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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF KERN

THE PEOPLE OF THE STATE OF CALIFORNIA, Plaintiff, **v.** **PAMELA R. OTT,** Defendant.	Case No. BF126665 D **PEOPLE'S POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THE INFORMATION PURSUANT TO PENAL CODE SECTION 995** Date: May 17, 2011 Time: 10:00 a.m. Dept: CC Action Filed: September 8, 2009

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STATEMENT OF THE CASE

On September 8, 2009, the People filed a Second Amended Complaint in this case, alleging that the defendant, as well as co-defendants Gwen D. Hughes (Case No: BF 126665A) and Hoshang M. Pormir, (Case No: BF 126665C), committed the following crimes in Kern County, between August 1, 2006 through January 31, 2007: Count 1, a felony violation of Penal Code section 368(b)(3), Elder or Dependent Adult Abuse Resulting in Death, victim Mae Brinkley; Count 2, another felony violation of Penal Code section 368(b)(3), Elder or Dependent Adult Abuse Resulting in Death, victim Joseph Shepter; Count 3, another felony violation of Penal Code section 368(b)(3), Elder or Dependent Adult Abuse Resulting in Death, victim Alexander Zaiko; Count 4, a felony violation of Penal Code section 368(b)(2), Elder or Dependent Adult Abuse with Great Bodily Injury, victim Jack Wallace; Count 5, a felony violation of Penal Code section 368(b)(1), Elder or Dependent Adult Abuse, victim Vergil Kregger; Count 6, another felony violation of Penal Code section 368(b)(1), Elder or Dependent Adult Abuse, victim Eddie Dolenc; Count 7, another felony violation of Penal Code section 368(b)(1), Elder or Dependent Adult Abuse, victim Louise Zimmerman, and count 8, another felony violation of Penal Code section 368(b)(1), Elder or Dependent Adult Abuse, victim Opal Towery. In addition, co-defendant Gwen Hughes was also charged with two counts of Penal Code section 245(a)(1), Assault with a Deadly Weapon.

To these charges the defendants pled not guilty, and a preliminary hearing was held on August 23, 24, and 25, 2010, in the Superior Court, County of Kern, before the Honorable John Lua, sitting as a magistrate. All three defendants were held to answer for trial in the Superior Court on all the counts charged against them. The People then filed an Information in the Superior Court containing the same charges in the Second Amended Complaint, and the defendants were arraigned on October 15, 2010, which was continued to December 3, 2010. At that time the defendants pled not guilty and the matter was set for a hearing on motions for April 5, 2011, and a Status Conference on April 29. 2011.

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STATEMENT OF FACTS

The facts relevant to this motion are contained in the Reporter's Transcript of the Preliminary Hearing, on file with this court. The court is respectfully requested to take judicial notice of the contents of the transcript. For the court's convenience, the following summary is prepared from that Reporter's Transcript.

Testimony of Special Agent Donny Fong

Bureau of Medical Fraud and Elder Abuse ("BMFEA") special agent Donny Fong ("Agent Fong") testified that he was assigned to investigate reports of chemical restraint of residents at the skilled nursing facility (SNF) of KVHD, located in Lake Isabella, California. (R.T. 321, lines 13-28.) The KVHD Director of Nursing Gwen D. Hughes, KVHD Director of Pharmacy Debbi C. Hayes, and KVHD Medical Director Hoshang M. Pormir were alleged to have prescribed and authorized the administering of psychotropic medications to residents in order to chemically restrain them for staff convenience. (R.T. 324, lines 9-12.) Agent Fong also testified that the investigation was referred to the Department of Justice, BMFEA from the California Department of Public Health ("DPH") after they received a complaint alleging the use of forceful injections on a resident at KVHD. (R.T. 323, line 26-R.T. 324, line 3.) Testimony of former KVHD nurse Holly Lightner indicated that all residents at the skilled nursing facility were elderly and many of the residents suffered from Alzheimer's disease or dementia. (R.T. 13, lines 24-28.)

Agent Fong testified that he was informed by DPH personnel that in January 2007, DPH conducted an investigation of KVHD regarding the use of chemical restraints on KVHD residents. (R.T. 324, et seq.) Agent Fong and Kathryn Locatell, M.D., testified that following a DPH investigation, DPH immediately placed KVHD in "Immediate Jeopardy" for causing resident harm and administratively and cited them for using chemical restraints and unnecessary medications on 23 of their residents. (R.T. 325, lines 13-24; R.T. 181, lines 5-9.)

Agent Fong testified that he interviewed Linda Wilkinson ("Wilkinson"), the acting District Administrator for DPH office in Bakersfield, California. (R.T. 322, lines 2-10.) Agent Fong testified that Wilkinson told him of a complaint her office received from an ombudsman in January 2007 regarding KVHD resident Louise Zimmerman being held down by staff and given

an injection of psychotropic medication by force. (R.T. 323, line 26-R.T. 324, line 3.) Agent Fong testified that Wilkinson initiated an investigation on KVHD in January 2007. (R.T. 324, lines 4-8.) Agent Fong's testimony indicated that DPH selected a sample of 29 residents, of whom they found sixteen to be chemically restrained. (R.T. 324, lines 9-12.)

Agent Fong's testimony included statements to him from Debbie Hayes, who told him that when instructed to do so by Defendant Hughes, she had written doctor's orders for psychotropic medications for KVHD residents. (R.T. 327, lines 7-8; R.T. 332, lines 5-10.)

Agent Fong testified that based on these findings, DPH immediately placed KVHD in "Immediate Jeopardy" because of failure to comply with federal regulations, harm to patients and a high possibility of future harm to patients. (R.T. 325, lines 13-24.)

Agent Fong's testified that Hughes initiated Interdisciplinary Team (IDT) meetings to discuss the behaviors of KVHD residents. (R.T. 326, line 22-R.T. 327, line 1.) During these IDT meetings, Hughes directed pharmacist Hayes to write prescriptions for psychotropic medications for some of the residents. (R.T. 327, lines 7-8; R.T. 332, lines 5-10.) Hayes informed Agent Fong that she trusted Defendant Hughes' knowledge of psychotropic medications. (R.T. 334, lines 5-6.) The orders were executed without a psychiatric or medical diagnosis performed by a psychiatrist or physician. (R.T. passim.) KVHD did not employ a psychiatrist during the timeframe of the alleged crimes. (R.T. 18, lines 10-13.)

Agent Fong interviewed former KVHD nurse Margaret Bibby, who informed Agent Fong she was the one who administered one of the forceful injections. (R.T. 338, line 10-R.T. 339, line 1.) Bibby also informed Agent Fong that at some later date she witnessed another nurse forcibly administer a similar injection while several aides held Ms. Zimmerman down. (R.T. 339, line 6-R.T. 340, line 3.)

Agent Fong interviewed Patricia Orr, a registered nurse and former Charge Nurse at KVHD. (R.T. 342, lines 7-9.) Agent Fong's testified that Orr told him that during interdisciplinary team (IDT) meetings, Orr witnessed Defendant Hughes direct KVHD pharmacist Debbie Hayes to write doctors' orders for psychotropic medications to be administered to KVHD residents. (R.T. 342, lines 13-17.) Orr informed Agent Fong that the orders included

prescriptions for Depakote, Seroquel, Risperdal and Zyprexa. (R.T. 358, line 27-R.T. 359, line 2.)

Testimony of Holly Lightner, L.V.N.

Former KVHD Licensed Vocational Nurse Holly Lightner stated that KVHD was using psychotropic medications as chemical restraints on many of their residents during the time period covering the crimes alleged. (R.T. 17, lines 25-27.) Lightner also testified that Hughes would order psychotropic medications for minor behavioral issues displayed by the residents. (See R.T. 104, lines 4-12.) This included, Lightner testified, surreptitiously sprinkling psychotropic medications on residents' food without their knowledge or consent. (R.T. 119, lines 11-16.)

Lightner and the other nursing staff began to notice many dramatic changes in the behaviors of the KVHD residents: they were very lethargic, somnolent, some could not talk, some were not cognizant and were like complete "zombies." (R.T. 23, lines 1-7.) Some of these residents became completely dependent for care, could not eat or drink, some became nonambulatory, and sat in Geri-chairs all day or were bedridden. (Ibid; see also, generally, R.T. 176-294.)

Testimony of Kathryn Locatell, M.D.

After extensive voir dire, the court accepted Dr. Kathryn Locatell as an expert in the fields of geriatric medicine, nursing home administration, nursing home medicine and standard of care, pharmacology and the use of specific psychotropic medications. (R.T. 169, line 1- R.T. 172, line 4.)

Dr. Locatell reviewed the medical records of KVHD residents Mae Brinkley, Joseph Shepter, Alexander Zaiko, Jack Wallace, Vergil Kregger, Eddie Dolenc, Louise Zimmerman, and Opal Towery. (R.T. 184, line 23- R.T. 185, line 15.) Dr. Locatell testified that there were commonalities among the records of these residents: they were each prescribed psychotropic medications, "apparently, by someone other than the physician," and the medications "were administered without adequate informed consent,...without justification at excessive dosages or at excessive durations." (R.T. 185, lines 21-27.) Further, Dr. Locatell testified that it was her opinion "they all constituted chemical restraints used, not to treat a specific medical condition or

medical symptom, but clearly for the convenience of the staff." (R.T. 185, line 27- R.T. 186, line 2.) Dr. Locatell clarified that "each prescription violated numerous standards of care…[a]nd in each case great harm was done to the resident." (R.T. 186, lines 3-6.) Dr. Locatell testified it was her opinion that "[i]n five of the eight cases, the residents died…because, at least in part, of the administration of these drugs." (R.T. 186, lines 6-8.)

Dr. Locatell testified that 97-year-old KVHD resident Mae Brinkley had been receiving Depakote "about three weeks before her death." (R.T. 189, lines 22-23.) Dr. Locatell further testified that Ms. Brinkley "was described as lethargic, unable to swallow her medications, sleeping most of the day, having trouble swallowing, and eventually was near death, unresponsive and moaning, and was sent to the hospital." (R.T. 190, lines 11-15.) At the hospital, Dr. Locatell continued, Ms. Brinkley was found "to be significantly dehydrated, suffering from a severe fecal impaction, and expired at the hospital after an attempt to treat her." (R.T. 190, lines 16-19.) According to Dr. Locatell's testimony, given Ms. Brinkley's advanced age and her physical condition, the dosage of Depakote ordered was clearly excessive and that Ms. Brinkley "never rebounded from that when the drug was stopped." (R.T. 190, line 25- R.T. 192, line 6.) It was Dr. Locatell's testimony that in her opinion the Depakote was a significant factor in Ms. Brinkley's death. (R.T. 192, lines 25-26.)

Dr. Locatell testified that 76-year-old KVHD resident Joseph Shepter was sent to the emergency room from the KVHD SNF with dehydration, and died about 5 hours later. (R.T. 194, lines 19-23.) He also had a foul-smelling bedsore on his right heel. (Ibid.) According to Dr. Locatell's testimony, at different times Shepter was given doses of the psychotropic medications Seroquel, Depakote, and Zyprexa. (R.T. 193, lines 21-23.) Shepter was lethargic, constipated, dehydrated, "wasn't eating or drinking" and lost twenty-four pounds (R.T. 194, lines 13-18.) On the day that Mr. Shepter was admitted to the emergency room, Dr. Locatell testified, he was severely dehydrated and "overwhelmingly infected." (R.T. 196, lines 8-10.) Dr. Locatell's testimony was that in her opinion the drugs administered and the dosages used were a "gross violation of any standard of care for nursing homes," and they played a "major role" in Mr. Shepter's death. (R.T. 195, lines 5-14.)

Dr. Locatell testified that 85-year-old KVHD resident Alexander Zaiko had been treated for pneumonia at the KVHD hospital, and discharged to KVHD's skilled nursing facility "for rehabilitation." (R.T. 196, lines 21-24.) However, Dr. Locatell's testimony indicated that one day after being admitted to the SNF, Zaiko's existing dosage of Zyprexa was increased by 50% without medical justification, and in addition to the Zyprexa, a regimen of Depakote was ordered shortly thereafter without diagnosis or medical justification. (R.T. 196, line 25-197, line 7.) Dr. Locatell also testified that due to this medication, "within just eight days, he is in extremis [and] is diagnosed with severe dehydration." (R.T. 197, lines 10-13.) Dr. Locatell testified it was her opinion that the drugs administered to Mr. Shepter caused "severe side effects that prevented him from being able to consume enough fluid to keep alive. He died due to those effects and the dehydration that they caused." (R.T. 197, line 28- R.T. 198, line 4.)

Dr. Locatell testified that 83-year-old KVHD resident Jack Wallace was given high doses of psychotropic medications of Seroquel, Depakote, and Ativan at KVHD. (R.T. 199, lines 2-11.) She further testified the "combination of [these] drugs was not survivable in someone like Jack Wallace," and that the medication was prescribed by "without any evidence of a medical exam, without adequate evaluation of the risks and benefit, without consent, at excessive doses." (R.T. 199, lines 11-22.) In describing the doses, Dr. Locatell testified they were "astounding," and that "they were increased and increased to the point that…he went to the hospital near death." (R.T. 198, lines 23-27.) Dr. Locatell testified that the dosages "far exceed[ed] the thresholds for nursing homes." (R.T. 198, line 27- R.T. 199, line 1.) The end result, according to Dr. Locatell's testimony, was that Mr. Wallace was "severely dehydrated, his kidneys had…shut down because of the severe dehydration, and he spent three days in the hospital." (R.T. 200, lines 6-11.)

Dr. Locatell stated that 84-year-old KVHD resident Vergil Kregger was given "more than double [the dose of] what any prudent person" would prescribe for someone like Ms. Kregger, for "unclear behavioral symptoms" and "with no medical assessment." (R.T. 200, line 25- R.T. 201, line 4.) Dr. Locatell also testified that Ms. Kregger, a "tiny, little 84-year-old woman," was later administered a "completely uncalled-for" injection of the antipsychotic drug Zyprexa. (R.T. 204, lines 7-10.) Dr. Locatell's testimony indicates that after demonstrating side effects from Zyprexa,

Ms. Kregger was ordered a prescription for Seroquel which was "way too high of a dosage [with no] diagnosis" justifying the prescription. (R.T. 204, line 20- R.T. 205, line 6.) Dr. Locatell testified that the Seroquel was only stopped after Ms. Kregger began falling asleep with food in her mouth, a choking hazard. (R.T. 205, lines 10-19.) At this time, Dr. Locatell's testimony indicates, defendant Dr. Pormir was apparently seeing Kregger on a monthly basis but his notes contain no discussion of the resident's behaviors and the decisions to medicate her. (R.T. 205, line 20- R.T. 206, line 2.)

Dr. Locatell testified that 90-year-old KVHD resident Eddie Dolenc was given unnecessary psychotropic medication of Seroquel and Duragesic while he was still being administered a lower dose of his existing Depakote prescription. (R.T. 207, line 10- R.T. 209, line 19; R.T. 207, lines 10-12.) Dr. Locatell testified that the mixture medications made Dolenc extremely sedated such that he was unable to able to eat or drink, and that he likely died from the combination. (R.T. 208, line 25- R.T. 209, line 19.) Dr. Locatell testified that Mr. Dolenc was "remarkably stable for age 90, and quite healthy apart from dementia." (R.T. 206, lines 23-27.) Dr. Locatell's testimony indicated that less than three weeks after being admitted to KVHD, Mr. Dolenc was "unable to drink, his intake was extremely poor, he couldn't swallow, and then [was] just found dead." (R.T. 208, lines 4-8.)

Dr. Locatell testified that 89-year-old KVHD resident Louise Zimmerman was forcibly administered the psychotropic medication, Risperdal, without consent, medical diagnosis or evaluation. (209, line 25- R.T. 210, line 7.) Dr. Locatell's testimony showed that while Ms. Zimmerman was "described as being verbally aggressive or verbally abusive," there was "no documentation whatsoever of any psychotic behavior" at the time the psychotropics were administered. (R.T. 210, lines 24-28.) Further, testified Dr. Locatell, even though Ms. Zimmerman's chart indicated she was "throwing food, hitting staff, biting, hitting, throwing food trays at staff, and refusing her medications," those are not "symptoms of any psychotic condition that would warrant the administration of a drug like Risperdal, especially when she refused it." (R.T. 211, lines 6-12.)

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Dr. Locatell also noted in her testimony that Ms. Zimmerman was held down by "four or five nursing staff" in order to forcibly inject her with the Risperdal, and that this was "[a]bsolutely not" within the standard of care for a stroke-disabled, 89-year-old resident like Ms. Zimmerman. (R.T. 211, line 20- R.T. 212, line 7.) Dr. Locatell's testimony shows the Risperdal injection was in "depot" form, meaning the drug would stay in Ms. Zimmerman's system for two weeks. (R.T. 211, lines 1-5.) Dr. Locatell's testimony indicated that due to this depot administration, when Ms. Zimmerman began to experience very serious side effects like "significant swallowing problems" which required her "meds...to be crushed and put in pudding," and eye infections due to the drying effect of the drugs, Ms. Zimmerman could not recover until the drugs were stopped. (R.T. 213, lines 4-21.)

Dr. Locatell also testified regarding the treatment of 95-year-old KVHD resident Opal Towery, who was, without any medical justification whatsoever "forcibly medicated with [the antipsychotic drug] Zyprexa." (R.T. 213, line 22- R.T. 214, line 8.) Dr. Locatell testified that Ms. Towery's chart indicated she was "not demented," "very independent" and got around in a "motorized wheelchair." (R.T. 214, lines 15-18.) Dr. Locatell also testified that it appeared to her that Ms. Towery's wheelchair was taken away primarily because Defendant Hughes "didn't want these residents going around in their motorized wheelchairs." (R.T. 214, lines 19-24.) Dr. Locatell's testimony indicated that Ms. Towery was taken off of her mild sedative, Ativan, and began complaining about her wheelchair and other things. (R.T. 215, lines 1-6.) In response, she was injected with Zyprexa, after being led to believe it was Ativan, a drug she liked. (R.T. 216, lines 21-27.)

Dr. Locatell's testimony indicates that after the injection, Ms. Towery was "[s]low to respond, drooling, hard to awaken then extremely confused, tremors, complained of leg pains. It took three people to assist her to even stand up. She was unable to bear weight...somnolent, almost unresponsive, leg tremors and impaired articulation." (R.T. 217, line 25- R.T. 218, line 3.) Dr. Locatell testified that apparently due to this extreme reaction, Ms. Towery was prescribed Risperdal—even though she "was cognitively intact without a psychiatric diagnosis or even any kind of mental or psychiatric evaluation." (R.T. 218, lines 12-15.) After the Risperdal, testified

Dr. Locatell, Ms. Towery had "slurred speech, hands trembling, change in her level of consciousness, not eating, lost more than eight pounds." (R.T. 218, line 27- R.T. 219, line 2.)

Dr. Locatell's testimony indicates that Dr. Pormir was the physician of record for each of the eight alleged victims, and that in no case was a medical or psychiatric evaluation or diagnosis made which would justify prescribing and administering the psychotropic medications. (R.T. 219, lines 14-22.) Dr. Locatell also testified that in her opinion, the administrations of these drugs in all cases was inappropriate, and that in all cases there was either inadequate follow-up or no follow-up. (R.T. 219-221.) Dr. Locatell's opinion, by her testimony, was that "[e]ach one of these residents was significantly harmed" by the administration of the psychotropic medications, and of the three residents who did not die as a result, they all "were intensely uncomfortable" and "anguished in at least one of the cases." (R.T. 221, lines 24-27.) As to the five residents who died as a result of receiving the medications, Dr. Locatell testified that in her opinion they were greatly injured in the course of dying. (R.T. 222, lines 9-12.) It was also Dr. Locatell's testimony and opinion that the administration of the drugs was a "major contributing factor" to those five residents' deaths; that without the administration of the drugs, "those residents would not have died when they died or under the circumstances that they died." (R.T. 222, lines 23-26.)

Testimony Specifically Relating to Defendant Ott

Former KVHD licensed vocational nurse Holly Lightner ("Lightner") testified that defendant Ott was the hospital administrator during the time of the alleged elder abuse. (R.T. 15, lines 6-9.)

She also testified that defendant Ott was present at some of the SNF's interdisciplinary team meetings where resident care was discussed (R.T. 29, lines 5-11), including one where Lightner complained about the administration of psychotropic medications without proper prior testing (R.T. 27, lines 8-15; R.T. 28, lines 25-29; R.T. 99, lines 23-25). Lightner testified that she voiced this complaint because of her observation that after receiving psychotropic medication, residents "became lethargic [and] were unable to propel themselves." (R.T. 23, lines 1-2.)

Lightner testified that she contacted an elder abuse ombudsman and later Nancy Wilkinson at the Department of Public Health ("DPH") regarding what she felt was elder abuse. (R.T. 33,

line 6-34, line 19.) Lightner testified that she informed defendant Ott of the alleged abuse, especially with regard to questionable use of psychotropic medications and the decline of resident health, before calling the ombudsman and before the DPH survey occurred. (R.T. 31, line 27- R.T. 32, line 2.) Lightner testified that she and another nurse met in person with defendant Ott three times, and also by written note, regarding the changes in resident behavior and health following the administration of psychotropic medications. (R.T. 30, line 25- R.T. 31, line 3)

Lightner was unable to testify to exact dates of her meetings with defendant Ott, or as to the specific dates of the interdisciplinary team meetings. (See R.T. 429, line 15, et seq.) However, Lightner's testimony repeatedly indicated general timeframes well within the four months charged in the information, and internally consistent with her testimony regarding the context and content of individual meetings. (See R.T. 30, lines 3-7, 13-15; R.T. 30, line 25- R.T. 31, line 3; R.T. 31, lines 16-19; R.T. 31, line 27- R.T. 32, line 2; R.T. 33, line 11; R.T. 63, line 13; R.T. 109, lines 8-11; et seq.) Lightner testified that the meetings she had with Ott dealt both with defendant Gwen Hughes and the "change and decline" of the "patients on psychotropic medications...to let [defendant Ott] know what changes were being made [by defendant Hughes] at the skilled nursing facility." (R.T. 129, lines 11-21.) The magistrate noted "[t]he meetings with Ms. Ott are important...[to show] she informed Ms. Ott generally of the patients' care and how it was being administered." (R.T. 430, lines 3-8, emphasis added.)

Lightner testified that following one incident where defendant Hughes ordered Depakote be administered to a resident "for refusing to go to the cafeteria," Lightner notified Ott of the incident and the order. Lightner further testified that in December of 2006 she had a meeting with Ott about psychotropic medications being administered to the residents, about the general decline in resident conditions and in particular about two residents who had passed away, she felt, unnecessarily—Joseph Shepter and Mae Brinkley. (R.T. 138, lines 7-19.) Lightner repeatedly testified, both on direct and cross examination, that the result of each meeting with Ott was essentially the same: that "Gwen [Hughes] knew what she was doing." (R.T. 31, lines 16-19; R.T. 131, lines 4-21.) Lightner's testimony indicated that Ott essentially gave Defendant Hughes

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"free reign to do whatever she wanted and—without, actually, overseeing, or, I don't believe, ever checking out what we were telling her." (R.T. 131, lines 12-17.)

Special agent Donny Fong ("Agent Fong") also testified as to defendant Ott having notice of the abuses occurring at KVHD. Agent Fong's testimony indicated that during an interview with KVHD employee Cecilia Juni, Juni essentially corroborated Lightner's testimony with regard to Ott's reaction to employee complaints about overmedication. According to Agent Fong, Juni informed him that after she voiced her concern that residents might be overmedicated, Ott "told her [Juni] everything would be okay, that Gwen Hughes knew what she was doing." (R.T. 344, lines 12-20.) Agent Fong further testified that Juni informed him she first notified Ott of her concerns "a month after Gwen Hughes was hired at Kern Valley Health District, and numerous occasions" prior to the January 2007 DPH survey. (R.T. 343, line 19- R.T. 344, line 11.) Agent Fong testified that Juni informed him she told Ott "some of these residents appeared overmedicated, and that these residents were no longer coming to her activities because they were in Geri-Chairs." (R.T. 343, lines 21-27.)

Agent Fong also testified about his interview of defendant Ott. Agent Fong noted Ott claimed—contrary to Lightner's testimony and Juni's interview—that prior to the DPH survey in January of 2007, "she was unaware that residents were receiving psychotropics, [and] unaware that residents were having adverse reactions to psychotropic medications." (R.T. 346, lines 8-16.) In the same interview, Ott informed Agent Fong that "Gwen Hughes reported directly to her." (R.T. 346, lines 17-20, emphasis added.) Last, after the DPH survey and after an investigation of her own, Ott admitted to Agent Fong that "she considered the incident as elder abuse to the highest level." (R.T. 347, lines 9-10.)

The People's medical expert, Dr. Kathryn Locatell, testified that the administrator of a SNF has a duty to supervise even lower ranked staff who have the actual duty of patient care. (R.T. 294, line 28- R.T. 295, line 4.) She also testified that a Director of Nursing such as

Defendant Hughes has that actual duty of patient care (ibid), and that the "director of nursing reports to the administrator" (R.T. 300, lines 20-21.)

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The magistrate at the preliminary hearing found that while defendant Ott "did not willfully cause the harm" constituting the crime alleged, she was "placed on notice from certain witnesses that [the harm] was taking place," and that therefore she was "willfully permitting the harm to occur." (R.T. 428, line 27- R.T. 429, line 3.) Even though the magistrate took some issue with Lightner's credibility (R.T. 429, lines 17-24), the magistrate still found that "as far as Ms. Ott is concerned, in placing notice on Ms. Ott, the Court is going to find [Lightner's meetings with her] did fill that role in placing Ms. Ott on notice." (R.T. 430, lines 14-17.) The magistrate reiterated that Defendant Ott "willfully permitted the patients to be placed in such a situation that their health would be in danger," when Ott "was placed on notice…a month after [Defendant] Hughes joined the facility…[or] somewhere in September." (R.T. 429, lines 6-14.) Yet, even given notice, the magistrate noted, "Ms. Ott didn't do anything to correct or rectify the situation." (R.T. 431, lines 19-21.)

ARGUMENT

I. THE STANDARD OF REVIEW ON A MOTION MADE PURSUANT TO PENAL CODE SECTION 995 IS A LOW BAR, AND REVIEW IS LIMITED TO THE TRANSCRIPT OF THE PRELIMINARY HEARING.

A. Standard Of Review On a Section 995 Motion Is Reasonable For Probable Cause.

The text of Penal Code section 995 provides that an information "shall be set aside" only if the defendant has been "committed without reasonable or probable cause." An information should not be set aside under section 995 if there is some rational ground to believe a crime has been committed, and that the accused is guilty of it. (*Cooley v. Superior Court* (2002) 29 Cal.4th 228, 251; *People v. Slaughter* (1984) 35 Cal.3d 629, 637; *People v. Hall* (1971) 3 Cal.3d 992, 996; *Rideout v. Superior Court* (1967) 67 Cal.2d 471, 474.)

Probable cause exists if a person of ordinary caution or prudence would be led to believe and conscientiously entertain a strong suspicion of the guilt of the accused. (*Galindo v. Superior Court* (2010) 50 Cal.4th 1, 8; *Cooley v. Superior Court*, *supra*, 29 Cal.4th at 251; *Rideout v. Superior Court*, *supra*, 67 Cal.2d at 474.) However, in determining a motion under Penal Code section 995, the Court may not reweigh the evidence or substitute its judgment for that of the

committing magistrate—either as to the weight of the evidence or credibility of witnesses (*Peopl v. Block* (1971) 6 Cal.3d 239, 245; *People v. Plengsantip* (2007) 148 Cal.App.4th 825, 835.) Additionally, "[e]very legitimate inference that may be drawn from the evidence must be drawn in favor of the information." (*Caughlin v. Superior Court* (1971) 4 Cal.3d 461, 464-465; *Rideout v. Superior Court* (1967) 67 Cal.2d 471, 474;.)

Thus, an information should be set aside only when there is a total absence of evidence to support a necessary element of the offense charged. (*Alvarado v. Superior Court* (2007) 146 Cal.App.4th 993, 1000; *People v. Superior Court (Jurado)* (1992) 4 Cal.App.4th 1217, 1226.)

B. Review Of Magistrate's Decision Is Limited To The Evidence In The Transcript.

In determining a motion to set aside an accusatory pleading under Penal Code section 995 for insufficiency of the evidence, the reviewing court is limited to the evidence contained in the preliminary hearing transcript. (*Currie v. Superior Court* (1991) 230 Cal.App.3d 83, 90; *Stanton v. Superior Court* (1987) 193 Cal.App.3d 265, 269-270.) "A motion under Penal Code 995 cannot resolve problems not apparent from the transcript of the preliminary hearing; generally, its purpose is to review the sufficiency of the pleading based on the record before the magistrate at the preliminary hearing." (*Merrill v. Superior Court* (1994) 27 Cal.App.4th 1586, 1596.)

Thus, any of defendant Ott's arguments in her motion under section 995 related to different standards or regulations which may or may not be applicable to a rural health care district (see Def.'s Mot. to Dismiss Pursuant to Penal Code section 995 p.14, line 16-p.15 line 11) are necessarily irrelevant to the review under the instant motion. Apart from the fact that defendant Ott did not raise this argument at the preliminary hearing, a change in regulations would have no legal effect on defendant Ott's criminal liability.

As the Court of Appeals has noted before, "[d]eprivation of a substantial right [at the preliminary hearing] is properly addressed by a section 995 motion when the error is visible from the 'four corners' of the preliminary hearing transcript." (*People v. Duncan* (2000) 78 Cal.App.4th 765, 772.) Defendant Ott did not raise this point at the preliminary hearing, thus the issue is not within "the 'four corners' of the preliminary hearing transcript." If the Defendant wishes to raise

such an affirmative defense or a novel point of fact, this motion is not the proper context in which to raise it.

II. THE TRANSCRIPT OFFERS REASONABLE GROUNDS TO SHOW DEFENDANT OTT HAD A DUTY TO CONTROL DEFENDANT HUGHES AND FAILED TO DO SO, PERMITTING THE INFLICTION OF UNJUSTIFIABLE PHYSICAL PAIN OR MENTAL SUFFERING ON THE VICTIMS.

Penal Code section 368(b)(1) holds criminally liable those who, having a duty to protect elders—directly or by controlling a third person—permit the elders to suffer unjustifiable physical pain or mental suffering. The California Supreme Court, in *People v. Heitzman*, 9 Cal. 4th 189, 212 found that a duty to protect elders under Penal Code 368 will be found in accord with existing tort law principles. This includes the duty of employers to control employees and other special relationships where the defendant has taken charge of the person whose conduct actually inflicted the harm. The elements listed under CALCRIM 830 additionally require the people to prove that the failure to protect or control under section 368(b)(1) was criminally negligent.

Because the transcript shows defendant Ott failed to fulfill her duty to control defendant Hughes, both as her employer and because she personally took charge of defendant Hughes, and because that failure was criminally negligent, defendant Ott was lawfully committed.

A. Penal Code 368(b)(1) Provides Grounds To Hold Defendant Ott Criminally Liable For Failing to Control Defendant Hughes.

Following the acknowledgment in subsection (a) that "crimes against elders and dependent adults are deserving of special consideration and protection," Penal Code section 368(b)(1) allows for criminal punishment of "[a]ny person who knows or reasonably should know that a person is an elder…and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder…to suffer, or inflicts thereon unjustifiable physical pain or mental suffering[;] or having the care or custody of any elder…, willfully causes or permits the person or health of the elder…to be injured, or willfully causes or permits the elder…to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for

two, three, or four years."

Accordingly, CALCRIM 830 requires the government to prove, in relevant part, that (a) the victims were elders; (b) when the defendant acted, she knew or reasonably should have known that the victims were elders; (c) the defendant, while having custody of the victims,...permitted the victims to suffer, be injured, or endangered under circumstances or conditions likely to produce great bodily harm or death; (d) the defendant had a legal duty to supervise and control the conduct of the person[s] who caused or inflicted unjustifiable physical pain or mental suffering on the victims, but failed to supervise or control that conduct; and the defendant was criminally negligent when she caused or permitted the victims to suffer, be injured, or endangered.

Defendant Ott does not contest that the victims in this case are elders, nor that she knew the victims were elders when she failed to control defendant Hughes. Additionally, the transcript indicates that defendant Ott had custody of the victims, as she was the hospital administrator of the facility at the time of the alleged crimes. (R.T. 15, lines 6-9.)

Whether or not no evidence was presented regarding Ott's medical training, is or is not not a licensed nursing home administrator, and even that a lay person would not have any understanding of the drugs involved in this case (Def.'s Mot. to Dismiss Pursuant to Penal Code section 995 pg. 10, lines 19-25, page 11, line 1,) is irrelevant to defendant Ott's criminal liability. No portion of section 368(b)(1), nor any element of CALCRIM 830, requires the People to prove such points in order for Ott to be held criminally liable for the crimes alleged.

1. Defendant Ott Had A Legal Duty To Control Defendant Hughes, And Failed to Uphold That Duty.

While generally no duty exists to control the conduct of other persons, a duty does exist if the defendant has a special relationship with the actor who ultimately commits the crime alleged. (*People v. Heitzman* (1994) 9 Cal.4th 189, 212.) Special relationships recognized by the Court for the purposes of Penal Code section 368 include common law relationships such as the employer-employee relationship, and where a person takes charge of a third person she knows or should know to be likely to cause bodily harm to others if not controlled. (*Ibid.*) While the

statute is the source of liability, the common law provides the rationale that failure to act can be equivalent to an affirmative act in some situations. (*People v. Rolon* (2008) 160 Cal.App.4th 1206, 1216.)

The transcript of the preliminary hearing clearly indicates that defendant Ott was the hospital administrator at the time of the alleged crimes. (R.T. 15, lines 6-9.) This fact alone is sufficient to establish the employer-employee relationship between defendants Ott and Hughes, thus imposing on Ott the duty to control Hughes. However, even if Ott's position as administrator alone was insufficient to set up the requisite relationship, Ott herself admitted to Agent Fong that "Gwen Hughes reported *directly to her*." (R.T. 346, lines 17-20, emphasis added.)

Further, after the DPH investigation, Ott apparently intended to fire defendant Hughes. (R.T. 347, lines 11-15.) Between defendant Ott's statement to Agent Fong and her attempt to fire Hughes, Ott's conduct demonstrates that not only did she "take charge" of Hughes, but that she "possess[ed] the *ability* to control" Hughes, as required under *Heitzman* (*supra*, 9 Cal.4th at 213.). The final element of the taking-charge theory requires that defendant Ott knew or should have known defendant Hughes was likely to cause bodily harm to others if not controlled. (See *People v. Heitzman, supra*, 9 Cal.4th at 212.) The transcript indicates that at least two KVHD employees attempted to alert Ott to the drastic results of Hughes' conduct, one as early as September of 2006. (R.T. 343, line 28-R.T. 344, line 6; R.T. 30, line 25-31, line 3.)

As the magistrate stated, both nurse Lightner's meetings and Juni's meetings with defendant Ott put her on notice as to Hughes' conduct (*ibid.*), but "Ms. Ott didn't do anything to correct or rectify the situation." (R.T. 431, lines 19-21.) Instead, as related by Agent Fong, defendant Ott responded, "everything would be okay, that Gwen Hughes knew what she was doing." (R.T. 344, lines 12-20.)

Thus, there is probable cause to believe that, whether by defendant Ott's direct employer-employee relationship with defendant Hughes, or because Ott personally took charge of Hughes and knew or should have known that not controlling Hughes could likely cause bodily harm to the elders at KVHD, defendant Ott had a duty to control defendant Hughes' conduct. The death and

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harms suffered by the victims, as indicated in the transcript, demonstrates that Ott failed to uphold that duty.

2. Because Defendant Ott Failed To Control Defendant Hughes, The Victims Suffered Unjustifiable Physical Pain Or Mental Suffering.

When defendant Ott failed to fulfill her duty to control defendant Hughes, many of the residents at the KVHD skilled nursing facility suffered unjustifiable physical pain or mental suffering, and four of them died. The People's expert, Dr. Kathryn Locatell, reviewed the medical records of KVHD residents Mae Brinkley, Joseph Shepter, Alexander Zaiko, Jack Wallace, Vergil Kregger, Eddie Dolenc, Louise Zimmerman, and Opal Towery (R.T. 184, line 23-185, line 15), who are the victims in this case. Each victim was prescribed psychotropic medications, "apparently, by someone other than the physician," and the medications "were administered without adequate informed consent,...without justification at excessive dosages or at excessive durations." (R.T. 185, lines 21-27.) Further, it was Dr. Locatell's testimony that in all cases the prescriptions "constituted chemical restraints used...clearly for the convenience of the staff." (R.T. 185, line 27-186, line 2.) Dr. Locatell clarified that "each prescription violated numerous standards of care...[a]nd in each case great harm was done to the resident." (R.T. 186, lines 3-6.) Dr. Locatell testified it was her opinion that "[i]n five of the eight cases, the residents died...because, at least in part, of the administration of these drugs." (R.T. 186, lines 6-8.)

As to Count One of the Information, 97-year-old KVHD resident Mae Brinkley had been receiving Depakote "about three weeks before her death." (R.T. 189, lines 22-23.) Ms. Brinkley "was...lethargic, unable to swallow her medications, sleeping most of the day, having trouble swallowing, and eventually was near death, unresponsive and moaning, and was sent to the hospital." (R.T. 190, lines 11-15.) At the hospital, Ms. Brinkley was found "to be significantly dehydrated, suffering from a severe fecal impaction, and expired at the hospital after an attempt to treat her." (R.T. 190, lines 16-19.) It was Dr. Locatell's opinion that the Depakote was a significant factor in Ms. Brinkley's death. (R.T. 192, lines 25-26.)

As to Count Two of the Information, 76-year-old KVHD resident Joseph Shepter was sent to the emergency room from the KVHD SNF with dehydration, and died soon after. (R.T. 194,

lines 19-23.) He also had a foul-smelling bedsore on his right heel. (*Ibid.*) Shepter was lethargic, constipated, dehydrated, "wasn't eating or drinking" and lost twenty-four pounds (R.T. 194, lines 13-18.) On the day Mr. Shepter was admitted to the emergency room, he was severely dehydrated and "overwhelmingly infected." (R.T. 196, lines 8-10.) Dr. Locatell's opinion was that the administration and dosage of the drugs were a "gross violation of any standard of care for nursing homes," and they played a "major role" in Mr. Shepter's death. (R.T. 195, lines 5-14.)

As to Count Three of the Information, 85-year-old KVHD resident Alexander Zaiko had been discharged to KVHD's skilled nursing facility "for rehabilitation" following treatment at KVHD's main hospital for pneumonia. (R.T. 196, lines 21-24.) However, one day after being admitted to the SNF, Zaiko's dosage of Zyprexa was increased by 50% without medical justification, and in addition to the Zyprexa, a regimen of Depakote was ordered without diagnosis or medical justification. (R.T. 196, line 25-197, line 7.) Due to this overmedication, "within just eight days, he is in extremis [and] is diagnosed with severe dehydration." (R.T. 197, lines 10-13.) Dr. Locatell's opinion was that the drugs administered to Mr. Shepter caused "severe side effects that prevented him from being able to consume enough fluid to keep alive. He died due to those effects and the dehydration that they caused." (R.T. 197, line 28-198, line 4.)

As to Count Four of the Information, 83-year-old KVHD resident Jack Wallace was given high doses of psychotropic medications of Seroquel, Depakote, and Ativan at KVHD. (R.T. 199, lines 2-11.) Dr. Locatell testified that the "combination of [these] drugs was not survivable in someone like Jack Wallace." (R.T. 199, lines 11-22.) In describing the doses, Dr. Locatell testified they were "astounding," and that "they were increased and increased to the point that…he went to the hospital near death." (R.T. 198, lines 23-27.) In the end, Mr. Wallace was "severely dehydrated, his kidneys had…shut down because of the severe dehydration, and he spent three days in the hospital." (R.T. 200, lines 6-11.)

As to Count Five of the Information, 84-year-old KVHD resident Vergil Kregger was given "more than double [the dose of] what any prudent person" would prescribe for someone like Ms. Kregger, for "unclear behavioral symptoms" and "with no medical assessment." (R.T. 200, line 25-201, line 4.) Ms. Kregger, a "tiny, little 84-year-old woman," was also administered

a "completely uncalled-for" injection of the antipsychotic drug Zyprexa. (R.T. 204, lines 7-10.) Ms. Kregger was then ordered "way too high of a dosage [of Seroquel with no] diagnosis." (R.T. 204, line 20-205, line 6.) The Seroquel was only stopped after Ms. Kregger began falling asleep with food in her mouth, a choking hazard. (R.T. 205, lines 10-19.)

As to Count Six of the Information, 90-year-old KVHD resident Eddie Dolenc was given Seroquel and Duragesic while he was still being administered a lower dose of his existing Depakote prescription. (R.T. 207, line 10-209, line 19; 207, lines 10-12.) The mixture medications made Dolenc extremely sedated such that he was unable to able to eat or drink, and Dr. Locatell testified that he likely died from the combination. (R.T. 208, line 25-209, line 19.) Less than three weeks after being admitted to the SNF at KVHD, Mr. Dolenc was "unable to drink, his intake was extremely poor, he couldn't swallow, and then [was] just found dead." (R.T. 208, lines 4-8.)

As to Count Seven of the Information, 89-year-old KVHD resident Louise Zimmerman was forcibly administered the psychotropic medication, Risperdal, without medical diagnosis or evaluation. (209, line 25-210, line 7.) Ms. Zimmerman was held down by "four or five nursing staff" in order to forcibly inject her with the Risperdal. (R.T. 211, line 20-212, line 7.) The Risperdal injection was in "depot" form, meaning the drug would stay in Ms. Zimmerman's system for two weeks at a time. (R.T. 211, lines 1-5.) Ms. Zimmerman began to experience very serious side effects like "significant swallowing problems" which required her "meds…to be crushed and put in pudding," and eye infections due to the drying effect of the drugs. (R.T. 213, lines 4-21.)

As to Count Eight of the Information, 95-year-old KVHD resident Opal Towery, was, without any medical justification whatsoever "forcibly medicated with [the antipsychotic drug] Zyprexa." (R.T. 213, line 22-214, line 8.) Prior to the injection, Ms. Towery's chart indicated she was "not demented," "very independent" and got around in a "motorized wheelchair." (R.T. 214, lines 15-18.) Ms. Towery's wheelchair was taken away primarily because Defendant Hughes "didn't want these residents going around in their motorized wheelchairs." (R.T. 214, lines 19-24.) After the injection, Ms. Towery was "[s]low to respond, drooling, hard to awaken

then extremely confused, tremors, complained of leg pains. It took three people to assist her to even stand up. She was unable to bear weight…somnolent, almost unresponsive, leg tremors and impaired articulation." (R.T. 217, line 25-218, line 3.) Ms. Towery was then prescribed Risperdal—even though she "was cognitively intact without a psychiatric diagnosis or even any kind of mental or psychiatric evaluation." (R.T. 218, lines 12-15.) After the Risperdal, Ms. Towery had "slurred speech, hands trembling, change in her level of consciousness, not eating, lost more than eight pounds." (R.T. 218, line 27-219, line 2.)

It was Dr. Locatell's opinion that "[e]ach one of these residents was significantly harmed" by the administration of the psychotropic medications, and of the three residents who did not die as a result, they all "were intensely uncomfortable" and "anguished in at least one of the cases." (R.T. 221, lines 24-27.) As to the five residents who died as a result of receiving the medications, Dr. Locatell testified that in her opinion they were greatly injured in the course of dying. (R.T. 222, lines 9-12.) It was also Dr. Locatell's testimony and opinion that the administration of the drugs was a "major contributing factor" to those five residents' deaths; that without the administration of the drugs, "those residents would not have died when they died or under the circumstances that they died." (R.T. 222, lines 23-26.)

Thus, there is probable cause to believe that as a result of defendant Ott's failure to uphold her duty to control defendant Hughes, the victims in this case suffered unjustifiable physical pain or mental suffering.

3. Defendant Ott's Failure To Control Defendant Hughes Was Criminally Negligent.

As noted above, CALCRIM 830 requires an additional showing not only that the defendant failed to uphold a legal duty, which subsequently caused unjustifiable physical pain or mental suffering to an elder, but that such failure was criminally negligent. Criminal negligence is conduct which is such a departure from the conduct of an ordinarily prudent person under like circumstances, as to be incompatible with a proper regard for human life. (*People v. Valdez* (2002) 27 Cal.4th 778, 783.) "Under the criminal negligence standard, knowledge of the risk is determined by an objective test: If a reasonable person in defendant's position would have been

aware of the risk involved, then defendant is presumed to have had such an awareness." (*Ibid.*)

The transcript indicates, and the magistrate found, that both nurse Lightner's meetings and Ms. Juni's meetings with defendant Ott put her on notice as to defendant Hughes' conduct (R.T. 430-431), but "Ms. Ott didn't do anything to correct or rectify the situation." (R.T. 431, lines 19-21.) Instead, as related by Agent Fong, Ott responded, "everything would be okay, that Gwen Hughes knew what she was doing." (R.T. 344, lines 12-20.) Nurse Lightner informed Ott "of the patients' care and how it was being administered." (R.T. 430, lines 6-8.) The magistrate found that defendant Ott's notice in this regard was "important, in that [Lightner] was able to observe the demise of these patients or the deterioration of their health condition." (R.T. 430 9-13.)

Once defendant Ott took the time to verify the information she had been receiving from Ms. Juni and nurse Lightner—which was only after the DPH survey—she admitted to Agent Fong that "she considered the incident as elder abuse to the highest level." (R.T. 347, lines 9-10.) The transcript thus gives very strong evidence that defendant Ott actually knew of defendant Hughes' conduct at the earlier stages of the abuse, which goes beyond the reasonable person standard in *Valdez* (*supra*, 27 Cal.4th at 783).

That defendant Ott knew of the *risk* the conduct involved can reasonably be inferred from the facts in the transcript. Most important is Ott's statement to Agent Fong that she considered Hughes' conduct "as elder abuse to the highest level." (R.T. 347, lines 9-10.) That is, she considered the very conduct she was made aware of previously by nurse Lightner and Ms. Juni to be elder abuse; she simply had not taken the time to verify it prior to the DPH survey. This is plainly "incompatible with a proper regard for human life." (See *People v. Valdez*, *supra*, 27 Cal.4th at 783.)

Even if defendant Ott's admission by itself to Agent Fong is insufficient, the transcript shows myriad evidence supporting probable cause to believe she was or should have been aware of the risk to the elder patients. Defendant Ott was the hospital administrator at the time of the alleged abuse (R.T. R.T. 15, lines 6-9), and does not contest that the patients at the KVHD skilled nursing facility were elders, nor that she knew they were elders. Once being advised by both a KVHD nurse and the activities director that these elders were possibly being overmedicated,

defendant Ott merely deferred to defendant Hughes, because she "knew what she was doing." (R.T. 344, lines 12-20.) In fact, because Ott would not act, the transcript indicates nurse Lightner only found resolution by reporting the circumstances to an ombudsman outside the hospital. (R.T. 33, line 6-R.T. 34, line 19.)

From these facts, a reasonable person would believe there was a high risk of serious injury to the elder victims. The elders were living in a SNF, possibly being overmedicated to the point of immobility (R.T. 343, lines 21-27). Advanced medical training is not required to understand that overmedication can be fatal. As in *Valdez*,, criminal negligence "is the appropriate standard when the act is intrinsically lawful, such as leaving an infant with a babysitter, but warrants criminal liability because the surrounding circumstances present a high risk of serious injury." (*supra*, 27 Cal.4th at 789.) Accordingly, the magistrate correctly found defendant Ott's conduct criminally negligent. (R.T. 430, line 27-R.T. 431, line 1.)

Therefore, defendant Ott was criminally negligent because she knew or should have known of the high risk of serious injury to the elders at KVHD, and because her failure to act was incompatible with a proper regard for human life.

CONCLUSION

The transcript demonstrates, at a minimum, that there is probable cause to believe the victims in this case are elders and that defendant Pamela Ott was aware of this fact at the time of the alleged crimes; that defendant Pamela Ott permitted the victims to suffer, be injured, or endangered under circumstances or conditions likely to produce great bodily harm or death; and, that defendant Pamela Ott was criminally negligent in failing to uphold her duty to control defendant Gwen Hughes.

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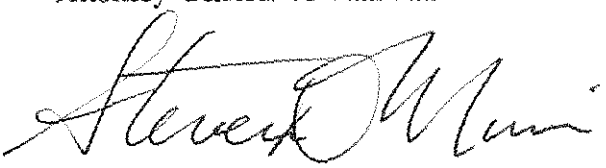
Therefore the People have satisfied their burden of proof at the preliminary hearing, and Defendant Ott was lawfully committed for trial in the Superior Court. For these reasons the People thereby respectfully request the court to deny defendant Pamela Ott's Motion to Dismiss the Information Pursuant to Penal Code section 995.

Dated: May 5, 2011

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California



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Certified Law Student

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DECLARATION OF SERVICE BY U.S. MAIL

Case Name: **THE PEOPLE OF THE STATE OF CALIFORNIA v. PAMELA R. OTT**
No.: **BF126665 D**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service that same day in the ordinary course of business.

On May 5, 2011, I served the attached **PEOPLE'S POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THE INFORMATION PURSUANT TO PENAL CODE SECTION 995** by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the internal mail collection system at the Office of the Attorney General at Bureau of Medi-Cal Fraud and Elder Abuse, 1425 River Park Dr., Suite 300, Sacramento, CA 95815-4524, addressed as follows:

Mark Raimondo
Kern County Public Defender's Office
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Bakersfield, CA 93301
(Counsel for Gwen Hughes)

Fred Gagliardini
1527 19th Street, Suite 326
Bakersfield, CA 93301
(Counsel for Hoshang Pormir)

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on May 5, 2011, at Sacramento, California.

Rachel Carey
Declarant

Rachel Carey
Signature

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DECLARATION OF SERVICE BY FACSIMILE AND MAIL

Case Name: **THE PEOPLE OF THE STATE OF CALIFORNIA v. PAMELA R. OTT**

No.: **BF126665 D**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar at which member's direction this service is made. I am 18 years of age or older and not a party to this matter; my business address is Bureau of Medi-Cal Fraud & Elder Abuse, 1425 River Park Dr., Suite 300, Sacramento, CA 95815-4524. I am familiar with the business practice at the Office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service that same day in the ordinary course of business. My facsimile machine telephone number is (916) 274-2929.

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James Faulkner
Faulkner Law Offices
Attorney at Law
1825 18th Street
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Fax #: (661) 327-1220
Attorney for Defendant

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on May 5, 2011, at Sacramento, California.

Rachel Carey
Declarant

Rachel Carey
Signature

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KAMALA D. HARRIS
Attorney General

State of California
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OFFICE: **Department of Justice, Office of the Attorney General**
LOCATION: **Sacramento**
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MESSAGE/INSTRUCTIONS

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