opinions in this regard are unsupported and should be excluded.

As a preliminary matter, Dr. Kupers considered the possibility of malingering. He emphasized that it is "always important to rule out malingering in the course of a forensic examination." Kupers Report (excerpts attached as Ex. 13) at 42. He concluded based on his clinical examination that Mr. Vermillion was not exaggerating his symptoms, because he exhibited a tendency to minimize symptoms, not overstate them, and because the constellation of symptoms he described made sense in light of Mr. Vermillion's experiences. *Id.* In deposition, Dr. Morgan acknowledged that scholarly reports of the negative mental health consequences of solitary confinement were "not inconsistent" with Dr. Kupers' description of Mr. Vermillion's symptoms. Ex. 4 at 120:7–13. He agreed this consistency "could be an indication of honest reporting." *Id.* at 120:20–21. Nor is psychological testing an infallible, truth-telling serum. *Id.* at 118:14–17. Such tests can indicate that a person is malingering when they are not, and can conclude that a person is telling the truth when they are actually malingering. *Id.* at 118:18–19:1.

Nonetheless, Dr. Morgan opines that given Mr. Vermillion's (1) "incentive to deceive (i.e., for financial gain)," and (2) "his history of exhibiting an antisocial personality disorder," Dr. Kupers' use of the clinical interview to rule out malingering was insufficient. Ex. 1 at 12.

As to (1), Dr. Morgan has no basis for attributing to Mr. Vermillion a financial incentive to deceive. Under Dr. Morgan's formulation, every person examined as part of a lawsuit operates with the incentive to lie and deceive. Ex. 4 at 120:22–21:6.

In arriving at this conclusion, Dr. Morgan cites a study by Dr. Heilbrun and others supposedly finding that "the majority of persons (67%) assessed in a forensic context distorted their presentations in response to external motivations," Kirk Heilbrun et al., *An MMPI-Based Empirical Model of Malingering and Deception*, 8 BEHAVIORAL SCIENCES & THE LAW 45 (1990) (attached as Ex. 14), and asserts that financial gain is one such external motivation. Ex. 1 at 12. The subjects of the Heilbrun study, however, were patients at a forensic hospital committed as either incompetent to stand trial or not guilty by reason of insanity. Heilbrun et al. (Ex. 14) at 48. They were not civil litigants responding to purported "financial gain," and so these results are not in any way applicable to Mr. Vermillion. *See General Electric et al. v. Joiner*, 522 U.S. 136, 146 (1997) (upholding exclusion of expert opinions extrapolated from far-removed studies, finding that the studies were too "dissimilar to the facts presented in this litigation" to support the experts' conclusions). Moreover, Dr. Morgan's recitation of the Heilbrun results is misleading. *See* Ex. 1 ("67% . . . distorted their presentations in response to external motivations"). The Heilbrun study assessed the usefulness of a new approach to categorizing response styles by testing inter-rater reliability. Heilbrun et al. (Ex. 14) at 45. Of 159 subjects, researchers could not categorize 33% (52 subjects) using the new approach. *Id.* at 51. Of the remaining 67%, they classified 22% as Reliable respondents. *Id.* Forty-six percent of response styles were classified as Defensive (21%), Irrelevant (16%) or Malingering (9%). *Id.* The authors observed that Defensive and Irrelevant response styles were far more prevalent than

Malingering, notable due to the out-sized attention paid to the phenomenon.[5] *Id.* Furthermore, those response-style categories categorized as other than "reliable" do not uniformly fit Dr. Morgan's description of subjects "distorting their presentations in response to external motivations." For example, Irrelevant refers to a response style "when one does not become engaged in the evaluation process; responses are not necessarily relevant to question content and may be random." *Id.* at 45.

Additionally, Dr. Morgan's proposed testimony that all participants in a lawsuit have a motive to lie for financial gain is unduly prejudicial against civil litigants, Fed. R. Evid. 403, and usurps the jury's role as arbiter of credibility. *See Isaacs v. Hill's Pet Nutrition, Inc.*, 2008 WL 820273, at *3 (S.D. Ind. Mar. 25, 2008) ("those opinions of the doctors' opinions that appear to be reasonably calculated to opine on Isaacs' credibility generally, are inadmissible").

Dr. Morgan next cites *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers*, by Melton et al., as support for his assertion that "interview-based approaches to detecting malingering are of such limited utility" (citing Melton et al.), "that tests specially designed to detect malingering should be a routine part of forensic science." Ex. 1 at 12. Actually, the cited text espouses "a number of strategies . . . for systematically investigating response style." Melton et al., *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (2018) (excerpts attached as Ex. 15) at 58; Ex. 4 at 117:3–17. And it identifies *the clinical interview* as "the most common and venerable" among them. Melton et al. (Ex. 15) at 58; Ex. 4 at 117:13–21. The full quotation

[5] The 67% figure that Dr. Morgan references does not appear on the face of the study. *See* Heilbrun et al. (Ex. 14). Dr. Morgan appears to have removed the 52 out of 159 (33%) subjects that could not be categorized from consideration. Following that reduction, the 35 subjects deemed Reliable account for 33% of the remaining 107 subjects, and those classified as Defensive, Irrelevant or Malingering account for the remaining 67%. But that figure only accounts for 46% of the total 159 subjects, *not* "the majority of persons . . . assessed." *Cf.* Ex. 1 at 12.

from which Dr. Morgan cites is consistent with Dr. Kupers' approach of performing psychological testing only when the clinical interview suggests malingering. The *Handbook* reads: "Increasingly, mental health professionals have concluded that because interview-based approaches to detecting malingering are of such limited utility, employment of instruments specifically designed for this purpose should be considered the standard of practice *whenever there is a basis for suspecting over-reporting of symptoms*." Melton et al. (Ex. 15) at 59 (emphasis added); Ex. 4 at 117:22–18:13. And therein lies the problem: without examining Mr. Vermillion, Dr. Morgan lacks foundation to question Dr. Kupers' assessment that there was no basis for suspecting over-reporting.

Indeed, Dr. Morgan admits he is not qualified to opine as to the "standard of practice" for a psychiatrist (such as Dr. Kupers) performing such evaluations. When asked if conducting psychological testing for every person involved in a lawsuit was standard practice for psychiatrists, Dr. Morgan testified: "I don't know what the standard practice or best practice is for a psychiatrist being as that I'm not a psychiatrist. I can't—I can't opine on that." Ex. 4 at 122:10–13. Dr. Morgan therefore lacks expertise and grounds to conclude that Dr. Kupers should have done more to rule out the possibility that Mr. Vermillion was malingering.

As to (2), Dr. Morgan cannot base his opinions on Mr. Vermillion's unique mental health profile because he did not examine him. Yet Dr. Morgan opines that due to Mr. Vermillion's past antisocial personality disorder diagnosis, Mr. Vermillion has the propensity to be deceitful, thereby concluding that Dr. Kupers should have suspected malingering. Ex. 1 at 12.

Dr. Morgan describes antisocial personality disorder as a "condition marked by a pervasive pattern of disregard for and violation of the rights of others . . . as indicated by at least three symptoms, including breaking the law, deceitfulness, impulsivity, disregard for others'

safety, consistent irresponsibility, and lack of remorse." *Id.* at 12–13 (emphasis in original). Although Dr. Morgan acknowledges that a patient need only identify three out of six listed symptoms to warrant this diagnosis, he underlines "deceitfulness" and extrapolates from the mere fact of Mr. Vermillion's past diagnosis that he is a liar until proven otherwise.

Dr. Kupers rejected the antisocial personality disorder diagnosis based upon the results of his interview. Ex. 13 at 43. He noted that Mr. Vermillion had been diagnosed with antisocial personality disorder in the past. *Id.* But Dr. Kupers concluded that, "[w]hile that would be a relevant diagnosis for him as a much younger man, when he was abusing substances and getting in a lot of trouble, his current ability to plan ahead, work very hard and diligently on his legal pursuits, remain clean and sober and help other prisoners with their legal cases pretty much rules out the diagnosis of antisocial personality disorder." *Id.* For that reason, Mr. Vermillion's previous antisocial personality disorder had no relevance to Dr. Kupers' assessment of the interview's integrity.

Dr. Morgan agreed that "a mental health professional has to evaluate someone to reach a conclusion as to their mental health." Ex. 4 at 83:5–9. Without evaluating Mr. Vermillion, Dr. Morgan cannot say whether Mr. Vermillion currently meets criteria for an antisocial personality disorder diagnosis. Testimony as to a past antisocial personality disorder diagnosis that Dr. Morgan cannot say is still accurate will prejudice the jury against Mr. Vermillion without offering any probative value. Thus, this opinion should be excluded under Federal Rules of Evidence of 402 and 403, as well as 702.

2. Dr. Morgan's Opinions Alleging Confirmation Bias and Failure to Consider Preexisting Factors Are Inadmissible.

Dr. Morgan also criticizes Dr. Kupers for failing to rule out "confirmation bias" and "preexisting factors." Regarding confirmation bias, Dr. Morgan insists that Dr. Kupers should

have "demonstrate[d] efforts to minimize bias" due to his "extreme position." Ex. 1 at 13. He does not explain what Dr. Kupers should have done to minimize perceived bias. Without any grounding in scientific expertise, this attack on Dr. Kupers improperly invades the jury's role to weigh credibility. *See United States v. Hall*, 165 F.3d 1095, 1107 (7th Cir. 1999) ("[T]he credibility of eyewitness testimony is generally not an appropriate subject matter for expert testimony because it influences a critical function of the jury—determining the credibility of witnesses.") (citation omitted).

As to preexisting factors, the critique boils down to a repackaging of his opinion that Dr. Kupers did not rule out malingering. Dr. Morgan acknowledges statements Mr. Vermillion made during his clinical interview that "attribute his current mental health functioning to the effects of segregation," rather than preexisting, chronic concerns. Ex. 1 at 13. But he refuses to credit Mr. Vermillion's reported statements without psychological testing to prove their veracity. *Id.* However, "[e]xperienced forensic clinicians" such as Dr. Kupers, "develop their own interview questions" to detect malingering. Melton et al. (Ex. 15) at 58. Dr. Morgan cannot render an opinion on the need for psychological testing in Mr. Vermillion's case, because he did not examine him, and because he is unfamiliar with standard practice for forensic psychiatrists.

For these reasons, Dr. Morgan's opinions criticizing Dr. Kupers' assessment of Mr. Vermillion should be excluded and Dr. Morgan should not be permitted to testify to any aspect of Mr. Vermillion's mental health.

B. Dr. Morgan's Opinions Minimizing the Harms that Attend Solitary Confinement Are Based on Unreliable Methods and Data.

The *Daubert* framework for evaluating admissibility of expert testimony is equally applicable to the social sciences. *Tyus v. Urban Search Mgmt.*, 102 F.3d 256, 263 (7th Cir. 1996). Experts in the social sciences must derive their opinions from reliable methods and base

their opinions on sufficient facts and data in order for those opinions to be admissible. *Hale v. Gannon*, 2012 WL 3867039, at *1 (S.D. Ind. Sept. 5, 2012). Courts may consider additional factors bearing on reliability, including "[w]hether a theory or technique . . . can be (and has been) tested; [w]hether it has been subjected to peer review and publication; [w]hether, in respect to a particular technique, there is a high known or potential rate of error and whether there are standards controlling the technique's operation; and [w]hether the theory or technique enjoys general acceptance within a relevant scientific community." *Kumho Tire*, 526 U.S. at 149–50 (internal quotation marks and citations omitted).

1. Dr. Morgan Has No Basis to Conclude that Conditions in the Segregation Units He Has Studied Are Similar to Conditions at Issue in this Case.

Dr. Morgan seeks to opine that solitary confinement produces "mild to moderate health and mental health effects comparable to the effects of incarceration as a general matter," and that "some inmates placed in AS will experience negative effects, some will not experience negative effects, and some will experience improved functioning." Ex. 1 at 5. For these opinions to be admissible, they must be helpful to the jury. In other words, they must connect to the facts of the case. *Porter v. Whitehall Labs., Inc.*, 9 F.3d 607, 613 (7th Cir. 1993) ("Expert testimony which does not relate to an issue in the case is not relevant and, ergo, non-helpful.") (quoting *Daubert*, 509 U.S. at 591); *see also Hemmings v. Tidyman's Inc.*, 285 F.3d 1174, 1184 (9th Cir. 2002) ("Whether testimony is helpful within the meaning of Rule 702 is in essence a relevancy inquiry."); *United States v. Downing*, 753 F.2d 1224, 1242 (3d Cir. 1985) ("An additional consideration under Rule 702—and another aspect of relevancy—is whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute.").

Dr. Morgan cannot opine as to the harm of conditions at issue in this case because he has no exposure to them. He has never been to an Indiana prison, Ex. 4 at 81:18–19, has never been to the WCU, *id.*, and did not familiarize himself with literature about those conditions, *id.* at 82:8–14. *See, e.g., Ancho*, 157 F.3d at 519 (holding that a district court properly excluded an expert witness because, among other reasons, "he did not even see fit to visit the accident scene"). His report does not address the prison conditions at issue in this case. *Id.* at 85:20–86:1 ("Q: And your report doesn't describe the segregation unit at issue in this case, correct? A: No, not beyond what was reported in Dr. Kupers' and Mr. Pacholke's report."). He acknowledges that segregation in the United States is not uniform and that variation in conditions matters a great deal:

> Q: Do you agree that the conditions in segregation vary across facilities in prison systems?
> **A: I do.**
> Q: Do you agree that those conditions are important in assessing the effects of segregation on prisoners?
> **A: I do.**
> Q: For example, do you agree that the degree of isolation varies across prison segregation units?
> [Objection as to form.]
> **A: I do.**
> Q: And is it important in evaluating a segregation unit to be aware of the degree of isolation?
> **A: Yes.**

Id. at 84:9–22.

In the other solitary confinement cases Dr. Morgan has worked on, he made the effort to tour the facility so as to have a basis for his opinion. *Id.* at 57:22–25 (describing touring prisons in Alabama, California, and Canada). Dr. Morgan said that he did not tour the WCU because he was not asked to opine "as to Mr. Vermillion's mental state as it pertained to the effects of segregation." *Id.* at 85:10–12. But "the effects of segregation" is the precise topic of Dr.

Morgan's report. *See* Ex. 1 at 1 ("the use of restrictive housing (such as AS) will, on average, produce mild to moderate physical and mental health effects comparable to the effects of incarceration as a general matter"). He grounds his opinions as to the effects of segregation by relying on his experience in Kansas, *id.* at 3, his litigation work in Alabama, California and Canada, *id.* at 4, and studies of systems in Colorado, Kansas, and Canada. *Id.* at 6–8 (citing O'Keefe 2010, Chadick 2018, and Zinger 2001, respectively). None of the sources he relies on provides a sufficient basis for understanding conditions in the WCU. Because Dr. Morgan's opinions are not tethered to the conditions at issue in this case, they are irrelevant, will not help the jury assess the effects of segregation at the WCU, and should be excluded.

2. Dr. Morgan Relies on Inapplicable Studies and Misleading Data.

Dr. Morgan's 2016 meta-analysis shapes his view that solitary confinement produces "mild to moderate health and mental health effects on average," comparable to the consequences of general imprisonment, and that some individuals in solitary confinement will experience negative consequences, while some will improve and others will remain unchanged. Ex. 1 at 11. A court in Canada, informed by preeminent scholars in this field of serious errors in the meta-analysis, did not "give much weight to Dr. Morgan's meta-analysis conclusions." Ex. 4 at 63:3–16. Dr. Craig Haney has authored an article thoroughly exposing these errors. *See* Haney (Ex. 11) at 398–407. Dr. Morgan's meta-analysis is fatally flawed, as are the ways in which he attempts to derive meaning from the results.

First, Dr. Morgan's meta-analytic study excludes most relevant data on the harms of solitary confinement. *Id.* at 399–400. Meta-analysis is a tool to measure the "magnitude of relationships between variables." *Id.* at 398. The integrity of Dr. Morgan's meta-analytic approach requires that there be multiple, high-quality controlled studies whose effect sizes can

then be synthesized. But "[t]he prison setting rarely lends itself to collection of meaningful quantitative data capable of generating the kinds of effect sizes on which meta-analyses depend." *Id.* That is, there are few quantitative, controlled studies of the effect of segregation on prisoners, because it is unethical to demand that prisoners endure the torture of solitary confinement solely for research. *See* Ex. 4 at 135:14–36:2 ("Q: And the research that's developed on solitary confinement has not, in fact, relied on control studies because of the difficulties in conducting such studies in prison, right? A: Yes, that's one of the primary issues.")

For this reason, much of the research on solitary confinement is qualitative. Haney (Ex. 11) at 367. But "there is a substantial amount of it and the findings are robust." *Id.* At least two U.S. Supreme Court justices have cited this research approvingly, as have multiple other members of the federal judiciary.[6] *See Apodaca v. Raemisch*, 139 S. Ct. 5 at n.8 (2018) (Sotomayor, J., concurring); *Davis v. Ayala*, 135 S. Ct. 2187 (2015) (Kennedy, J., concurring) (stating that "penology and psychology experts, including scholars in the legal academy, continue to offer essential information and analysis" and observing that "research . . . confirms what this Court suggested over a century ago: Years on end of near-total isolation exact a terrible price."); *Porter v. Clarke*, 923 F.3d 348, 356 (4th Cir. 2019) (explaining that "[n]umerous studies reveal that prolonged detention of inmates" in solitary conditions on death row has damaging results); *Grissom v. Roberts*, 902 F.3d 1162, 1175–78 (10th Cir. 2018) (Lucero, J., concurring) (citing research on solitary confinement including the work of Terry Kupers, Craig Haney, and Stuart Grassian); *Williams v. Sec'y Pennsylvania Dep't of Corr.*, 848 F.3d 549, 566 (3d Cir. 2017) (citing "[t]he robust body of scientific research on the effects of solitary confinement" as

[6] *See also Ruiz v. Texas*, 137 S. Ct. 1246 (2017) (Breyer, J., dissenting from denial of stay of execution) (observing that Mr. Ruiz's "severe anxiety and depression, suicidal thoughts, hallucinations, disorientation, memory loss, and sleep difficulty" are symptoms "long associated with solitary confinement").

support for the conclusion that "the deprivations of protracted solitary confinement so exceed the typical deprivations of imprisonment" as to create a liberty interest in avoiding solitary).

Dr. Morgan's meta-analyses artificially limited the universe of solitary confinement research. Haney (Ex. 11) at 399–401. Research Synthesis 1 reviewed 150 studies for potential inclusion in the meta-analysis but included just 14 (9.3%). Morgan (Ex. 10) at 4; Haney (Ex. 11) at 400. Research Synthesis 2 identified 40,589 such articles and reduced that number to 61 it deemed related to the research question. It then excluded all but 19 for meta-analysis (31.15%). Morgan et al. (Ex. 10) at 4–5; Haney (Ex. 11) at 400. Moreover, many of the included studies "have little or nothing to do with the key question of whether and when solitary confinement is psychologically harmful," instead addressing medical outcomes, recidivism, and institutional misconduct. Haney (Ex. 11) at 400 & n.18 (finding that only six studies in Research Synthesis 1 and ten in Research Synthesis 2 address the psychological effects of solitary confinement). This unrepresentative sample is not a sound basis for a meta-analytic study purporting to provide a comprehensive synthesis of the research. *Id.* ("A meta-analysis that includes so little of the available relevant literature is not a synthesis of much of anything.").

Second, Dr. Morgan's meta-analysis uses unreliable data. *See British Columbia Civil Liberties Ass'n. v. Canada (Attorney General)*, 2018 BCSC 62 (2018) (excerpts attached as Ex. 16) ¶¶ 253 & 254 (agreeing with criticisms of the Colorado Study and finding that "the Morgan et al. Study is unhelpful in understanding solitary confinement because of flaws in the Colorado and Zinger studies").

The meta-analysis relies heavily on a 2010 study of prisoners in Colorado (the Colorado Study). Haney (Ex. 11) at 401–02 (explaining that because of the Colorado Study's comparatively large sample size, the weights given to effect sizes derived from the Colorado

Study "dwarf" others in the meta-analyses). The Colorado Study is a longitudinal study of two comparator groups of prisoners in Colorado—one group in administrative segregation and the other in general population—with various sub-groups. *See generally* Maureen O'Keefe et al., "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation," *Final Report to the National Institute of Justice* (2010) (Ex. 17); Ex. 1 at 8; Haney (Ex. 11) at 379–80. The goal was to isolate the variable of solitary confinement to determine its effect. But because both comparison groups were exposed to the treatment variable (i.e., solitary confinement), the resulting data is not reliable and should not be admitted at trial. Haney (Ex. 11) at 380–86.

The contamination began at the very start of the Colorado Study. The study selected participants by identifying prisoners who were given disciplinary tickets and then were either sent to administrative segregation (and designated members of the treatment group) or to general population (control group). *Id.* at 380–81. But the disciplinary process necessarily involved exposure to solitary confinement for a significant period of time, thereby contaminating the control group at the start. *Id.* at 380–84. Moreover, conditions in disciplinary segregation were more severe than those in administrative segregation. *Id.* at 381–82. So what the Colorado researchers really studied was how prisoners rated their mental health immediately after moving from a highly restrictive form of segregation to a less restrictive form of segregation. *See* Peter Scharff Smith, "The Effects of Solitary Confinement: Commentary on *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*," CORRECTIONS & MENTAL HEALTH (June 2011) (attached as Ex. 18) at 7 ("study participants were already damaged by solitary confinement when the study began").

There was also cross-contamination during the study itself. Haney (Ex. 11) at 384–86. Some members of the treatment group left segregation for unspecified periods to move to less restrictive housing, and some members of the control group were exposed to solitary during the study.[7] *Id.* Yet the aggregated results did not exclude study participants who were subject to cross-contamination. *Id.* at 385; Ex. 4 at 147:16–24.

Dr. Morgan professes awareness of the critiques of the Colorado Study, but he exhibited a surprising lack of familiarity with the Study itself. He agreed that "[t]he most serious critique of the Colorado study is that there was fatal contamination of the control group," Ex. 4 at 142:11–14, and that if there were such contamination there "could" be real questions as to the value of the data. *Id.* at 142:15–17. He agreed that Dr. Haney "found that half of the administrative segregation [group] of prisoners, 60—about half, 62 of 127, spent an unspecified period of time in general population or elsewhere during the study." *Id.* at 143:5–9. But he didn't recall whether or not participants were in disciplinary segregation at the start of the study, *id.* at 143:1–5, and was unable to describe the selection procedure for identifying participants. *Id.* at 143:8–12.

There are other major problems with the Colorado Study. *See* Haney (Ex. 11) at 386–98. The sole mechanism for collecting data on prisoners' mental health was self-scoring pen and paper tests. *Id.* at 396. Dr. Haney explains:

> Researchers who use many rating scales (especially ones not validated for the particular population) generally use other methods of data collection as a validity check. The most basic is a face-to-face interview to establish rapport and acquire background information. When possible, behavioral data (by records reviews or

[7] *See also* Smith (Ex. 18) at 6 (describing contamination in the Colorado Study and concluding that "the GP control group was not really a GP control group at all since the majority of these experienced either AS or punitive segregation during their participation in the study, and in addition most—perhaps all—experienced AS immediately prior to their AS hearing, after which they went into GP"; "the Colorado study is in fact *not* a study comparing segregation/solitary confinement with non-segregation/solitary confinement, since most of the GP inmates experienced solitary confinement during the study").

> behavioral rating scales completed by others) are included. These different sources of information should be reconcilable, and the interviews provide the glue that binds them.

Id. While the Colorado Study researchers had access to mental health and medical records and crisis reports that could have provided a check as to the accuracy of the prisoners' self-reporting, they ignored this data. *Id.* at 396–97; Stuart Grassian & Terry Kupers, "The Colorado Study vs. the Reality of Supermax Confinement" (Ex. 19) at 6–7. They eschewed face-to-face interviews altogether. Haney (Ex. 11) at 396; Smith (Ex. 18) at 2 (criticizing Colorado Study on basis that tests were administered "without in-depth interviews" and "self-reported data was not collected by a psychiatrist, a psychologist, or an experienced prison researcher").

In addition, the applicability of the Colorado Study data to solitary confinement in other systems is highly fraught because of the nature of Colorado's administrative segregation program. Haney (Ex. 11) at 389–390. Colorado divides its administrative segregation into three levels and provides additional privileges at each level. *Id.* Those at Level 3 are still in administrative segregation, but they have an array of privileges including institutional work outside of their cells that are not common features of solitary. *Id.* at 390 and n.5. These differences led a court in California to discount the relevance of the Colorado Study to their solitary confinement regimen entirely.[8] *See Joiner*, 522 U.S. at 146 (upholding exclusion of expert opinions derived from studies too "dissimilar to the facts presented in this litigation").

[8] *See Corp. of the Canadian Civil Liberties Ass'n.*, 2017 ONSC 7491 (Ex. 6) ¶¶ 236–37 ("The respondent also relied on the O'Keefe study completed in Colorado in 2010. I do not accept this study is valid in Canada because the system of administrative segregation is different in Canada. Specifically, at page 11 of the study the authors describe the incentive-based Colorado program. This program has three quality-of-life levels. Each level brings with it more privileges which must be earned through appropriate behavior. At quality-of-life level 3, inmates in administrative segregation are allowed four three-hour visits per month, four 20-minute phone sessions, $25 worth of canteen per week and the opportunity to work as a porter or barber in the institution. This is not comparable to the Canadian system.").

The WCU does not have a similar privileges program. *See* Summary Judgement Opinion and Order (Doc. No. 214) at 11–12.

Moreover, "[i]t is critical under Rule 702 that there be a link between the facts or data the expert has worked with and the conclusion the expert's testimony is intended to support." *United States v. Mamah*, 332 F.3d 475, 478 (7th Cir. 2003). As discussed *supra*, Dr. Morgan cannot assess the relevance of segregation conditions in Colorado to conditions in the WCU, because *he has never been to the WCU*.

Despite the Colorado Study's problems and Dr. Morgan's inability to connect the conditions studied in Colorado to the conditions at the WCU, he relies on the Colorado Study heavily—not only in his meta-analysis, but in his expert report. His report describes the Colorado Study as the "[g]old standard" of methodological approaches to examining the effects of solitary confinement, emphasizing the outsized weight he attributes to this unintelligible study. Ex. 1 at 8. The unreliability of Dr. Morgan's testimony is compounded by the fact that he cannot opine as to the value of the studies relied on in his meta-analysis, because he is admittedly not an expert in design of controlled studies. Ex. 4 at 134:22–24 ("Q: Do you hold yourself out as an expert in the design and execution of controlled studies? A: No.").

The discredited Colorado Study is not the only unreliable source that Dr. Morgan relied on for his meta-analyses. He relied on the Zinger 2001 study in the meta-analysis and in his expert report, repeating its purported finding of "no significant mental health decompensation for segregated inmates compared to their peers in the general prison population." Ex. 1 at 6–7. But the Zinger study suffered from multiple flaws, including a major attrition problem. Over the 60-day period of the study, the number of administrative segregation prisoners dropped from 83 to 23. Ivan Zinger et al., "The Psychological Effects of 60 Days in Administrative Segregation," 43

CANADIAN J. CRIMINOLOGY 47 (2001) (Ex. 20) at 63; Haney (Ex. 11) at 403. Of those 23, only 10 were involuntary, meaning that attrition decreased the number of involuntary segregation participants by 80%. Zinger et al. (Ex. 20) at 64; Haney (Ex. 11) at 403. The study's authors explain that "[t]he problem with attrition is especially relevant to the evaluation of the psychological effects of segregation," because "[s]ubjects who decide to no longer participate in the experiment may be the same individuals who would not cope well with the conditions of segregation and would be negatively affected by them." Zinger et al. (Ex. 20) at 56.

The Zinger study also involved prisoners who *volunteered* for segregation; another problem with multiple studies Dr. Morgan relied on for his meta-analysis. Ex. 4 at 164:5–10 (Zinger 2001 (attached as Exhibit 20); 168:2–12 (Walters 1963 (attached as Ex. 21); 168:24–69:10 (Ecclestone 1974 (attached as Ex. 22)). Researchers have warned against extrapolating the effects of voluntary segregation to the very-different context of forced segregation. Haney (Ex. 11) at 402–03 ("Voluntarily isolated prisoners . . . control their own fates; at least in theory, they can leave. . . . They should not be treated as if their experiences represent the effects of solitary confinement on involuntarily segregated prisoners."). Dr. Morgan agreed that "whether a prisoner is in solitary voluntarily or involuntarily could effect that prisoner's experience in their confinement." Ex. 4 at 164:11–14. *See Sheehan v. Daily Racing Form, Inc.*, 104 F.3d 940, 942 (7th Cir. 1997) (statistical study claiming that negative correlation between employees' age and retention proved age discrimination was inadmissible under *Daubert* because it failed to consider or correct for obvious alternative explanatory variables).

These studies also analyzed such short periods of time that they do not provide reliable data for opinions as to the effects of solitary confinement in a case such as this one. *Id.* at 164:15–18 (Zinger (Ex. 20) 60 days); 168:17–20 (Walters (Ex. 21) 4 days); 169:11–13

(Ecclestone (Ex. 22) 10 days). Such studies are not meaningfully similar to the facts of this case. *See Joiner*, 522 U.S. at 146 (approving exclusion of expert's use of dissimilar scientific studies). Yet another study compared two different forms of solitary confinement and had no general population control group. *Id.* at 166:3–22 (Cloyes 2016 (attached as Ex. 23)).

Third, Dr. Morgan's interpretation of the results of his meta-analysis lacks rigor and is unreliable.

The meta-analysis results purport to show small-to-moderate (0.06 to 0.55) effect sizes on measures of mental health and wellbeing for those in solitary confinement. Morgan et al. (Ex. 10) at 1. As discussed, the meta-analysis arrived at these results by synthesizing studies comparing those in solitary confinement to those in prison general population. In his expert report, Dr. Morgan then takes an illogical step forward. He compares the results from his meta-analysis to the effects of general incarceration on mental health and wellbeing. Ex. 1 at 10. He thus purports to compare the effects solitary confinement to the effects of general incarceration using the following (flawed) approach.

Solitary Confinement (X) : General Population (Y) = Association between Solitary Confinement and Mental Health Consequences

General Incarceration (Y)[9] *: Life Outside Prison (Z)= Association between General Incarceration and Mental Health Consequences*

The proper method would be to first assess the strength of the association between solitary confinement and mental health as compared to a control group of people *not in prison*, then test the strength of the association between general population and mental health as

[9] It is not even clear from Dr. Morgan's report that "general incarceration" excludes solitary confinement and is the equivalent of general population, as it should.

compared to a control group of people *not in prison*, and then compare the two effect sizes. Thus the correct formula is as follows:

Solitary Confinement (X) : Life Outside Prison (Z) = Association between Solitary Confinement and Mental Health Consequences

General Incarceration (Y) : Life Outside Prison (Z) = Association between General Incarceration and Mental Health Consequences

Dr. Morgan's attempts to compare the effect sizes of segregation from his 2016 meta-analysis to the effect sizes of general incarceration on prisoners' well-being have not been peer reviewed.[10] Ex. 4 at 186:10–17. *Cf. Tyus*, 102 F.3d at 263 (holding expert opinions were admissible where expert relied on "peer-reviewed articles accepted in his profession"). His method is an apples-to-oranges comparison that proves nothing. *See State Farm Fire*, 980 F. Supp. 2d at 1049 ("When conducting a comparative analysis, to meet the reliability that *Daubert* demands, an expert must select samples that are truly comparable . . . . care must be taken to be sure that the comparison is one between 'apples and apples' rather than one between 'apples and oranges.' ") (citations omitted).

Problems with Dr. Morgan's comparative analysis go beyond even this "fatal flaw." *Id.* His comparison of the effects of solitary confinement to the effects of general incarceration is a methodological disaster.

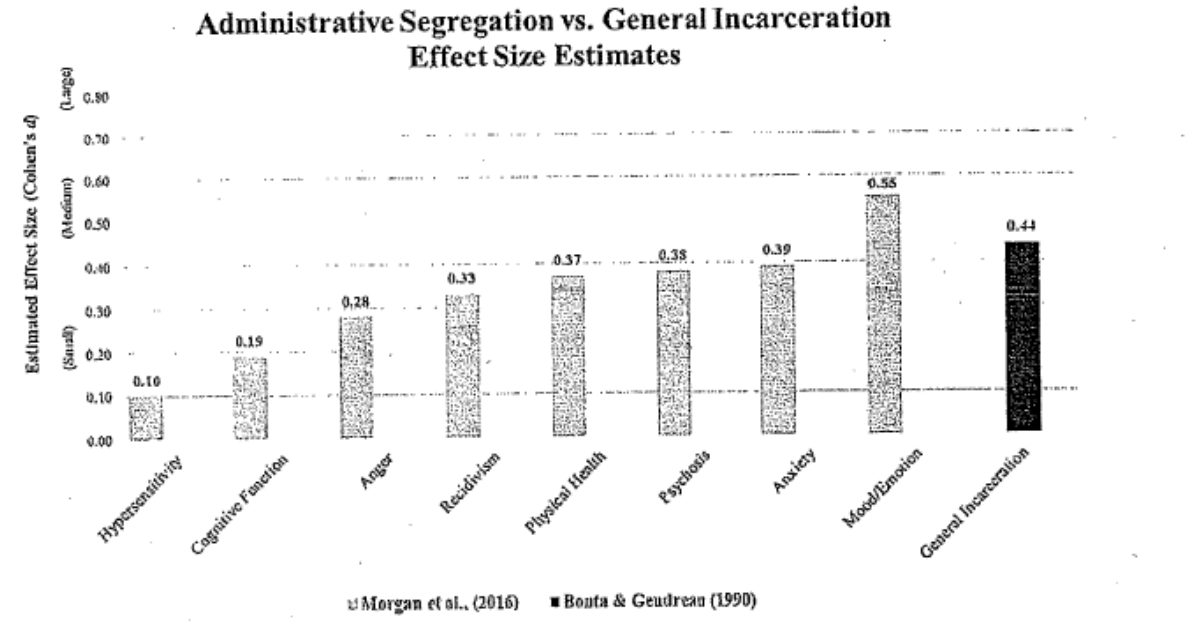
Dr. Morgan relies on the self-reported experience of a single prisoner, "Inmate A," whom he examined at Pelican Bay State Prison, California. He cites Inmate A's view that prisoners

[10] His bar chart, reproduced *infra*, appeared in the correctional magazine of the American Corrections Association, *Corrections Today*. Ex. 8 at 20. While Dr. Morgan categorizes this publication as peer-reviewed in his curriculum vitae, he acknowledged under deposition questioning that the peer reviewers are corrections industry professionals and not research psychologists. Ex. 4 at 15:2–6. Moreover, the magazine published the piece in an opinion column, "Speak Out." *See* Ex. 8; CORRECTIONS TODAY (Ex. 19) at 4 ("Corrections Today is the perfect space to share your opinions that are relevant to corrections. We invite submissions to the Speak Out column for just this opportunity.").

"eventually adjust and cope adequately in the structured environment of AS" as support for his hypothesis that prisoners "adapt to their environment, whether it be a general prison population setting or AS." Ex. 1 at 11. But out of the 130–150 prisoners Dr. Morgan interviewed, Inmate A was a major outlier. Ex. 4 at 198:1–200:8. Whereas Inmate A expressed no concerns or significant distress related to his isolation, "the majority of other inmates [Dr. Morgan] interviewed expressed distress and concern resulting from their segregation placement." *Id.* at 199:19–200:8. Dr. Morgan thus ignored the experiences of all those prisoners that did not fit his theory and elevated the experience of the one prisoner that did.

Dr. Morgan includes the following bar chart purporting to compare the effect size estimates for administrative segregation to the effect size estimates for general incarceration.

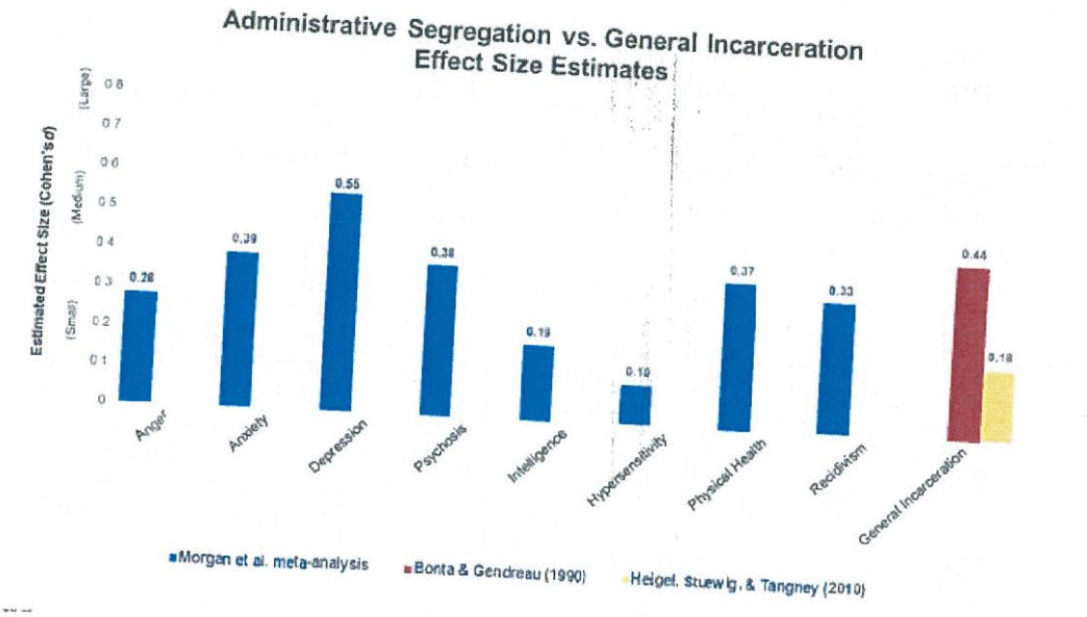
Figure 1.



Ex. 1 at 10. The blackened bar showing the effect size of "General Incarceration" derives from a 1990 study by James Bonta and Paul Gendreau. *See* James Bonta and Paul Gendreau,

Reexamining the Cruel and Unusual Punishment of Prison Life, L. & HUMAN BEH. 347 (1990) (attached as Ex. 24). Contrary to Dr. Morgan's representations in his report, the data he pulls from Bonta & Gendreau for the bar chart is not the effect size of general incarceration. Ex. 4 at 179:21–180:14. It is the effect size of *overcrowding*. *Id.* ("Q: So we're comparing the effect sizes of the harms of segregation to the effect sizes of the harms of living in an overcrowded prison? A: That would be fair."); *see* Bonta & Gendreau (Ex. 24) at 352. There is nothing to learn from this inapt comparison. Dr. Morgan's use of it here is deeply misleading.

In another solitary confinement case, Dr. Morgan submitted a bar chart (copied below) that was similar in all but one respect to the bar chart he uses here.



See Ex. 4 at 180:15–81:1. Dr. Morgan cited this bar chart as support for his conclusion that the adverse health effects of solitary confinement on health are similar to the adverse health effects of general incarceration. *See id.* at 180:15–182:1. Dr. Morgan acknowledged under cross-examination that the bar on that chart representing the effect size of the adverse health

effects of general incarceration was totally wrong—it was inverted. *Id.* at 182:2–82:19. The study he relied on for that comparison (Heigel et al. 2010 (attached as Ex. 25)) actually showed that people in general incarceration "improved in terms of their physical health functioning." *Id.* at 182:16–19. This error led a Canadian court to disregard Dr. Morgan's comparison opinions. *Corporation of the Canadian Civil Liberties Association v. the Queen*, 2017 ONSC 7491 (2017) (excerpts attached as Ex. 6) ¶ 95 ("Specifically, his report that administrative segregation was no more harmful than incarceration in the general prison population was based on an erroneous conclusion that there was a negative association between incarceration in the general population and health outcomes when the opposite was correct.").

Dr. Morgan did not revisit his incorrect methodology and adjust his conclusions when offering expert testimony in this case. Instead, Dr. Morgan reports the same conclusion, but without the bar chart comparison (or any evidence on health) to support his claim: "In totality, it can be expected that the use of restrictive housing (such as AS) will produce mild to moderate health . . . effects comparable to the effects of incarceration generally." Ex. 1 at 11. Dr. Morgan's opinion rests on nothing but his own "*ipse dixit*." *Kumho Tire*, 526 U.S. at 157.

Dr. Morgan's erroneous methods produce precisely the type of opinions that *Daubert* and its progeny require courts to address. His proposed testimony threatens to subvert the fairness of Mr. Vermillion's trial by persuading the jury that his charts and figures constitute objective and reliable scientific evidence.[11] Cross-examination to sufficiently demonstrate the errors in his

[11] Dr. Haney pinpoints the problem of Dr. Morgan's meta-analysis in this regard:

> The concern is not only that meta-analyses on important prison topics almost invariably ignore or underrepresent the larger literature, but also that they privilege certain kinds of studies far beyond their actual scientific merit, and do so in a way that many readers are unlikely to appreciate. One critique rightly observed that readers "might not be motivated to look beyond the meta-analyses themselves due to confidence in the objective, straightforward nature of the tasks of conducting a meta-analysis, reporting findings, and making recommendations." Reducing entire studies to single or multiple effect sizes almost invariably creates a false equivalency between them. Readers can be

opinions will require educating the jury on complicated topics involving effect sizes, meta-analysis, and controlled studies that are very far from what this case is about. Mr. Vermillion should not be required to put on a mini-trial to demonstrate the unreliability of Dr. Morgan's analysis, and the jury should not have to endure it. Instead, Dr. Morgan's opinions should be excluded.

C. Dr. Morgan Is Not Qualified to Testify to Correctional Industry Standards

Dr. Morgan is not qualified by experience or study to opine about correctional industry standards. *See* Ex. 4 at 194:12–20; *cf. Cage v. City of Chicago*, 979 F. Supp. 2d 787, 803 (N.D. Ill. 2013) ("experts may rely on their professional experience to offer opinion testimony regarding the standard of care and generally-accepted industry standards"). His experience working for a prison system is minimal, temporally remote, and limited to mental health operations. *See* Section I.A *supra.* He acknowledges he is not an expert in correctional practices. Ex. 4 at 194:18–20 ("Q: And I take it you do not hold yourself out as an expert in correctional practices? A: Correct.").

However, Dr. Morgan presumes the role of correctional expert, opining that Mr. Pacholke incorrectly states the correctional practices applicable at the time of Mr. Vermillion's solitary confinement. *See Gayton v. McCoy*, 593 F.3d 610, 617 (7th Cir. 2010) (explaining that the relevant question is "not whether an expert witness is qualified in general, but whether his qualifications provide a foundation for [him] to answer a specific question") (internal quotation marks and citation omitted). He does so by pointing out that two sources Mr. Pacholke refers to

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> easily mesmerized by arrays of numbers that appear simply and accurately to represent highly complex and substantially different underlying realities.

Haney (Ex. 11) at 399 (internal quotation marks and citation omitted). Substitute "jurors" for "readers" and Dr. Haney has explained the risk of misleading the jury with inaccurate meta-analytic data purporting to show the effects of solitary confinement.

are dated after Mr. Vermillion's release from solitary confinement. Ex. 1 at 15–16. Defense counsel are free to point out this issue in cross-examination, but Dr. Morgan will not add anything of substance to the jury's understanding on this topic. "[I]f he is to give testimony to assist jury members and expand their knowledge. . . , [he] must testify to something more than what is 'obvious to the layperson' in order to be of any particular assistance to the jury." *Ancho*, 157 F.3d at 519. Because Dr. Morgan admittedly lacks expertise on this topic, his opinion should be excluded.

III. CONCLUSION

Defendants' expert is unqualified, unfamiliar with the facts of this case, and espouses outlier opinions based on unreliable methods and data. He admits that his view of the harms of solitary confinement is "outside of the mainstream." Ex. 4 at 98:17–99:5. Dr. Morgan should not be allowed to offer opinion testimony in this matter. In the alternative, he should be precluded from testifying as to (1) Mr. Vermillion's mental health and Dr. Kupers' assessment thereof; (2) the propensity of civil litigants to lie for financial gain; (3) the effects of segregation; (4) comparison of the effects of solitary confinement to the effects of general incarceration; and (5) correctional practices.

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CERTIFICATE OF SERVICE

I hereby certify that on June 21, 2019, the foregoing was filed using the Court's CM/ECF electronic filing system. Copies of the filed documents will be electronically sent to all counsel of record in the CM/ECF system.