Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

B.K. by her next friend, MARGARET TINSLEY, *et al.*,
Plaintiffs/Appellees,
v.
GREGORY McKAY, *et al.*,
Defendants/Appellants.

On Appeal from the United States District Court
for the District of Arizona
No. 2:15-CV-00185-PHX-ROS
Hon. Roslyn O. Silver

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF ARIZONA, AND PRISON LAW OFFICE IN SUPPORT OF PLAINTIFFS/APPELLEES' OPPOSITION TO APPEAL OF CLASS CERTIFICATION ORDER

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CORPORATE DISCLOSURE STATEMENT

In accordance with Federal Rule of Appellate Procedure 26.1, *amici curiae* American Civil Liberties Union, American Civil Liberties Union of Arizona, and Prison Law Office state that they are nonprofit organizations with no parent corporations and in which no person or entity owns stock.

Dated: July 6, 2018

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*[1]

The American Civil Liberties Union (ACLU) is a nationwide, nonprofit, nonpartisan organization with over 1.6 million members dedicated to defending the principles of liberty and equality embodied in the Constitution and this nation's civil rights laws. In the nearly 100 years since its founding, the ACLU has been deeply involved in defending the rights of prisoners, detained immigrants, children in foster care, and other persons in government custody. The American Civil Liberties Union of Arizona is one of the ACLU's state affiliates.

The Prison Law Office engages in class action impact litigation to improve conditions in prisons, jails, and juvenile halls for adults and children, represents individual prisoners, educates the public about prison conditions, and provides technical assistance to advocates across the country. The Prison Law Office has litigated numerous large-scale prisoner and parolee class actions in the last 40 years. These include *Brown v. Plata*, 563 U.S. 493 (2011) (holding that court-mandated population limit for California prisons was necessary to remedy violations of prisoners' constitutional rights to

[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no person or entity, other than *amici curiae*, their members, and their counsel, made a monetary contribution to the preparation or submission of this brief.

adequate medical and mental health care in two statewide class action lawsuits), and *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206 (1998) (unanimously holding the Americans with Disabilities Act applies to state prisoners).

The ACLU, ACLU of Arizona, and Prison Law Office are counsel for the plaintiff class in *Parsons v. Ryan*, 754 F.3d 657 (9th Cir. 2014), and in the underlying and ongoing litigation against senior officials of the Arizona Department of Corrections ("ADC") challenging systemically inadequate medical, mental health, and dental care, and the abusive use of solitary confinement, in Arizona state prisons.

Because this case implicates this Court's holding in *Parsons*, the U.S. Supreme Court's decision in *Plata*, and the standards for constitutional and civil rights class actions more broadly, its proper resolution is of significant concern to *amici*. Moreover, as class counsel in *Parsons*, *amici* are uniquely situated to inform this Court of the profound systemic deficiencies in the Arizona prison system that were exposed and are being remedied because -- and only because -- *Parsons* proceeded as a class action rather than as a handful of individual lawsuits.

INTRODUCTION AND SUMMARY OF ARGUMENT

In their opening brief, Defendants contend that the thousands of children in their care who each suffer a substantial risk of harm caused by the systemic failures of Arizona's foster care system must individually litigate their claims and are foreclosed from class-wide relief. Defendants' approach misunderstands long-established law on the standards applicable to civil rights class actions and the history and purpose of Rule 23(b)(2).

When plaintiffs seek to proceed as a class to obtain relief from an unconstitutional policy or practice, they need not show that every single one of them has suffered the exact same injury arising in identical circumstances, as Defendants erroneously suggest. An unlawful policy or practice may cause differing degrees or variations of actual injury to individual class members. Constitutionally inadequate health care in a prison system will mean diabetes complications for one person or the exacerbation of a heart problem for another. If such variations were sufficient to defeat class certification, system-wide relief from illegal policies and practices would nearly always be foreclosed to civil rights plaintiffs.

Rule 23 authorizes class actions by persons such as foster children or incarcerated people who face a common, unreasonable risk of harm by virtue of the policy or practice they ask the court to enjoin. That is why, both before

and after the Supreme Court's decision in *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011), federal courts across the country have certified classes of foster children, incarcerated youth and adults, people with disabilities, immigrants in detention, pre-trial detainees, public school students, and others challenging an unconstitutional generally applicable policy or practice.

Under the standards Defendants contrive, no class would have been certified in *Parsons v. Ryan*, 754 F.3d 657 (9th Cir. 2014), and the grave abuses in the Arizona prison system would never have come to light and been remedied. Defendants not only ask this Court to take the radical and unsupported action of overruling its decision in *Parsons*; they also ask that the Court disregard the U.S. Supreme Court's decision in *Brown v. Plata*, 563 U.S. 493 (2011), decided the same Term as *Dukes*.

Defendants' interpretation of the class certification standard has no basis in the law or the history of Rule 23, and would fatally undermine the enforcement of constitutional and civil rights of individuals subject to unconstitutional governmental policies and practices, like those at issue in *Parsons* and in this case.

ARGUMENT

I. WITHOUT CLASS CERTIFICATION IN *PARSONS*, THE GRAVE ABUSES OCCURRING IN THE ARIZONA PRISON SYSTEM WOULD NEVER HAVE COME TO LIGHT

Defendants offer no cogent explanation – because there is none – why this Court should overrule its well-reasoned holding of four years ago in *Parsons*. Under Defendants' contrived standard for civil rights actions, this Court would not have affirmed class certification in *Parsons*, and the "unnecessary pain and suffering, preventable injury, amputation, disfigurement, and death" that routinely occur in the Arizona prison system would have never come to light to be remedied. APP 034.[2]

A. Procedural History of *Parsons*

Parsons was filed in March 2012 on behalf of approximately 33,000 people in the custody of the Arizona Department of Corrections ("ADC"). APP 057.[3] The prisoner plaintiffs moved for class certification, and on March 6, 2013, the district court certified, pursuant to Rule 23(b)(2), a class of "[a]ll prisoners who are now, or will in the future be, subjected to the

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[2] The relevant documents from the *Parsons* district court docket are filed herewith as *Amici*'s Appendix, and all citations are to the Bates numbering ("APP ___").

[3] The Arizona Center for Disability Law, Arizona's federally-designated protection and advocacy agency under the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. § 10801, *et seq.*), is also a plaintiff in the case. APP 014.

medical, mental health, and dental care policies and practices of the ADC." *Parsons v. Ryan*, 289 F.R.D. 513, 525 (D. Ariz. 2013).[4]

The defendant state prison officials petitioned this Court for review of the district court's class certification order pursuant to Rule 23(f); their petition was granted. On June 5, 2014, this Court affirmed. The Court observed:

> After all, every inmate in ADC custody is necessarily subject to the same medical, mental health, and dental care policies and practices of ADC. And any one of them could easily fall ill, be injured, need to fill a prescription, require emergency or specialist care, crack a tooth, or require mental health treatment. It would indeed be surprising if any given inmate did *not* experience such a health care need while serving his sentence.

Parsons, 754 F.3d at 678-79 (emphasis in original).

Subsequent to this Court's class certification ruling, the district court denied ADC officials' motion for summary judgment. *Parsons v. Ryan*, 2014 WL 3887867 (D. Ariz. Aug. 7, 2014). On October 9, 2014, the parties agreed to settle the case. APP 078-145. The settlement agreement ("Stipulation") included over one hundred health care performance measures

[4] The district court also certified a subclass of "[a]ll prisoners who are now, or will in the future be, subjected by the ADC to isolation, defined as confinement in a cell for 22 hours or more each day or confinement in the following housing units: Eyman—SMU 1; Eyman—Browning Unit; Florence—Central Unit; Florence—Kasson Unit; or Perryville–Lumley Special Management Area." *Id*.

(APP 106-113), and nine performance measures related to the subclass of people incarcerated in solitary confinement or "maximum custody" units. APP 136-137.

The health care performance measures enumerate ADC's specific obligations at its ten state-run prisons, and include measures related to minimum staffing levels, access to care, medical records, pharmacy, medical equipment, quality improvement, intake, diagnostic services, specialty care, chronic care, prenatal services, infirmary care, medical diets, mental health care, and dental care. APP 106-113. The maximum custody performance measures enumerate Defendants' obligations to ensure that, among other things, the people incarcerated in maximum custody are offered a certain amount of out-of-cell time, and that persons with serious mental illness receive additional mental health programming. APP 136-137. The Stipulation sets forth a measurement and reporting process to determine "whether ADC has complied with particular performance measures at particular complexes." APP 080 at ¶ 10.[5]

Following notice to the class and a fairness hearing, the district court approved the Stipulation in February 2015. APP 146-194. The Stipulation

[5] The ten prisons covered by the Stipulation are Douglas, Eyman, Florence, Lewis, Perryville, Phoenix, Safford, Tucson, Winslow, and Yuma.

provides that Defendants' duty to measure and report on a particular performance measure at a particular prison terminates when that performance measure has been compliant for eighteen months out of a twenty-four month period, and has not been out of compliance for three consecutive months during the previous eighteen-month period. APP 081-082 ¶ 10. Accordingly, if Defendants had complied with the Stipulation, these obligations would have terminated in February 2017.

From the beginning, however, ADC officials have persistently failed to comply with a number of performance measures critical to the health, safety, and lives of *Parsons* class members. *See* APP 528-530. On October 10, 2017, the district court, citing ADC's "pervasive and intractable failures to comply with the Stipulation," ordered prison officials to "show cause as to why the Court should not impose a civil contempt sanction of $1,000 per incident of non-compliance commencing the month of December 2017." APP 465, 468.[6] Following four days of evidentiary hearings, during which the two named defendants, ADC Director Charles Ryan and Assistant Director Richard Pratt, testified, the district court held Defendants in

[6] Defendants' appeal of this order was dismissed by this Court for lack of jurisdiction. *Parsons v. Ryan*, No. 17-17324, Order (9th Cir. May 21, 2018).

contempt and imposed $1,445,000 in fines. APP 550-551. The court concluded:

> The evidence shows that the mere threat of monetary sanctions was not sufficient to generate ADC's compliance with the Stipulation. More importantly, the evidence presented to the Court indicates that wide-spread and systemic failures remain.

APP 546. The court continued:

> The inescapable conclusion is that Defendants are missing the mark after four years of trying to get it right. Their repeated failed attempts, and too-late efforts, to take their obligation seriously demonstrate a half-hearted commitment that must be braced. … Accordingly, it appears the Court must do what Defendants will not: compel compliance with the Stipulation.

APP 547.

In a separate order issued the same day, the district court concluded:

> After more than three years, it is clear to the Court that Defendants are unable or unwilling to meet several of the Stipulation's requirements. Defendants have submitted, and the Court has adopted, multiple remediation plans. Defendants have revised and re-revised these remediation plans and yet, pockets of non-compliance persist.

APP 583 (record citations omitted). Accordingly, the court decided that it would "require Defendants to hire outside experts who can perform the analysis necessary to understand why deficiencies persist and to opine as to

the policies and procedures necessary to compel compliance with the Stipulation." APP 585 (footnote omitted).[7]

B. Arizona's Broken Prison Health Care System Results in Needless Suffering and Death.

In affirming class certification in *Parsons*, this Court observed that the plaintiffs' evidence "paints [a] … grim picture of ADC's operations from 2009 through the time this case was filed." 754 F.3d at 669. Subsequent proceedings in the case paint an equally grim picture – that of a profoundly broken prison health care system that routinely results in "unnecessary pain and suffering, preventable injury, amputation, disfigurement, and death." APP 034. Critically, this evidence of deadly systemic failures in the Arizona prison system has come to light *only* because *Parsons* proceeded as a class action, rather than as a handful of individual lawsuits as Defendants here would have it.

///

[7] The district court also concluded that Defendants' monitoring and reporting of their compliance with the Stipulation was unreliable. "At this point, the inescapable conclusion is there are profound and systemic concerns with the monitoring process at every stage of the process." APP 557. The court observed that "Defendants and their contractor are at times more interested in obtaining compliance with the Stipulation by playing a shell game than by providing care to the Plaintiff Class" (APP 562), and announced its intention to appoint a Rule 706 expert to "review the entire monitoring process." APP 563.

1. Class Certification in *Parsons* Exposed the Inadequate Health Care Staffing That Exists System-wide

This Court noted in *Parsons* that "plaintiffs allege that they are placed at risk of serious harm by a policy and practice of severe under-staffing across all ADC medical care facilities." 754 F.3d at 679. The Court concluded that this claim —which was supported by Defendants' own documents, *id*. at 668-69; and by expert reports, *id*. at 669-671 —"can be remedied on a class-wide basis by an injunction that requires ADC to hire more doctors." *Id*. at 689.

The district court noted in its denial of summary judgment that "Defendants' motion is lacking in argument or evidence establishing that staffing levels are sufficient to provide minimally competent and adequate medical care for the prison population," and observed that "access to care necessarily requires access to qualified staff and absent from Defendants' motion is any evidence regarding what level of staffing by position satisfies constitutional minima for a prison population of 36,000 and whether their existing staffing meets that standard." *Parsons*, 2014 WL 3887867 at *4.

In March and April 2016, fourteen months after the effective date of the Stipulation, the plaintiffs' correctional health experts reported that, in the Arizona prison system, "there are clearly too few medical staff to ensure that the patients receive timely care." APP 329 ¶ 29. Plaintiffs' medical expert,

Dr. Todd Wilcox, opined that patients continued to be at an "unreasonable risk of harm" as a result of inadequate staffing, and some "suffer preventable deaths." APP 321-322 ¶ 9.

In his review of all mortality reviews and medical records for dozens of patients who died during a several-month period ending in January 2016, Dr. Wilcox found grossly deficient care in 37% of the cases, and concluded that delays in diagnosis and treatment resulted in preventable deaths, shortened lifespans, and unnecessary pain and suffering. APP 325 ¶ 18. "[A] substantial proportion of the problematic deaths involved health care delivery system failures, including limited access to care based on an insufficient number of qualified providers and nurses . . . ." APP 326 ¶ 19.

Among those who died was a 59-year-old man with end-stage liver disease, who suffered from massive fluid retention, groin wounds, and sepsis. APP 333-334 ¶ 41. The Stipulation provides timelines for screening and responding to sick call requests. *See* APP 108 (Performance Measures 36 and 37). For weeks, this patient submitted sick call requests pleading for care for painful open wounds on his legs, but nurses failed to see him. APP 333-334 ¶¶ 41-42. After a few weeks, his fluid retention worsened so that "his skin split open and became infected. . . . [His] situation deteriorated to the point that he was being swarmed by flies." APP 334 ¶ 42 (emphasis in original).

He ultimately was transferred to a hospital more than a week later, where he died. *Id.*

Dr. Wilcox explained that with too few medical providers and nursing staff, "critical errors are likely to occur." APP 340 ¶ 53. He also found an ongoing pattern of ordered care -- including medications, labs, nursing care, and follow-up appointments -- not being provided, and concluded that this pattern was "another symptom of a badly understaffed medical care system." APP 364 ¶ 118.

The plaintiffs' mental health expert, Dr. Pablo Stewart, "repeatedly expressed [his] concern about the chronic understaffing in ADC's mental health program." APP 400 ¶ 10. Between April and December 2015, the system-wide fill rate for psychologists ranged from 46% to 52%; for mental health nurse practitioners, it ranged from 26% to 49%. APP 211-212 ¶ 24. The psychiatric director position was vacant from February through December 2015. *Id*. As of March 2017, the fill rate for psychologists was 52%; for psychiatrists, 67%; for recreational therapists, 20%; for the psychiatric director, 0%; and for the mental health registered nurse supervisor, 0%. APP 400 ¶ 11.

Dr. Stewart explained that there were two components to ADC's mental health staffing shortage:

> First, there appears to be a chronic inability to hire and retain staff, resulting in critical positions often being vacant. A December 18, 2015 letter from Shane L. Evans, Senior Manager of Compliance, to Lucy Rand, Assistant Attorney General, states that the statewide fill rate for psychologists is 50%, and for psych associates it is 77%. But even those figures significantly overstate ADC's mental health staffing, since they include contract staff, overtime, and agency or locums staff.
>
> [. . .]
>
> Second, even if all authorized mental health staff positions were filled, staffing would likely still be inadequate. . . . According to the ADC website, on March 11, 2016, ADC had 35,366 prisoners in its state prisons, yielding a prisoner to psychiatric provider ratio of **1,861 to 1**. By contrast, the Colorado Department of Corrections has . . . a ratio of **531 to 1**.

APP 211-212 ¶¶ 23, 25 (citations omitted) (emphasis in original). Dr. Stewart quoted ADC's own documents showing large backlogs of mental health patients awaiting care. APP 209 ¶ 21 ("[t]he current statewide Psychiatric appointment backlog is 1,385"); *id.* ("we have a large psych backlog – close to 1000"); APP 211 ¶ 22 ("Mental Health backlog has increased since we have had a decrease in staff").

Dr. Stewart reviewed the records of three people who died by suicide in ADC prisons. In two of these cases, the patient was not seen by mental health staff with the frequency required by the Stipulation in the weeks and

months prior to his or her suicide. APP 224 ¶ 56; APP 229-230 ¶ 70. In one case, ADC's own Mortality Review Committee concluded that the suicide was preventable and that "the patient's death was caused by or affected in a negative manner by health care personnel." APP 224-225 ¶ 57.

Dr. Stewart further detailed the "concrete harm" suffered by prisoners due to ADC's noncompliance with the Stipulation performance measure ("PM") requirements regarding the frequency with which mental health staff must see patients. APP 222 ¶ 48. For example, "[e]ven as [a patient] presented with floridly psychotic behavior, sitting naked in his cell and eating his feces, he was not seen by a [mental health] provider every 90 days as required by PM 81; nor was his treatment plan updated every 90 days as required by PM 77." *Id.*

On December 4, 2017, the district court appointed Advisory Board Consulting ("Advisory Board") pursuant to Fed. R. Evid. 706 to "to provide an assessment and recommendation for health care provider staffing and retention at the ADC facilities." APP 474-476. The Advisory Board's analysis found sustained and endemic failure to fill budgeted health care staff positions across the ADC system. Its findings include (all findings pertain to calendar year 2017; all emphasis in original):

> At Perryville, the state's only women's prison, "**[p]hysicians never reached budgeted staffing levels**." There was

> "**consistent understaffing of all [mental health] provider types for majority of the year**;" mental health staffing did not meet budgeted levels at any point during 2017. (APP 510).
>
> Phoenix, the state's designated mental health prison, was "[c]hallenged to meet Physician staffing at the beginning of 2017 with **no coverage from June to September 2017.**" There was also "[s]ignificant understaffing of Psychologists in first three quarters of the year" (APP 511).
>
> At Tucson, "[p]hysician staffing **rarely met even 1/3** of budgeted levels." "Although Psychiatrists and Psychologists were consistently staffed, there **weren't enough FTEs present to meet budgeted levels**" (APP 512).
>
> At Safford, medical provider coverage "[d]idn't meet budget 75% of the year because the 1.0 FTE **Medical Director stopped providing coverage** in mid-April, although was not [terminated] until December 1st" (APP 515).
>
> At Florence, "Medical Director and Physician staffing was inconsistent, with many weeks without coverage" (APP 521).
>
> Winslow had no mental health staff at any point during the year (APP 516).

On June 22, 2018, the district court ordered ADC to file within 30 days its plan to implement the Advisory Board's recommendations. APP 582.

2. **System-wide Deficiencies in Access to Health Care**

Patients in a prison facility must have an effective method for making their medical needs known to the medical staff. *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982). In Arizona, class members requesting a medical, dental, or mental health appointment must submit a written health

needs request form ("HNR"), and historically these HNR forms were collected in locked boxes located on prison units. Because these forms provide a crucial link between health care staff and prisoners, staff response time in triaging HNRs and then providing access to appropriate care is an essential monitoring parameter.

Under the Stipulation, patients who submit HNRs describing an urgent need must be seen the same day by a nurse; otherwise, they must be seen by nurses for sick call ("nurse line") within 24 hours of the receipt of the HNR. APP 108 (PMs 36, 37). Based upon the nurse's assessment, the patient may or may not be referred and scheduled to see a primary care provider ("PCP"). If the nurse determines the patient requires the attention of a PCP on a routine basis, the patient must be scheduled and seen by the provider within 14 days of the nurse appointment. *Id*. (PM 39). If PCPs order diagnostic procedures such as X-rays or biopsies, they are to review and act upon these reports within five days of receipt of the report. APP 109 (PM 46). As the district court noted, "[a]t least a dozen of the Stipulation's performance measures require health care staff to act within certain time frames and it is the submission of a HNR which starts the clock for assessing compliance with them." APP 566.

Failure to adhere to these timelines places patients at serious risk of substantial harm. The district court found ADC substantially noncompliant with many of these performance measures related to access to care on May 20, 2016, April 24, 2017, and October 11, 2017. APP 380-382; APP 394-395; APP 469-473. Partially in response to these findings of noncompliance, in May 2017 ADC announced that it was removing the boxes into which class members could deposit their HNR forms, and instead was adopting a so-called "open clinic process," under which patients could only submit the HNR form when visiting the nurse in person. APP 566-567.

The *Parsons* plaintiffs objected to the unilateral decision to remove the HNR boxes because it created an unnecessary barrier to access to health care. Dr. Wilcox opined that the removal of the HNR boxes "amounts to nothing more than a blatant attempt to avoid accountability and to eliminate the only traceable audit trail of patient requests for care" and "would guarantee a decrease in actual access to healthcare within the system. . ." APP 420 ¶¶ 27-28. The district court held four days of hearings in the summer of 2017 to assess whether this new process frustrated class members' access to care and the court's ability to assess compliance with the Stipulation. The evidence – including ADC's own documents – showed that under the new system, there was a limited window of time for class

members to access care and patients were turned away if they came outside of their designated time slots. There were long waits, often in harsh conditions, to see a nurse, which affected all class members but especially those with disabilities. APP 447-449, 451-458.

The district court recently ordered ADC to re-install the HNR boxes to ensure all patients have access to care, and so that compliance monitoring is more accurate:

> The testimony presented in Court indicated that not all inmates are able to attend an open clinic, wait to be seen, and submit an HNR without difficulty. Specifically, witnesses testified that some inmates were unable to attend the open clinic during the designated hours. Other inmates were too ill or disabled to get to and wait at the open clinic. Finally, some inmates were required to wait outside in temperatures exceeding 100 degrees while waiting to see nursing staff.

APP 567 (record citations omitted).

3. Systemic Deficiencies in the Provision of Specialty Care

One of the class claims certified in *Parsons* related to ADC's failure to provide class members with timely access to medically necessary specialty care provided by outside consultants, such as cardiologists and oncologists. 289 F.R.D. 513, 522 (D. Ariz. 2013). The Stipulation contains five separate performance measures related to the timely and competent provision of specialty care. APP 109. From April to October 2017, the district court found

ADC substantially noncompliant with four of these measures at certain facilities. APP 395, 470-471 (PMs 49, 50, 51, 52).

The court's rulings came after Dr. Wilcox documented the devastating impact of delays in care for three young men who had testicular cancer, "a condition which, if treated timely is almost always curable." APP 323 ¶ 13. One 42-year-old man underwent an orchiectomy (removal of his testicle as treatment for cancerous tumor) and should have seen an oncologist immediately after the surgery. Instead, he did not see an oncologist for five months. APP 324 ¶ 15. By the time he received a second surgery, eight months later, his cancer had spread widely, and he died of shock from a severe post-operative bleed. ADC's Mortality Review Committee concluded his death was preventable. *Id.* Another man, who was 30 years old, waited six months before receiving the recommended orchiectomy. With this delayed treatment, his cancer spread to his lungs and was deemed untreatable, and the patient had less than a year to live. Dr. Wilcox concluded, "[h]e will die of a treatable, curable disease." APP 323-324 ¶ 14. The third patient, 27 years old, likewise suffered multiple-month delays in his treatment for testicular cancer, both for his orchiectomy and his post-surgery chemotherapy. APP 324-325 ¶¶ 16-17.

More recently, Dr. Wilcox reviewed the medical record of a class member who filed on the district court docket on August 29, 2017 a "Notice of Impending Death." APP 437. This patient told the court that "ADOC and Corizon delayed treating my cancer. Now because of there [sic] delay, I may be luckey [sic] to be alive for 30 days. The delayed treatment they gave me is causing memory loss, pain." *Id.*[8] Dr. Wilcox noted that the patient's "prediction was prescient, as he died on September 7, 2017 from invasive squamous cell cancer that had resulted in a very large (6 by 7 cm) open lesion on his head that invaded the underlying skull bone and caused the bone to die and ultimately become infected. Once the tumor breached the bone, it was inevitable that it would directly invade his brain." APP 485 ¶ 5. Dr. Wilcox observed that this patient's case was "unfortunate and horrific, and he suffered excruciating needless pain from cancer that was not appropriately managed in the months prior to his death" (*id.*), and that the "first systemic issue I identified in [his] care is a failure in specialty care and treatment." APP 486 ¶ 7.

On July 8, 2017, the prison health care provider had submitted an "urgent oncology consult for radiation of frontal [squamous cell carcinoma]

[8] Corizon is the for-profit company that ADC selected to provide medical, dental, and mental health care to the persons incarcerated in the ten state prisons.

lesion" for this patient to Corizon's Utilization Management team at the company's headquarters. She wrote:

> THIS NEEDS EMERGENT TREATMENT. HE IS NOT SAFE AND IS AT VERY HIGH RISK FOR OSTEOMYELITIS OF THE SKULL OR MRSA CELLULITIS. THE WOUND IS HORRIFIC. [PATIENT] IS EXPOSED TO THE ENVIRONMENT (DUST, DIRT, HEAT, FLIES), DIRTY HOUSING AND SHOWER FACILITIES (OLD EVAP COOLERS, DORM STYLE HOUSING AND BATHING).
>
> I CANNOT STRESS HOW IMPORTANT IT IS THAT WE TAKE SOME TYPE OF IMMEDIATE ACTION.

APP 487-488 ¶ 12 (capitalization in original). This patient was finally hospitalized seven weeks later on August 28, 2017, one day before his "Notice of Impending Death" reached the courthouse, and died ten days thereafter. APP 488-489 ¶ 14.

ADC's own mortality reviews of persons who died in its custody in 2017 show recurrent failures to provide minimally adequate health care. As the district court found in holding ADC officials in contempt on June 22, 2018:

> Of the 18 mortality reviews submitted into evidence during the [order to show cause] hearing, ADC checked "yes" 6 times to the question: "Could the patient's death have been prevented or delayed by more timely intervention." ADC checked "yes" 8 times to the question: "Is it likely that the patient's death was caused by or affected in a negative manner by health care personnel."

APP 534-535 (record citations omitted). The district court went on to observe that ADC's physician monitor testified that he was contacting Corizon's regional director "almost daily about obtaining specialty care for specialty patients because their consults were languishing and prisoners were not being seen on a timely basis." APP 535. This monitor testified about his use of an "Escalation List" and a weekly meeting with Corizon high-level staff regarding extremely high acuity patients in critical need of specialty care, but "acknowledged that if the system worked as it should then high acuity patients would receive appropriate care as a matter of course and there would be no need for the Escalation List." APP 536. The district court concluded:

> Obtaining care for high acuity patients depends on committed individuals advocating for the care that the State has already paid Corizon to provide. Notwithstanding Defendants' use of the Escalation List, Defendants are not entitled to congratulations for developing an extraordinary method, which identifies a subset of high acuity patients, in order to ensure that they receive the care that all high acuity inmates are entitled to receive under the Stipulation. To be clear, these high acuity patients made it to the Escalation List because they had not received the health care to which all inmates are entitled. If the system worked as it should, there would be no need for this Escalation List.

APP 544 (emphasis in original).

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4. Systemic Deficiencies in Mental Health Care

The district court granted class certification on plaintiffs' claims regarding "[f]ailure to provide mentally ill prisoners medically necessary mental health treatment (i.e. psychotropic medication, therapy, and inpatient treatment)" and "[f]ailure to provide suicidal and self-harming prisoners basic mental health care." *Parsons*, 289 F.R.D. at 522-23. The Stipulation includes 27 performance measures related to mental health care. APP 111-113.

In April 2016, plaintiffs' mental health expert Dr. Pablo Stewart concluded that "ADC remains out of compliance with a number of critically important mental health Performance Measures, resulting in a substantial risk of serious harm or death to ADC prisoners with mental health needs." APP 243 ¶ 113. These included:

- PM 81 (requiring patients on psychotropic medications to be seen every 90 days by a psychiatrist or psychiatric nurse practitioner) ("Lewis was noncompliant every month from February through November; Tucson was noncompliant from June through December"). APP 213 ¶ 27.

- PM 85 (requiring patients to be seen by a psychiatrist or psychiatric nurse practitioner within 30 days of discontinuing psychotropic medication) ("no prison has achieved compliance with this measure in a single month between February and November 2015"). APP 214 ¶ 29.

- PM 80 (requiring patients classified as MH-3A to be seen a minimum of every 30 days by a mental health clinician)

("several consecutive months of noncompliance at Eyman (7 months), Tucson (8 months), and Lewis (6 months)"). APP 214-215 ¶ 31.[9]

Dr. Stewart has "repeatedly expressed [his] grave concern about ADC's chronically inadequate suicide prevention program, and the high rate of completed suicides in Arizona prisons," as well as "the frequency of avoidable suicides in ADC, including those that ADC's own mortality reviewers found to be avoidable." APP 397 ¶ 3. ADC's suicide rate is higher than the national average for state prison systems. *Id*. In a single twenty-day period in April and May 2017, four ADC prisoners died by suicide, in what Dr. Stewart called "an extraordinary and extremely alarming series of events," "a very rare occurrence, and … a sign of significant deficiencies in ADC's suicide prevention and mental health care more generally." APP 397-398 ¶ 4. One of these patients hanged himself mere hours after being removed from suicide watch. APP 398 ¶ 6.[10]

In another case, a patient received no attention whatsoever from ADC medical or mental health staff between his intake into the prison system and

[9] The Stipulation defines a "mental health clinician" as a psychologist or psychology associate. APP 102.

[10] More recently, two people incarcerated in ADC prisons died by suicide in an 11-day period in June 2018. *See* https://corrections.az.gov/article/inmate-death-notification-everest (June 16, 2018); https://corrections.az.gov/article/inmate-death-notification-maraventano (June 27, 2018).

his suicide four days later, conduct Dr. Stewart found to "fall[] far below the standard of care." APP 389 ¶ 23. Dr. Stewart also reviewed the case of a woman who swallowed razor blades while on a constant suicide watch; "[t]hat a patient on constant watch was able to obtain and swallow razor blades indicates a serious and lethal defect in watch procedures." APP 219-220 ¶ 42.

* * *

None of these systemic deficiencies would have come to light, and been subject to remedial orders from the district court, had *Parsons* not proceeded as a class action. Plaintiffs' experts would not have been given access to ADC facilities and documents, and the district court would not have appointed The Advisory Board pursuant to Fed. R. Evid. 706 to conduct a system-wide staffing study, in an individual lawsuit brought by Victor Parsons. Lawsuits by individual prisoners – even those represented by counsel – are often dismissed based on failure to exhaust administrative remedies (*see* 42 U.S.C. § 1997e(a)) or a failure to show deliberate indifference (*see Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). At best, they result in monetary or injunctive relief that is limited to the individual plaintiff; if the prisoner has died by suicide or from medical neglect, injunctive relief is not available at all. Individual lawsuits are simply not a

vehicle for repairing a dysfunctional state agency that daily exposes thousands of persons to a substantial risk of injury or death, whether it be a state foster care agency or a state prison system. That is precisely the role that the drafters envisioned for class actions brought pursuant to Rule 23(b).

II. THE PRIMARY PURPOSE OF RULE 23(B)(2) IS THE CERTIFICATION OF CIVIL RIGHTS CLASS ACTIONS.

The primary purpose of Rule 23(b)(2) was to enable civil rights class actions. Amended in 1966 in response to fierce resistance to desegregation following *Brown v. Board of Education*, 347 U.S. 483 (1954), Rule 23(b)(2) ever since has played a pivotal role in the enforcement of civil and constitutional rights. Prior to the 1966 amendments, governmental defendants, sometimes successfully, opposed certification of classes of African Americans challenging race-based policies, using arguments strikingly similar to those made by Defendants here.

For example, in *Reddix v. Lucky*, 252 F.2d 930 (5th Cir. 1958), "the court held a class action improper to challenge the action of the registrar in striking many Negroes from the voting lists as illegally registered, since the right of each voter would depend upon the action taken with regard to the voter's particular case." 7A Charles Alan Wright & Arthur R. Miller, *Federal Practice & Procedure* § 1752 (3d ed. 2018).

The 1966 amendments responded precisely to these arguments to make

clear that such cases were entirely appropriate for resolution as a class—and for class-wide declaratory or injunctive relief. The Advisory Committee noted that "various actions in the civil-rights field" were "illustrative" of the type of cases Rule 23(b)(2) "is intended to reach." Fed. R. Civ. P. 23 advisory committee's note to 1966 amendment; *see also* Wright & Miller, *supra*, § 1776 ("[S]ubdivision (b)(2) was added to Rule 23 in 1966 in part to make it clear that civil-rights suits for injunctive or declaratory relief can be brought as class actions."); *Dukes*, 564 U.S. at 361 ("In particular, the Rule reflects a series of decisions involving challenges to racial segregation—conduct that was remedied by a single classwide order.").

As a result, Rule 23(b)(2) has provided a crucial vehicle for successful challenges to unconstitutional policies and practices—from many of the seminal civil rights cases of the mid-twentieth century to recent prison conditions cases, such as *Parsons*. The instant case—a civil rights class action seeking injunctive relief to benefit all children in the Arizona foster care system—typifies the sort of civil rights actions for which Rule 23(b)(2) was designed.

III. *PARSONS* WAS CORRECTLY DECIDED AND DEFENDANTS' PROPOSED INTERPRETATION OF RULE 23 WOULD UNDERMINE THE ENFORCEMENT OF CONSTITUTIONAL AND CIVIL RIGHTS.

Defendants assert that this Court wrongly decided *Parsons* four years

ago, and propose that the Court overrule its prior well-founded decision in favor of a novel and unsupported standard for Rule 23(b)(2) that would harken back to the days of state and local government resistance to racial desegregation prior to the 1966 Amendments to the Rule.

In *Parsons*, this Court upheld a district court's order granting class certification where plaintiffs sued the ADC for systemic deficiencies and outlined a number of specific, uniform, statewide policies and practices that exposed all ADC prisoners to a substantial risk of serious harm. *Parsons*, 754 F.3d at 662. The district court found that all ADC prisoners were exposed to "specified statewide ADC policies and practices that govern the overall conditions of health care services and confinement," and this exposure resulted in "a substantial risk of serious future harm to which the defendants were deliberately indifferent." *Id*. at 678. The sort of claim-specific analysis *Parsons* applied is precisely what is required under Rule 23—both before *Dukes*, and after.

The Supreme Court reiterated in *Dukes* that "'[c]ivil rights cases against parties charged with unlawful [conduct] are prime examples' of what [Rule 23](b)(2) is meant to capture." 564 U.S. at 361 (quoting *Amchem Prods. Inc. v. Windsor*, 521 U.S. 591, 614 (1997)). *Parsons*, like this case, involved constitutional provisions under which exposure to a substantial risk of serious

harm is *itself* the constitutional violation. "[T]he proper standard for determining whether a foster child's due process rights have been violated is 'deliberate indifference,' the same standard applied to substantive due process claims by prisoners. This standard 'requires an objective risk of harm and a subjective awareness of that harm.'" *Henry v. Willden*, 678 F.3d 991, 1000-01 (9th Cir. 2012) (citation omitted) (quoting *Tamas v. Dep't of Soc. & Health Servs.*, 630 F.3d 833, 844-45 (9th Cir. 2010)).

Defendants contend that Plaintiffs' claims require an individualized inquiry into the facts of each child's situation and a separate remedy for each child. For this contention they point to *Lewis v. Casey*, 518 U.S. 343 (1996) and *Estelle v. Gamble*, 429 U.S. 97 (1976). But neither case supports that result—and Defendants' argument is, in any event, foreclosed by *Brown v. Plata*, 563 U.S. 493 (2011), decided the same Term as *Dukes*. In *Plata*, the U.S. Supreme Court affirmed a three-judge panel's grant of relief in two consolidated statewide class actions challenging inadequate medical and mental health care in California prisons.

> Because plaintiffs do not base their case on deficiencies in care provided on any one occasion, this Court has no occasion to consider whether these instances of delay—or any other particular deficiency in medical care complained of by the plaintiffs—would violate the Constitution under *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976), if considered in isolation. *Plaintiffs rely on systemwide deficiencies in the provision of medical and mental health care that, taken as a whole, subject*

> *sick and mentally ill prisoners in California to "substantial risk of serious harm" and cause the delivery of care in the prisons to fall below the evolving standards of decency that mark the progress of a maturing society*. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994).

Plata, 563 U.S. at 505 n.3 (emphasis added).

Where, as here, systemic deficiencies in statewide practices create a serious risk of harm to all class members, and as to which the claims of the class can be resolved in a unitary injunction, class certification is not only appropriate, it is necessary to promote judicial economy, to avoid a multitude of lawsuits arising out of the same facts and seeking the same relief, and to obtain a timely and effective remedy for ongoing constitutional violations that imperil the health and lives of class members.

Defendants' proposed standard for class certification would substantially undermine the enforcement of constitutional and civil rights and ensure that grave constitutional abuses – like those exposed as a result of class certification in *Parsons* – are never brought to light and remedied.

* * *

Because *Parsons* proceeded as a class action, profound deficiencies in Arizona's prison health care system – system-wide deficiencies that pose a daily risk to the health, safety and lives of the 33,000 class members – came to light. The district court has now entered a number of remedial orders to

address those systemic deficiencies. In Defendants' world, however, the *Parsons* litigation would have been confined to the personal situations of the 14 individual named plaintiffs, and these profound systemic deficiencies would have remained hidden from view. This Court should not adopt a rule that would allow such lethal failings by a state agency to go undiscovered and unremedied.

CONCLUSION

The district court's class certification order should be affirmed.

Dated: July 6, 2018

Respectfully submitted,

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

By: s/ David C. Fathi
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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the length limits permitted by Ninth Circuit Rule 32-1. This brief is 7,372 words, excluding the portions exempted by Fed. R. App. P. 32(f), if applicable. The brief's type size and type face comply with Fed. R. App. P. 32(a)(5) and (6).

Dated: July 6, 2018

s/ David C. Fathi
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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on July 6, 2018.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: July 6, 2018

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Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

B.K. by her next friend, MARGARET TINSLEY, *et al.*,
Plaintiffs/Appellees,
v.
GREGORY McKAY, *et al.,*
Defendants/Appellants.

On Appeal from the United States District Court
for the District of Arizona
No. 2:15-CV-00185-PHX-ROS
Hon. Roslyn O. Silver

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF ARIZONA, AND PRISON LAW OFFICE IN SUPPORT OF PLAINTIFFS/APPELLEES' OPPOSITION TO APPEAL OF CLASS CERTIFICATION ORDER APPENDIX, VOL. I

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law, Plaintiffs, v. Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities, Defendants	No. **CLASS ACTION** **CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF**

NATURE OF THE ACTION

1. Prisoner Plaintiffs and the Plaintiff Class are housed in Arizona Department of Corrections ("ADC") state prisons, and seek declaratory and injunctive relief against Charles Ryan and Michael Pratt, (collectively, "Defendants") in their official capacities. Prisoner Plaintiffs and the Plaintiff Class are entirely dependent on Defendants for their basic health care. However, the system under which Defendants Ryan and Pratt provide medical, mental health, and dental care (collectively, "health care") to prisoners is grossly inadequate and subjects all prisoners to a substantial risk of serious harm, including unnecessary pain and suffering, preventable injury, amputation, disfigurement, and death. For years, the health care provided by Defendants in Arizona's prisons has fallen short of minimum constitutional requirements and failed to meet prisoners' basic health needs. Critically ill prisoners have begged prison officials for treatment, only to be told "be patient," "it's all in your head," or "pray" to be cured. Despite warnings from their own employees, prisoners and their family members, and advocates about the risk of serious injury and death to prisoners, Defendants are deliberately indifferent to the substantial risk of pain and suffering to prisoners, including deaths, which occur due to Defendants' failure to provide minimally adequate health care, in violation of the Eighth Amendment. "Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Brown v. Plata*, 563 U.S. __, 131 S.Ct. 1910, 1928 (2011).

2. Arizona prisoners also suffer serious harm and are subject to a substantial risk of serious harm as a result of Defendants holding prisoners in isolation in supermax Special Management Units ("SMUs") in cruel and unusual conditions of confinement. Defendants continue to be deliberately indifferent to the substantial risk of pain and suffering, including deaths, which occur due to their systemic failure to provide minimally adequate conditions to prisoners in isolation, in violation of the Eighth Amendment.

3. Plaintiffs seek injunctive relief to compel Defendants to immediately provide prisoner-Plaintiffs and the class members they represent with constitutionally adequate health care and with protection from unconstitutional conditions of confinement.

JURISDICTION

4. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343. This civil action seeks declaratory and injunctive relief under 28 U.S.C. §§1343, 2201, and 2202; and 42 U.S.C. § 1983.

VENUE

5. Venue is proper under 28 U.S.C. § 1391(b), because the Defendants reside in the District of Arizona, and because a substantial part or all of the events or omissions giving rise to Plaintiffs' claims occurred in the District of Arizona.

PARTIES

Plaintiffs

6. Plaintiff Victor Parsons is a prisoner in ADC's Lewis complex. Mr. Parsons has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) with a

possible history of bipolar disorder. Mr. Parsons has received inadequate mental health care, including abrupt stopping and starting of medication, inappropriate medication, and delays in follow up appointments. For example, in June 2010, Mr. Parsons' medications were suddenly discontinued without explanation. After he began to decompensate and experience psychiatric symptoms, he submitted an HNR requesting treatment. Mr. Parsons' medication was abruptly restarted without titrating, placing him at high risk for severe side effects. Mr. Parsons has also experienced delays in his dental care. Mr. Parsons filed four HNRs in 2009 complaining that a temporary filling had fallen out of his tooth. Each time he was seen, Parsons was given another temporary filling that would fall out weeks later, forcing him to restart the process. He was told that the only alternative was to have his tooth pulled, but he refused. After five months, he finally received a permanent filling.

7. Plaintiff Shawn Jensen is a prisoner in ADC's Tucson complex. Defendants have failed to provide him with adequate and timely medical care, causing him harm and permanent injury. Mr. Jensen has a history of prostate cancer. In ADC custody, he encountered delays in having the cancer diagnosed and treated and continues to experience harm and injuries caused by Defendants' inadequate medical care. In November 2006, Mr. Jensen was tested with a Prostate Antigen (PSA) Test and found to have an elevated score of 8.4 and a nodule on the prostate. Once the PSA is over 7, most clinicians order a biopsy. A prison doctor referred him for a biopsy in January 2007, but he did not receive the biopsy until October 2009, after his PSA score had risen to 9.3. The

biopsy revealed he had Stage 2 prostate cancer, an aggressive form, and by February 2010 his PSA score was 12 and urologists recommended aggressive treatment of the cancer, a bone scan to determine the extent of the cancer, and surgery to remove the tumor. Mr. Jensen experienced gaps as long as two months in getting from the prison pharmacy the chemotherapy medication that was prescribed for him by outside urologists. He did not have the surgery until mid-July 2010. When he returned to prison after the surgery, Defendants provided incompetent medical care, and Mr. Jensen suffered harm and permanent injuries due to staff performing medical procedures for which they were not qualified.

8. Plaintiff Stephen Swartz is a prisoner in ADC's Lewis complex. In February 2010, Mr. Swartz suffered eye injuries and extensive facial fractures as a result of an inmate assault. He did not receive timely follow-up with a plastic surgeon or ophthalmologist, but was instead referred to an oral surgeon to treat the facial fractures. Despite multiple referrals from prison doctors for specialty care, Mr. Swartz did not see an ophthalmologist until January 2011, almost a year after he was assaulted, and has permanent partial paralysis to his face. Mr. Swartz filed numerous HNRs to address untreated neuropathic pain, and repeatedly waited months to learn whether pain medications would be approved and provided. He continues to report chronic pain. Mr. Swartz is also diagnosed with bipolar disorder and major depressive disorder, and despite multiple incidents of self-harm, has received inadequate mental health care while on suicide watch and in isolation in a SMU. Additionally, Mr. Swartz has had a cracked

molar for two years. When he went to the dentist for the pain, Mr. Swartz was refused a filling and told the only available treatment was to pull the tooth.

9. Plaintiff Dustin Brislan is a prisoner in ADC's Eyman complex, housed in a SMU. Mr. Brislan is diagnosed with bipolar disorder, schizoaffective disorder, and borderline personality disorder, and he has a designation of Serious Mental Illness ("SMI"). He engages in severe self-injurious behavior – including cutting, head banging, and self-starvation. As a result of his mental illness, he experiences depression, hallucinations, suicidal ideation, and paranoia. Despite the severity of Mr. Brislan's condition, Defendants have failed to provide him with minimally adequate mental health care. Mr. Brislan has received improper medication, and has experienced delays in receiving and abrupt changes to his medication. Mr. Brislan has not been monitored regularly by a psychiatrist, or received therapeutic treatment to address his extreme self-harming behavior. Instead, he has been placed on suicide watch for excessive lengths of time, where he did not receive adequate treatment and continued to commit repeated acts of self-harm.

10. Plaintiff Sonia Rodriguez is a prisoner in ADC's Perryville complex. She is designated as SMI, and she experiences depression, anxiety, and hallucinations. Defendants have failed to provide Ms. Rodriguez with minimally adequate mental health care, and she has experienced poor medication management, lack of therapeutic treatment, and conditions of cruel and inhumane confinement in Perryville's SMU and on suicide watch. The harsh conditions and extreme isolation of the SMU and on suicide watch have

worsened her mental conditions. Ms. Rodriguez has asthma, and has experienced multiple asthma attacks and breathing problems due to the ongoing use of pepper spray by correctional staff on the women housed in the SMU and in suicide watch. On multiple occasions, her medications have been abruptly discontinued or changed and her dosage adjusted without explanation or proper monitoring. As a result, Ms. Rodriguez has suffered severe side effects, including uncontrolled shaking, difficulty speaking, and physical "slowing" and lethargy, and a worsening of her mental health symptoms.

11. Plaintiff Christina Verduzco is a prisoner in ADC's Perryville complex, housed in a SMU. Ms. Verduzco is diagnosed with paranoid schizophrenia, bipolar disorder, and borderline personality disorder. She experiences a variety of symptoms, including auditory and visual hallucinations, anxiety, paranoia, and self-harm by cutting herself. Defendants have failed to provide her with minimally adequate mental health care. She is confined in isolation in Perryville's SMU and has been placed on suicide watch on multiple occasions, most recently in February 2012. While on suicide watch, Ms. Verduzco is forced to wear a smock that barely comes to the top of her thighs, such that her legs and arms are exposed to cold air. While on suicide watch, she has no way to turn out the lights, which are sometimes left on 24 hours a day, and she is subjected to safety checks every 10 to 30 minutes, where correctional staff wake her up if she is asleep. As a result, she cannot sleep, which aggravates her condition. Ms. Verduzco has minimal human contact, cannot go outside, brush her teeth, or bathe regularly. Outside of suicide watch in the SMU, her experience is similar: extended isolation, limited exercise, and

limited therapeutic treatment. Ms. Verduzco has asthma, but she has been pepper sprayed repeatedly by corrections officers. After being sprayed, she has been dragged out of her cell, hosed down, and thrown back into her cell. Ms. Verduzco has been pepper sprayed so much and so often that she now says she is developing a tolerance to the spray.

12. Plaintiff Jackie Thomas is a prisoner in ADC's Eyman complex, housed in a SMU. Mr. Thomas has been diagnosed with depression and seizure disorders. Although Mr. Thomas did not have suicidal ideation when he first arrived at the SMU, his mental and medical conditions have deteriorated over time as he has experienced prolonged periods of isolation in the SMU. While isolated in the SMU, he has become suicidal and committed multiple acts of self-harm, has developed insomnia and lost a great deal of weight. As a result, he has been placed in suicide watch multiple times, where he received minimal mental health care. Mr. Thomas has experienced multiple failures in the administration of his mental health care, including improper cessation and initiation of psychotropic medications, failure to administer prescribed medication, repeated use of ineffective medications and medications with severe side effects, lack of informed consent, and long delays in follow up and psychiatric evaluation. In November 2011, Mr. Thomas overdosed on Diclofenac and did not receive medical attention.

13. Plaintiff Jeremy Smith is a prisoner in ADC's Eyman complex, housed in a SMU. Mr. Smith is diagnosed with depression, a condition aggravated by interruptions in his mental health treatment and his prolonged and indefinite incarceration in the SMU. Mr. Smith's medications have been abruptly discontinued without explanation and

restarted at inappropriate times, after lengthy delays, and without proper evaluation by a psychiatrist. Mr. Smith also has been prescribed powerful medications not indicated for depression. For example, beginning in April 2008, Mr. Smith was given a potent antipsychotic medication carrying a risk of severe side effects, without first being seen by the doctor. His file contains no documentation as to why that medication was prescribed or any indication that Mr. Smith gave his informed consent to receive it. The impact of Mr. Smith's improper care is compounded by the extreme isolation he experiences in the SMU. Mr. Smith has formally renounced his former gang membership ("debriefed") and is thus eligible to be placed in a less restrictive setting; however, despite his mental health condition ADC refuses to transfer him out of the SMU.

14. Plaintiff Robert Gamez is a prisoner in ADC's Eyman complex, housed in a SMU. Mr. Gamez suffered a childhood head injury and has been diagnosed with borderline IQ, possible Post-Traumatic Stress Disorder (PTSD), and possible frontal lobe dysfunction, symptoms of which include major depression, panic and anxiety. Although Mr. Gamez displays symptoms consistent with frontal lobe dysfunction and an initial screen was positive, ADC never conducted follow up tests to confirm his diagnosis. Mr. Gamez has experienced multiple interruptions in care, including delays in responses to his Health Needs Requests ("HNRs"), delays in receiving and abrupt changes to his medication, receiving improper medication, inadequate monitoring and follow up visits, and a lack of psychological services for pronounced mental health deterioration during his prolonged isolation in the SMU. For example, beginning in August 2009, Mr. Gamez

submitted multiple HNRs describing symptoms of paranoia, anxiety, panic, and psychosis, and asking to be taken off his medications and out of isolation. Despite experiencing acute symptoms, Mr. Gamez was not seen for five months. Mr. Gamez's care was managed by a nurse practitioner, and he was not seen by a psychiatrist from 2007 to 2011 despite referrals from staff, multiple HNRs and deteriorating mental and physical health.

15. Plaintiff Maryanne Chisholm is a prisoner in ADC's Perryville complex. Ms. Chisholm has been diagnosed with hypertension, but was not referred to a cardiologist for eight months, despite experiencing chest pains and shortness of breath. Ms. Chisholm has been diagnosed with bipolar disorder, Obsessive Compulsive Disorder, and depressive disorder. She has experienced significant delays and interruptions in medication delivery and psychiatric care and follow-up, which have contributed to worsening symptoms. In April 2011, Ms. Chisholm reported experiencing a nervous breakdown and requested an adjustment of medication; however, she was not seen by a psychiatrist for one month and did not receive a follow up appointment as scheduled. Ms. Chisholm's mental health has also been adversely impacted by custodial harassment. Shortly after first meeting with Plaintiffs' counsel in October 2011, Ms. Chisholm was subjected to three aggressive room searches in as many weeks. When she asked for an explanation Ms. Chisholm was told that she was "causing problems." In February 2012, staff again searched her cell three separate times, and confiscated a book of art and her art supplies, which Ms. Chisholm relies on to manage her mental health symptoms. The art supplies were taken because she had painted a shelf in her cell without permission – in

2008. She also has a broken tooth and another tooth with a missing crown. The dentist told her the only available treatment was to pull her teeth, which she has refused.

16. Plaintiff Desiree Licci is an inmate in ADC's Perryville complex. Ms. Licci has a family history of cancer and was herself treated for cancer ten years ago. In 2010 she observed multiple masses growing on her breasts, mouth, and arms, and reported discomfort in her cervix. Starting in December 2010, Ms. Licci requested testing, and in April 2011 the prison doctor referred her to an oncologist. However, she has still not seen an oncologist and was not sent for a CT scan until September 2011. In the interim, Ms. Licci began experiencing frequent diarrhea, nausea, exhaustion, weight loss, pain, and other alarming symptoms. The CT scan detected multiple masses in Ms. Licci's reproductive organs and biopsies and a colonoscopy were ordered. Still, the Perryville gynecologist insisted that nothing was wrong with her reproductive organs. Ms. Licci did not receive an MRI until December 2011, and it was not properly administered. Ms. Licci had to submit a grievance and wait another month before receiving a second MRI, which confirmed multiple masses on both ovaries. In January 2012, Ms. Licci asked the Perryville Facility Health Administrator (FHA) why she still had not seen an oncologist approximately eight months after being referred by the prison doctor. The FHA told Ms. Licci the oncologist refused to see her without her complete file and that ADC "didn't have" Volume I of her file. However, ADC has Ms. Licci's complete file, as it was produced to Plaintiffs' counsel in January 2012. Additionally, Ms. Licci has a Port-a-cath implanted in her chest; however, nothing in her file indicates whether or not it was

properly flushed by medical staff prior to November 2011.

17. Plaintiff Joseph Hefner is a prisoner in ADC's Lewis complex. Mr. Hefner has impaired vision and experiences eye pain as a result of Defendants' failure to provide him with minimally adequate health care. In 2006, Mr. Hefner's vision deteriorated rapidly after an ADC nurse gave him expired eye drops. In 2006, and again in 2008, Mr. Hefner did not timely receive doctor-prescribed eye medication following eye surgery. Although he has submitted numerous HNRs for recurrent eye pain and twice been referred by an optometrist to see an ophthalmologist, Mr. Hefner has been waiting to see an ophthalmologist for over three years. In March 2011, Mr. Hefner was hospitalized for injuries sustained in a prison altercation. His outside medical records were not requested by the prison physician until three months later, after Mr. Hefner submitted multiple HNRs describing persistent pain and requesting treatment. The records were never reviewed. A CT scan was not done until October 2011, seven months after Mr. Hefner's injury. Mr. Hefner also has chronic gastroesophageal reflux disease (GERD) but his requests for a medical diet have been denied.

18. Plaintiff Joshua Polson is a prisoner in ADC's Eyman complex, housed in a SMU. Mr. Polson has been diagnosed with bipolar disorder, mood disorder, and psychosis. He experiences mood swings, hallucinations, paranoia, and depression, all of which are caused or worsened as a result of Defendants' failure to provide him with minimally adequate mental health care. Mr. Polson has a family history of suicide and he has attempted suicide three times. Nonetheless, he is incarcerated in isolation, where he

has minimal human contact, which results in increased suicidal ideation. He has experienced repeated gaps in his medication and sporadic monitoring of his medication levels. Additionally, Mr. Polson experiences chronic ear infections and has permanent hearing loss in his right ear following significant delays in care, including delays in seeing a physician, delays in follow-up appointments, and delays in referrals to outside specialists. After losing hearing in his right ear, Mr. Polson submitted multiple HNRs for chronic pain in his left ear, but was not evaluated by a doctor for over a month. Mr. Polson also experienced multiple problems with his dental care. He had long delays in treatment for teeth that were broken, and waited three years to receive partial dentures for many missing teeth. Mr. Polson filed a request to see the dentist about a front tooth that had broken off and was causing him a great deal of pain. He was told in response that he was requesting routine care, and he had to wait five months to see the dentist. The remaining portion of the tooth was not extracted until a year after it broke off.

19. Plaintiff Charlotte Wells is a prisoner in ADC's Perryville complex. Ms. Wells has a history of heart disease and high blood pressure, and suffered a heart attack prior to being incarcerated. She arrived to ADC custody in October 2009 complaining of chronic chest pains, and continued to experience dizziness and high blood pressure but was not evaluated by a cardiologist until she was hospitalized four months later for a blocked artery. Ms. Wells received a stent, but two days after returning to Perryville she again reported chest pains. Ms. Wells was not seen by a doctor or returned to the hospital, despite her history and the high risk of arterial clogging and heart attack immediately

following the placement of a stent. She experienced chest pain and high blood pressure, for which she was repeatedly evaluated not by an outside cardiologist but rather by the Perryville gynecologist. Ms. Wells continues to have problems with her blood pressure and intermittent chest pain. Additionally, Ms. Wells experienced broken fillings in two of her teeth in 2010. She complained of pain and requested the fillings be repaired, but was told the only option was to have the teeth pulled, or submit a HNR and wait months to have the fillings approved. She did this, and endured pain for several months before her filings were replaced; however, when she got the filling, the dentist cracked an adjacent tooth. Again, she was told she could have the tooth pulled, or to submit another HNR and wait for a filling. She has waited since November 2011 for repair to the damaged tooth.

20. Plaintiff Arizona Center for Disability Law ("ACDL") is designated as Arizona's authorized protection and advocacy agency under the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), 42 U.S.C. § 10801*, et. seq*. ACDL has statutory authority to pursue legal, administrative, and other appropriate remedies to ensure the protection of individuals with mental illness who are or will be receiving care and treatment in the State of Arizona. 42 U.S.C. § 10805(a)(1). ACDL is pursuing this action to protect and advocate for the rights and interests of prisoners who are "individuals with mental illness" as that term is defined in 42 U.S.C. § 10802. The interests that ACDL seeks to vindicate by bringing this lawsuit – the protection of the rights of individuals with mental illness – are central to ACDL's purpose.

Defendants

21. Defendant Charles Ryan is the Director of the ADC, and he is sued herein in his official capacity. As the Director of the ADC, Mr. Ryan is responsible for establishing, monitoring, and enforcing overall operations, policies, and practices of the Arizona state prison system, which includes the provision of constitutionally adequate medical, mental health, and dental care for all prisoners committed to the custody of ADC. A.R.S. §§ 31-201, 41-1604 (A), 41-1608. As Director, Mr. Ryan is responsible for decisions concerning staff hiring, supervision, deployment, and training that directly affect prisoners' abilities to obtain adequate and necessary health services. He is responsible for providing constitutional conditions of confinement in all units, including but not limited to isolation units. At all times relevant hereto, he has acted under color of state law.

22. Defendant Richard Pratt, P.A.,[1] is the Interim Division Director of the Health Services Division of the ADC and is sued in his official capacity. As Division Director, Mr. Pratt is responsible for establishing, monitoring, and enforcing system-wide health care policies and practices. He is responsible for supervising the provision of adequate medical, mental health, and dental care for all prisoners within the custody of the department, including but not limited to isolation units. At all times relevant hereto, he has acted under color of state law.

FACTUAL ALLEGATIONS

[1] Mr. Pratt's Physician Assistant license (#2342) with the Arizona Regulatory Board of Physician Assistants expired on Oct. 1, 2004 and has not been renewed as of the date of this filing. Mr. Pratt recently replaced Michael Adu-Tutu, D.D.S., as Division Director of Health Services. Plaintiffs' allegations refer to Defendant Pratt because he is the current Division Director, and notwithstanding that the majority of acts and omissions described herein occurred during the tenure of Mr. Pratt's predecessor, Dr. Adu-Tutu.

23. Defendants promise prisoners through written policies to provide sufficient resources to provide the "community standard of health care," but fall far below that measure. ADC Dept. Order 1101.01, 1.1. Defendants' written policies are more honored in the breach than in the observance, leaving prisoners at the mercy of de facto policies that put their lives and health at risk.[2] Defendants are well aware of severe system-wide deficiencies that have caused and continue to cause significant harm to the prisoners in their custody, yet they have failed to take reasonable measures to abate the impermissible risk of harm. In recent years, Defendants ignored repeated warnings of the inadequacies of the health care system and of the dangerous conditions in their isolation units that they received from inmate grievances, reports from outside groups, and complaints from prison personnel, including their own staff. For example, in December 2009, a prison physician emailed Defendant Ryan complaining that ADC officials were breaking the law by not providing adequate health care. James Baird, M.D., the Director of Medical Services, responded on behalf of Defendant Ryan and stated, "[t]he Department has not been found, as yet, to be deliberately indifferent. … Is the Department being deliberately indifferent? Maybe. Probably. That would be up to a Federal Judge to decide. I do think that there would be numerous experts in the field that would opine that deliberate indifference has occurred."

24. The Deputy Medical Director for Psychiatry at the Eyman prison warned Defendant Ryan and Defendant Pratt's predecessor as Health Services Director, Michael

[2] As used hereafter, "policy and practice" includes unwritten policies, customs, and actual practices of Defendants.

Adu-Tutu, D.D.S., in a series of emails in the fall of 2009 that prisoners "are not receiving a reasonable level of psychiatric care. We are out of compliance with our own policies regarding minimum frequency of contact with a provider, as well as community standards for adequate care. The lack of treatment represents an escalating danger to the community, the staff and the inmates."

25. On October 12, 2011, counsel for Plaintiffs submitted a 21-page demand letter to Defendant Ryan, describing numerous systemic problems in the health care system and isolation units operated by Defendants, and detailing multiple examples of harm and injuries to prisoners resulting from these inadequate policies and practices. Defendant Ryan initially responded by requesting three months to investigate these problems. In the subsequent months, counsel for Plaintiffs continued to notify Defendants of individual prisoners asking for immediate attention to health care problems. However, as of this date, Defendant Ryan has not provided any substantive response to the issues raised in the letter other than to say that he did not think the ADC health care system had any systemic problems.

I. Defendants Deprive Plaintiffs of Constitutionally Adequate Health Care in Violation of the Eighth Amendment

26. Plaintiffs and the Plaintiff class allege the following. Defendants Ryan and Pratt have a policy and practice of failing to provide prisoners with adequate health care, and are deliberately indifferent to the fact that the systemic failure to do so results in significant injury and a substantial risk of serious harm.

A. Prisoners Face Lengthy and Dangerous Delays in Receiving and Outright Denials of Health Care

27. Defendants have a policy and practice of failing to provide timely access to health care and are deliberately indifferent to the risk of harm and injury to prisoners that results from this systemic failure. To request health care, prisoners must submit a HNR form, describing the need for medical, dental, or mental health attention, regardless of whether they have informed medical staff about their symptoms. Prisoners face numerous barriers in submitting this required form: oftentimes, there are no HNR forms in living units; staff give prisoners photocopies of HNR forms that are later rejected for not being originals; correctional officers refuse to provide forms to prisoners or discourage them from filing them; and officers read completed HNRs and tell prisoners they are not sick, and refuse to accept or forward the HNR to health care personnel.

28. In addition, officers sometimes prohibit prisoners from assisting fellow inmates in completing HNRs, even though the officers are aware that this prevents some prisoners from filing requests. This prohibition also harms prisoners who are acutely ill, experiencing severe mental health problems, vision-impaired, developmentally disabled, illiterate, have injuries or permanent disabilities that make it difficult to write, or are otherwise unable to fill out the forms, especially because staff members will not provide assistance. For example, Plaintiff Smith has an injury to his hand that prevents him from writing. He asked officers to assist him in completing the HNRs, but the officers stated they were prohibited by ADC policy from helping him.

29. In addition to restricting the ability of prisoners to request health care,

Defendants have a policy and practice of failing to provide care after receiving notice of prisoners' needs, and are deliberately indifferent to the harm that results. Even if the completed HNR is forwarded to health care staff, it is not processed in a timely manner, so prisoners have to file multiple HNRs and face long delays of many weeks and often months before they receive medicine or are examined by qualified clinicians, and experience harm and unnecessary pain and suffering as a result.

30. Oftentimes, medical staff members respond to a HNR stating only that the prisoner is on a waiting list to see a physician, dentist, psychiatrist, or outside specialist, even in response to HNRs alleging serious injuries that require immediate action. Plaintiffs Hefner, Gamez, and Swartz have received responses telling them to "be patient" to HNRs alleging serious pain or injuries. Plaintiff Licci was told by the Perryville Facility Health Administrator (FHA) that she was "hindering [her] own care" by filing grievances and HNRs about not seeing an outside specialist about numerous suspicious masses on her reproductive organs. Plaintiff Verduzco, who has a history of self-harm and multiple suicide attempts, filed a HNR reporting headaches, that she was experiencing auditory hallucinations, and that she needed help with her psychotropic medication, begging, "I'm scarde [sic]. Confused." She received a written response three days later, stating "You will be put on the waiting list to be seen." A prisoner who had a stent implanted at an outside hospital in August 2011 after a heart attack was ordered by the surgeon to see a cardiologist within a month. The prisoner has filed multiple HNRs asking to be referred to a cardiologist, but the most recent response he received to his

HNR in January 2012 was "Medical aware. Please be patient. Thanks." Another prisoner with major disabilities and multiple chronic medical problems received a response to one HNR stating, "due to the fact that the provider has to see a large amount of inmates, the number of issues addressed per inmate will be limited to one main issue." He was told in a different response that he "must learn to accept and live with [the] reality" of pain and discomfort. A staff member told a prisoner who filed multiple HNRs over a two-month period for untreated high blood pressure, seeing stars, and having problems getting out of bed, that a two month wait for medical care is acceptable, and that he should "pray" for his health issues to be cured.

31. Defendants have been warned repeatedly about these unreasonable delays in access to health care. In April 2009, a physician at the Eyman complex sent an email entitled "Deficient access to care, Risk exposure" to Defendant Pratt's predecessor as Health Services Director, Dr. Adu-Tutu, and other prison officials, noting it took prisoners "about 6 weeks to be seen" after the medical department receives a HNR, and that the situation was a "multi car accident waiting to happen." The delays have only grown worse: in February 2011 a Perryville psychiatrist warned Dr. Ben Shaw, the Director of Mental Health Services who reports to Defendant Pratt, that "we are backed up 3-4 months with the HNRs and longer for regular follow-ups."

32. Lengthy delays in responding to HNRs and providing necessary health care are the system-wide norm, as reflected in countless examples. Plaintiff Hefner filed multiple HNRs in the spring of 2011 about pain and injuries to his ribs and torso after an

attack, but was not seen by a doctor for three months. Plaintiff Polson has recurrent ear infections, but when he has them he must file multiple HNRs and wait anywhere from three to six weeks to be seen and given antibiotics or ear drops.

33. This failure to timely respond to HNRs is compounded by Defendants' failure to create an effective tracking and scheduling system for health care appointments or of prisoners' medical records. There also are no standardized protocols or timeframes dictating deadlines by which a prisoner requesting care must receive a face-to-face appointment with a nurse, doctor, or other clinician. As a result, inadequately-trained lower-level staff triage the HNRs and decide whether to schedule an examination, without sufficient information.

34. The harm from the delays in care is aggravated by Defendants' policy and practice of having ADC clinicians make treatment decisions without examining prisoners, instead relying on brief notes or descriptions from lower-level medical assistants and even correctional officers who have no medical training. In the unsupervised gatekeeping role Defendants force on them, these lower level medical and custody staff often do not recognize or acknowledge the symptoms a patient displays until the condition has become so acute as to be life threatening or results in permanent injury. For example, Plaintiff Polson had chronic ear infections for months that were not being cured with basic antibiotics. During that time, he was only seen by a Licensed Practical Nurse (LPN) or medical assistant who would consult with a doctor over the phone; the physician would not physically examine him. He had blood oozing out of his ear after multiple ear

infections, but was told by a physicians' assistant and a LPN that it was just a scratch. Due to Mr. Polson's recurrent untreatable infections and a prior diagnosis of the particularly antibiotic-resistant methicillin-resistant staphylococcus aureus ("MRSA"), the minimum standard of care requires the physician to personally examine Mr. Polson and culture his ear to make sure a different medicine would work. This was not done, and Mr. Polson suffered permanent hearing loss.

35. Plaintiff Hefner has a complicated ophthalmological history including surgery for glaucoma and cataracts, and experiences iritis (recurrent inflammation of the iris) after being given expired eye drops by a prison nurse in 2006. He submitted seven HNRs for eye pain and problems between August 2009 and October 2011. Because HNRs are not reviewed by a physician or clinical staff member, the staff who review the HNRs have repeatedly chosen to triage his request by placing him on a waitlist to see an optometrist, rather than an ophthalmologist. As of January 2012, he still had not yet seen an ophthalmologist, despite twice being referred by the optometrist.

36. Defendants also have a policy and practice of relying on unqualified personnel to perform medical procedures for which they are unqualified, with horrific results. For example, Plaintiff Jensen had prostate cancer surgery in July 2010 and returned to the Tucson prison with an internal Foley catheter connecting his bladder to his urethra through the bladder neck. The catheter was to stay in place for three weeks and be removed only by the outside urologist or surgeon. Two weeks after his return, the catheter began to leak urine. Mr. Jensen submitted two HNRs but was not seen until 48

hours later by a nurse who said he could wait until his scheduled follow-up appointment. The next day, still experiencing pain and leaking urine, he was seen by a nursing assistant ("NA") who requested a doctor's order to irrigate the Foley catheter. The physician did not examine Mr. Jensen before authorizing the procedure. When the NA attempted to irrigate Mr. Jensen's catheter, she instead shoved it deeper inside him and twisted it 180 degrees, causing excruciating pain. The improper manipulation of the catheter tore out his internal stitches, and the catheter ended up outside his bladder, lying freely in his abdomen, such that urine drained from his torn bladder directly into his abdominal cavity. Despite Mr. Jensen's excruciating pain, and the absence of urine, he was not taken to the ER or to see an outside specialist until his previously scheduled follow-up appointment three days later, at which point the outside clinicians rushed him to the operating room for emergency surgery. As a result of the injuries sustained during the NA's attempt to irrigate the catheter, he has required multiple follow up surgeries to repair the bladder, remove scar tissue, and treat infections. In February 2012, Mr. Jensen was told by an outside urologist that he needed surgery to replace his irreparably destroyed bladder.

B. Defendants Do Not Provide Prisoners With Timely Emergency Treatment

37. Defendants Ryan and Pratt have a policy and practice of not providing prisoners with timely emergency responses and treatment, and do not have an adequate system for responding to health care emergencies.

38. There is not an adequate number of on-duty health care staff to respond to possible emergencies. For example, the Tucson complex's Whetstone Unit, designated

for prisoners with the gravest and most complex medical needs, does not have clinical staff on duty between the hours of 6 pm and 6 am.

39. Defendants have not adequately trained security and health care staff on how to handle health care emergencies, and as a result of this failure to respond properly and timely to emergencies, prisoners suffer avoidable harm and injuries, including unnecessary deaths. While trained in basic first aid, correctional officers are not trained to evaluate medical situations. Yet correctional staff act as gatekeepers, making critical decisions about whether emergency care is warranted. In July 2010, correctional officers at the Tucson prison stood by and watched a severely mentally ill prisoner named Tony Lester bleed to death after his second suicide attempt. Mr. Lester, who had paranoid schizophrenia, multiple personality disorder, and auditory hallucinations, had been taken off suicide watch, taken off his medications, and housed in the general population, where he was given a hygiene kit that included a razor. He used the razor blade to slit his throat, groin, and wrists, and he wrote the word "VOICES" in his blood on an envelope. An ADC internal investigation found that the four responding officers stood by and did not administer any basic first aid. One officer told investigators he didn't want to be "wallowing through" Mr. Lester's blood, and another said his limited training did not teach him how to stop bleeding. When an internal investigator asked one officer, "So you guys just stood around for 23 minutes and watched this guy bleed to death?", the officer stated that his response was to call Mr. Lester's name and to try to elicit a reaction.

40. In October 2011, a prisoner at the Eyman prison collapsed in his living unit

from a heart attack. Other prisoners yelled for security staff to contact medical staff. Officers told the prisoners to "wait and see what happens," and did not summon help or provide assistance to the stricken prisoner. In desperation, another inmate checked the prisoner's pulse, and finding none, began to perform CPR. After a few minutes, the prisoner began breathing again. Only then did officers summon medical staff. Three hours later, the prisoner was sent from the medical unit back to his living unit and told he had a medical appointment in a few days. The prisoner had another heart attack the next day and died. After his death, the prisoner who saved his life after the first heart attack by performing CPR was issued a disciplinary write-up for violating a rule that prisoners may not perform medical procedures on other inmates.

41. It is not only correctional staff that lack necessary training in responding to emergency situations. Lower level medical staff, who serve as the first line of response to prisoners' requests for medical assistance, often do not recognize when a prisoner is experiencing an emergency. In September 2011, Plaintiff Swartz swallowed a metal spring and copper wire, and told medical staff he had done so. The mental health staff members did not believe him and joked about how they would need to cut him open. They had him screened with a metal detector or metal wand, and told him he would have to wait to pass the pieces of metal. Using a metal detector to detect the presence of objects in adults does not comport with the appropriate standard of care, which requires physicians to obtain X-rays and/or CT scans to determine the location of the object, and to emergently remove sharp objects from the esophagus, stomach, or small intestine via

endoscopy. Mr. Swartz had an X-ray the following day, after he swallowed yet another object, this time a sharpened paper clip. The X-ray revealed multiple pieces of metal in his stomach, including the spring and paper clip, but the prison doctor did not refer him for an endoscopy, and instead told Mr. Swartz he would have to pass the objects, which he did painfully several weeks later. Ignoring sharp ingested objects puts a patient at risk for perforation of internal organs and death.

42. In another example, in May 2011, a prisoner who was four months pregnant began experiencing painful contractions and spotting blood, and went to Perryville's medical unit. The staff person on duty told her it was nothing serious, that her problems were "all in your head," and that she could not see a clinician for evaluation or treatment. She was sent back to her living unit, and she continued to experience great pain and cramping for an hour and a half, until she miscarried.

43. Even when properly responding to an emergency, medical staff face barriers to providing timely emergency assistance. For example, a prisoner in the Yuma prison has three to four seizures per week because he does not regularly receive epilepsy medication. He regularly encounters delays in the emergency response during his seizures because of the configuration of his living unit – the entrance door is 34 inches wide, and facing the entrance is a wall approximately four feet high. As a result, medical staff cannot get a gurney through the doorway without spending critical time contorting the gurney through the door and around the wall. Other prisoners or officers must help lift the gurney over the wall, or drag the convulsing prisoner to the door of the unit.

C. Defendants Fail to Provide Necessary Medication and Medical Devices to Prisoners

44. Defendants have a policy and practice of failing to prescribe, provide, and properly manage medication, or of only providing incorrect, interrupted, or incomplete dosages of medication. Defendants also have a policy and practice of failing to provide necessary medical devices and supplies. Prisoners experience delays and gaps in receiving medicine or supplies, including those prescribed by outside doctors. Delays and gaps also occur when prisoners transfer from one ADC prison to another. Prisoners face abrupt discontinuation of their medications for weeks or months, before being seen by a new provider. For example, Plaintiff Swartz was transferred in December 2011 from Phoenix to Lewis, but had to file multiple HNRs and wait several weeks before he began receiving the psychotropic medications prescribed by Phoenix physicians.

45. Defendants have a policy and practice of not providing prisoners with the full course of their medication, not providing prisoners medication as prescribed or in a timely fashion, and inappropriately starting and stopping medication. As a result, prisoners suffer unnecessary harm, and in the cases of prisoners with psychotic and mood disorders, suffer withdrawal symptoms and the recurrence of symptoms such as hallucinations and suicidal ideation. For example, Plaintiff Parsons' medications were abruptly discontinued without any clinical explanation and he was not seen for his resulting psychiatric problems for two weeks. At that point he was prescribed an entirely different medication.

46. Psychotropic medications that are to be taken daily regularly go

undelivered, without explanation or warning. Plaintiff Gamez has had medications abruptly started, stopped and restarted, including a potent antipsychotic medication. Plaintiff Rodriguez was switched multiple times from Risperdal to Haldol to treat her psychosis, but with no documented explanation for the changes, and with a more rapid titrating on and tapering off the medications than is consistent with the therapeutic indications of use.

47. Prisoners also are given expired medication or incorrect dosages of medication, resulting in harm. When Plaintiff Hefner originally suffered his eye injury, a nurse at the Safford prison gave him eye medication that had expired more than three months previously. When he used the medication, his vision dramatically worsened, and he developed iritis. A prisoner at the Tucson complex was given the incorrect dosage of medication to treat his seizures in September 2011. He suffered a stroke, and despite pleas for help from his fellow inmates, waited more than a day before medical staff saw him and referred him to an outside hospital's Intensive Care Unit. Now, due to the stroke, he slurs his speech, has difficulty walking and relies on a wheelchair, and is incontinent.

48. Defendants have a policy and practice of only providing medicine listed on a limited formulary of approved medication, and routinely substitute doctor-approved drug regimens with drugs on the ADC-approved formulary. As a result of this policy and practice, prisoners are deprived of medications that are well-established as effective for their health conditions, and receive inferior, ineffective, or obsolete medications, or nothing at all. For example, when Plaintiff Brislan was incarcerated, mental health staff

discontinued his prior, effective medications because they were not listed on the formulary. Instead, he was prescribed Buspar, an older anti-anxiety medication, even though he told the nurse it had not worked for him in the past. His mental health symptoms continued to worsen while on Buspar. Plaintiff Parsons was given a potent antipsychotic medication for hyperactivity, a condition for which the drug is not normally prescribed, and had other psychiatric medications discontinued several times. On multiple occasions, Plaintiff Gamez was prescribed antipsychotic and anti-epileptic medications such as Thorazine and Tegretol for off-label treatment of irritability and mood disorder caused by a childhood traumatic brain injury, even though there are other drugs that are more effective for treating these symptoms, with fewer side effects.

49. According to the 2011 deposition testimony of one of ADC's doctors, the prescription of non-formulary medication is frequently subject to delay and erroneous denial. ADC policies restricting these prescriptions result in multiple requests by prison doctors over months until an ad-hoc committee of medical and administrative staff at ADC's central office reviews the request. As a result, prisoners experience delays in treatment and unnecessary harm. For example, Plaintiff Swartz went for more than six weeks without medication for pain from his serious injuries and broken facial bones from an assault, while awaiting central office approval of the physician's prescription for Tramadol. However, he was not prescribed a different pain medication on the formulary list pending the approval of Tramadol. Without the medication, he experienced intense pain and had problems eating.

50. Defendants have a policy and practice of not providing medically necessary devices, thus depriving these prisoners of basic sanitation. Plaintiff Jensen and other prisoners who need catheters are given fewer clean catheters than they need, and thus have to re-use the catheters, putting them at risk of bladder and urinary tract infections. Plaintiff Jensen has repeatedly not been provided an adequate number of catheters, and at times has had to rely on his wife to order and pay for the catheters, and have them delivered to the prison. Prisoners who need incontinence briefs or wipes often go without them, or are told they only are allowed one diaper per day. As with Plaintiff Jensen, prisoners fortunate enough to have the assistance of family members often rely on them to obtain toileting supplies and have them delivered to the prison.

D. Defendants Employ Insufficient Health Care Staff

51. Many of the severe deficiencies in ADC's health care system are caused by Defendants' failure to employ sufficient health care staff positions to provide adequate health care to prisoners. There are simply insufficient medical, dental, and mental health clinicians (i.e. physicians, psychiatrists, dentists, physicians' assistants, registered nurses, and other qualified clinicians) on staff to meet the significant and documented health care needs of the almost 33,100 prisoners in ADC custody.

52. As an ADC doctor at the Florence prison testified in September 2011, "we are chronically and consistently understaffed." The same doctor had previously noted this problem in an email to prison staff, stating that "[s]omething bad is going to happen sometime" and pleading for help. In an email to Defendant Pratt's predecessor, Dr. Adu-

Tutu, and other administrative and medical officials, this same physician noted that "[w]e just don't have the man power to do our assigned duties," are "unable to meet our policy and constitutional mandates," and the provision of health care "continue[s] to be a multi-car accident waiting to happen." And in an email to other ADC medical staff, the doctor noted that "inadequate staffing levels and unrealistic workloads lead to significant breakdowns in the front line services we are trying to provide" and concluded that "we are not meeting our own or anybody else's standard of care."

53. Defendants' policy and practice of chronically and consistently understaffing health care positions results in multiple deficiencies and inadequate health care: there is not enough staff to timely respond to prisoners' requests for health care and to emergencies, to provide uninterrupted medication delivery, or to adequately screen, monitor and provide follow-up care to prisoners with serious and chronic illnesses. The inadequate health care staffing is caused by Defendants' systematic elimination of health care staffing positions in recent years, including physicians, dentists, registered nurses, and psychiatrists, and Defendants' failure to actively recruit, hire, train, supervise and retain sufficient and competent health care staff.

54. Despite rising health care costs across the country, ADC spending on health care staff positions dropped more than $4.4 million, or 8.4%, from Fiscal Year ("FY") 2009 to FY 2011 while the overall state prison population declined by less than 1%. These positions were eliminated despite warnings from Defendants' own health care staff that prisoners would suffer serious harm from the resulting delays in access to care,

emergency response, specialty care referrals, and inadequate chronic care and medication management. For example, in February 2011, the sole psychiatrist on staff at Perryville – a complex with 3,500 prisoners and multiple special mental health units for female prisoners – wrote an email entitled "Please help" to prison officials, warning them that mental health staffing was "abysmal," and as a result mental health staff had to "renew meds for dozens of people per week without getting to see them because there is not enough time." The psychiatrist concluded, "I'm doing the best I can but it is still not enough. I do not want to leave my position here as I feel that I do some good for the women here and society in general but I am stretched very thin." In June 2011 the same psychiatrist wrote an email entitled "Please assist Florence" to Defendant Ryan and Defendant Pratt's predecessor Dr. Adu-Tutu, and other ADC officials describing the "dire situation" at Florence as it was the last day that complex would have a psychiatric provider. She described the problems the remaining low-level staff were having in providing medication for prisoners. Defendant Ryan's response was, "Your concerns are not falling on 'deaf ears'. I acknowledge your messages."

55. The harm resulting from staffing shortages is not limited to Perryville and Florence. The Deputy Medical Director for Psychiatry at Eyman warned Defendant Ryan and Dr. Adu-Tutu in a series of emails in the fall of 2009 that prisoners "are not receiving a reasonable level of psychiatric care. We are out of compliance with our own policies regarding minimum frequency of contact with a provider, as well as community standards for adequate care. The lack of treatment represents an escalating danger to the community,

the staff and the inmates." Defendant Ryan responded with a brusque one sentence response that "a strategy is being pursued."

56. That strategy, if one was indeed pursued, has failed. As of August 2011, more than half of all mental health staff positions were vacant at the Eyman complex, which houses multiple mental health units and two SMUs, where prisoners are held in isolation. As of October 31, 2011, there was not a single psychiatrist on staff for the entire Eyman complex. Nor are any psychiatrists currently employed on staff at the Florence, Lewis, and Tucson complexes, which along with Eyman are designated to house prisoners classified as "MH-4: High Need," signifying the prisoners need specialized placement in a mental health program and intensive psychiatric staffing and services. As of August 2011, the Yuma prison housed 52 prisoners classified as MH-3, which ADC's criteria describe as prisoners who require "regular, full-time psychological and psychiatric staffing and services" and who need mental health treatment and supervision. Yet as of November 2011, the only mental health staff person for the entire Yuma complex was a lower-level, Psychology Associate II. That position does not require medical training or a Ph.D., but rather only a degree in counseling or social work. A Psychology Associate II cannot manage or prescribe medications under current state law, and should be supervised by a psychologist.

57. Defendants have knowingly ignored the warnings of their own staff and others about the staffing shortages, and as a result prisoners continue to suffer from constitutionally inadequate health care and substantial risk of serious harm due to

Defendants' deliberate indifference to the impact of the system-wide staffing shortages.

II. Even If Prisoners See Health Care Providers, They Do Not Receive Adequate Medical, Dental, or Mental Health Care

A. Substandard Medical Care

58. Plaintiffs Jensen, Swartz, Chisholm, Licci, Hefner, Polson, and Wells, and the Medical Subclass, allege the following. Defendants Ryan and Pratt have a policy and practice of failing to provide prisoners with adequate medical care, and are deliberately indifferent to the fact that the systemic failure to do so results in significant injury and an substantial risk of serious harm to prisoners. Defendants' failure to provide adequate medical care results in prisoners experiencing prolonged, unnecessary pain and suffering, preventable injury, amputation, disfigurement, and death.

1. Defendants Fail to Provide Prisoners With Care for Chronic Diseases and Protection From Infectious Disease

59. Defendants have a policy and practice of failing to provide prisoners with medically necessary care to address ongoing medical needs or diseases. Defendants' deliberate indifference to their systemic failure to properly treat or manage prisoners' chronic illnesses exacerbates prisoners' conditions, and frequently leads to preventable permanent injuries or deaths. For example, a prisoner who needed medical care for gastrointestinal bleeding and an untreated hernia tragically did not receive proper treatment even after Defendants were aware of his problems. His hernia ruptured his stomach lining and he was found dead after "vomiting up his insides," according to witnesses. Prior to his death, he reported that a prison doctor told him the hernia was

"merely cosmetic," yet when the prisoner asked about his prognosis, the doctor joked, "I wouldn't go to Vegas with you." A prisoner who has Hepatitis C requested treatment in a HNR, but was told in response that since he had received a disciplinary ticket, he was not eligible for treatment until one year after the date of the ticket.

60. Defendants also have a policy and practice of not providing medical diets ordered by clinicians for prisoners with chronic conditions such as high blood pressure, high cholesterol, kidney failure, and diabetes. Instead, all prisoners, including those with chronic conditions requiring special diets, are given a nutritionally inadequate, high-fat and high-sodium diet. Plaintiff Hefner has chronic gastroesophageal reflux disease (GERD) and requires a special diet. However, his request for a medical diet was denied, and the meals he is given often aggravate his condition, forcing him to choose between eating food that will cause physical distress, or eating nothing.

61. Defendants also have a policy and practice of failing to effectively enforce state law prohibiting smoking inside buildings, endangering the health of prisoners and Defendants' employees with chronic medical conditions such as asthma, chronic obstructive pulmonary disease, allergies, or emphysema, and posing a health risk to prisoners and staff exposed to second-hand smoke. Plaintiffs Gamez and Thomas both have asthma, and report that second-hand cigarette smoke has triggered asthma attacks.

62. Defendants have a policy and practice of failing to mitigate the risk of infectious and communicable diseases, such as MRSA, Vancomycin-Resistant Enterococcus (VRE), Hepatitis C, and tuberculosis. Defendants fail to maintain basic

sanitation to prevent the exacerbation of chronic conditions and the spread of infectious diseases. Many sections of ADC's prisons are filthy, fail to meet basic sanitation standards, and expose prisoners to serious, and sometimes fatal, communicable diseases. These conditions include urine-soaked mattresses, uncontrolled infestations of vermin, and cell walls and floors covered with black mold or smeared with the feces, spit, and blood of other inmates. Prisoners with cuts or other injuries to their bodies have contracted serious infections from the unsanitary conditions of the prison. A prisoner living in unsanitary conditions in the Tucson complex developed a staph infection but was not examined by medical staff until the infection had spread to his eyes. He now has minimal vision in his right eye and has lost vision in his left eye.

2. Defendants Fail to Provide Timely Access to Medically Necessary Specialty Care

63. Defendants have a policy and practice of failing to provide prisoners with specialty care, or doing so only after extensive and unreasonable delays, often resulting in unnecessary pain and suffering, permanent injuries, and death. Defendants do not employ medical specialists, but instead send prisoners to contracted outside specialists. In 2009, reimbursement rates for prison medical contractors were capped so as to be no higher than those paid by the State's Medicaid program, the Arizona Health Care Cost Containment System. Defendants knew of the impending change to the reimbursement system, but failed to take steps to ameliorate the foreseeable impact of the change in policy. As a result, all outside medical providers ended their contracts with ADC. For much of 2009 and 2010, Defendants had no contracts in place with outside providers, and even today

have few outside specialists under contract to treat ADC prisoners. Prior to the rate change, ADC's spending on outside medical services in FY 2009 was $70,860,190. In FY 2011, the first full year following the change in rates, spending on specialty services had plummeted by 38% to $43,807,120, while there was no corresponding decline in the number of prisoners in ADC's custody. Two years later, as a result of the accumulation of pending referrals and the smaller number of contracted providers, prisoners still encounter lengthy delays in getting specialized care for serious medical needs.

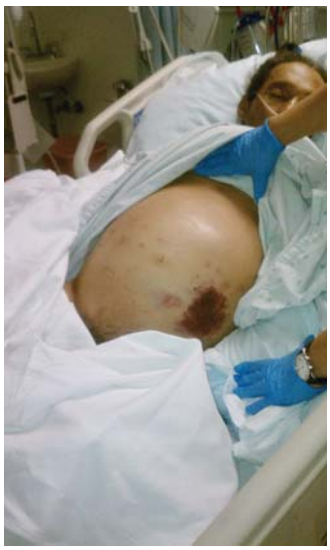
64. Defendants have been warned repeatedly by their own prison doctors and are well aware that delays in referrals, including those caused by an overly burdensome approval process for outside specialists harm prisoners, but Defendants are deliberately indifferent to the resulting harm. An ADC physician testified that it takes months for specialty referrals to be processed and that physicians are not notified of the decision from ADC headquarters as to whether the referral will be granted. This doctor told prison officials "the referral system has broken down." Another ADC physician described in an email to prison officials how difficult it was to refer to a specialist a patient with a suspected carcinoma of the lip. After repeatedly submitting urgent referrals, he finally sent the request directly to the Division Director of Health Services. The physician described a system where referrals are "falling through cracks," and estimated that "an extensive list of examples… would probably exceed 30% of [his] consults."

65. Defendants' policy and practice of systematically failing to provide timely access to outside specialists causes prisoners unnecessary harm. In late February 2010,

Plaintiff Swartz was attacked by other inmates and suffered eye injuries and fractures of his cheek bone, orbital bone around his eye, and upper jaw bone – fractures that, if not treated, result in the person's face caving in, and in permanent disfigurement. Outside emergency room doctors advised that he be seen within a week by an ophthalmologist and plastic surgeon. Prison doctors submitted these referrals to the review committee, but they were not approved. Instead, Mr. Swartz was sent to an oral surgeon, who operated on his face without an anesthesiologist present. Mr. Swartz was over-sedated and had to have an antidote to be revived. His face was partially paralyzed due to nerve damage from the botched surgery and over-sedation, and his eyelid drooped, causing dryness to his cornea. It was not until almost eleven months after the injury that he finally saw an ophthalmologist regarding his various injuries. Almost two years after the attack, he has yet to have his eye and facial damage repaired by a specialist.

66. In another tragic case, medical staff at the Tucson prison complex did not diagnose, treat, or refer to specialists a prisoner named Ferdinand Dix who had untreated small cell lung cancer that had spread to his liver, lymph nodes, and other major organs, causing sepsis, liver failure, and kidney failure. For two years, Mr. Dix had filed multiple HNRs and exhibited many symptoms consistent with lung cancer, including a chronic cough and persistent shortness of breath, and he tested positive for tuberculosis. Due to the metastasized cancer, Mr. Dix's liver was infested with tumors and grossly enlarged to four times normal size, pressing on other internal organs and impeding his ability to eat, but no medical staff even performed a simple palpation of his abdomen. Instead, medical

staff told him to drink energy shakes. When Mr. Dix was finally taken to an outside hospital in a non-responsive state in February 2011, his abdomen was distended to the size of that of a full-term pregnant woman, as seen in the photograph below. Mr. Dix died from the untreated cancer a few days after ADC finally sent him to the hospital.



67. Defendants have a policy and practice of failing to order or approve outside diagnostic testing, including biopsies of suspicious tumors and growths, and are deliberately indifferent to the resulting harm to prisoners. For example, Plaintiff Jensen waited more than two years to have a biopsy of the mass in his prostate, because contracts with outside providers were cancelled. By the time he was finally seen and treated, the cancer was much worse, resulting in more invasive surgery and the need to permanently use a catheter. Beginning in 2010 Plaintiff Licci observed multiple masses growing on her breasts, mouth, and arms, and reported discomfort in her cervix. The masses were observable in physical examinations. She began experiencing frequent diarrhea, nausea,

exhaustion, weight loss, pain, and other alarming symptoms. Ms. Licci has a family history of cancer and was treated for cancer in 2001. Starting in December 2010 she requested testing and a prison doctor ordered a referral to an oncologist. However, Ms. Licci was not sent to an oncologist and did not receive a CT scan until late September 2011. At that time the masses were described as "lighting [the CT scan] up like a Christmas tree," and the specialist ordered biopsies and a colonoscopy. Still, the Perryville gynecologist insisted that nothing was wrong with her. She finally had an MRI in December 2011, but it was not properly administered. Ms. Licci had to file additional HNRs and grievances before receiving a second MRI, which confirmed multiple masses on both ovaries. She still has not seen an oncologist or had biopsies.

68. A prison physician submitted a request that Plaintiff Hefner have a CT scan to rule out a rib fracture and injury to his spleen in March 2011 after he was injured in an attack, but the request was never reviewed or completed. Mr. Hefner experienced persistent pain and submitted three different HNRs in April and May of 2011, but was not seen by a doctor until June 29, 2011, at which time the CT scan was again requested. He did not get a CT scan until late October, 2011, suffering unnecessary pain in the interim.

69. When outside physicians see prisoners, they often prescribe treatment regimens and medication. However, when prisoners return to prison, Defendants fail to monitor symptoms or provide follow-up treatment ordered by outside hospital physicians in accordance with the prescribed treatment regimens and medical standards of care. As a result, prisoners suffer infections and unnecessary setbacks in their recovery and must

return to the hospital.

B. Substandard Dental Care

70. Plaintiffs Swartz, Parsons, Chisholm, Polson, and Wells, and the Dental Subclass, allege the following. Defendants Ryan and Pratt have a policy and practice of failing to provide medically necessary dental services, and are deliberately indifferent to the fact that the systemic failure to do so results in injury and a substantial risk of serious harm to prisoners.

71. Prisoners wait months or years for basic dental treatment and suffer significant pain and other harm. Plaintiff Polson was put on the "routine care" waiting list for dental treatment even though he has multiple teeth that are visibly missing or broken. The prison dentist designated him as qualified for partial dentures in April 2008, but they were not fitted until April 2011. He regularly does not receive his soft food diet. He also filed a HNR after a dead front tooth broke, asking to be seen by the dentist, and to receive a soft diet, and inquiring about the status of receiving the dentures. The only response on the HNR was "You are requesting ROUTINE care. You are on ROUTINE care list." He was not seen by the dentist until five months later.

72. The primary dental service provided by Defendants is tooth extraction, even if a much less invasive procedure such as a filling is medically appropriate and necessary. Prisoners regularly face the horrible dilemma of saving a tooth and suffering pain, or ending the pain and losing a tooth that otherwise could be saved. Plaintiff Swartz is currently in this position. Some prisoners initially refuse the extractions, but eventually

acquiesce after suffering pain for a long period of time, or their condition worsens until extraction is the only treatment option available. After Plaintiff Wells reported missing fillings in two of her teeth in December 2010, the prison dentist recommended they be extracted. She refused, and the dentist told her to file an HNR requesting replacement fillings. Ms. Wells endured pain for several months before her fillings were replaced; however, in the process an adjacent tooth was cracked, exposing a nerve. She was told by the dentist to submit another HNR to get that tooth repaired. Several months later, she still has not received appropriate care and suffers pain.

73. Prisoners who are fortunate enough to get fillings are not given permanent fillings, but rather temporary fillings that are not designed to last more than a few months at most. Plaintiff Parsons filed an HNR in June 2008 regarding a cavity, but was not seen until September of that year, at which time he was given a temporary filling. He filed four HNRs in 2009 complaining that the temporary filling had fallen out of his tooth. Each time, he was given another temporary filling that would fall out weeks later, and he would have to restart the process.

C. Substandard Mental Health Care

74. Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, Parsons, Chisholm, and Polson, Plaintiff Arizona Center for Disability Law, and the Mental Health Subclass, allege the following. Defendants Ryan and Pratt have a policy and practice of failing to provide prisoners with adequate mental health care, and are deliberately indifferent to the fact that the systemic failure to do so results in injury and a

substantial risk of serious harm to prisoners.

1. Defendants Deny Mentally Ill Prisoners Medically Necessary Mental Health Treatment, Including the Proper Management and Administration of Psychotropic Medication, Therapy, and Inpatient Treatment

75. Defendants have a policy and practice of denying treatment or providing inadequate treatment to prisoners with serious mental health needs. Because of chronic understaffing, mentally ill prisoners have insufficient interactions with psychiatrists; many receive at most a five- or ten-minute interactions once or twice a year in which they are asked only if their medications are working. According to Defendants' own records, some contacts with mental health staff are as brief as two minutes. As a result, clinicians cannot make informed decisions about care. For example, Plaintiff Gamez did not see a psychiatrist from 2007 to 2011, despite exhibiting worsening mental health and behaviors such as paranoia, anxiety, panic, and psychosis. Instead, a nurse practitioner merely prescribed a variety of psychotropic medications, including drugs not indicated for his diagnosis and behavior. On two separate occasions when Plaintiff Brislan was placed in suicide watch for weeks for engaging in self-harming behavior and suffering severe side effects from a variety of psychotropic medications, he did not see a psychiatrist for stretches of five and seven months.

76. Since they possess at most a glancing familiarity with their patients, clinicians are unable to meaningfully evaluate crucial decisions affecting safety and health, such as the clinical appropriateness of indefinite confinement in SMUs and other units that hold prisoners in long-term isolation with minimal opportunities for human

interaction. For example, Plaintiff Gamez experienced hallucinations and deterioration in his mental health due to abrupt interruptions in his medication, yet for two years he never saw a psychiatrist while in Eyman's SMU. Similarly, while in Eyman's SMU, Plaintiff Thomas did not see a psychiatrist for almost a year even though he had been moved to the suicide watch unit multiple times.

77. This systemic failure of mental health treatment extends to the management of psychotropic medication. Defendants have a policy and practice of failing to monitor and provide follow-up treatment after prescribing psychotropic medications. In addition, prisoners who are on psychotropic medications that increase heat sensitivity are exposed to levels of heat that pose potentially lethal risks. Defendants are aware of the resulting problems and the risk of serious harm to prisoners. In June 2011, the sole psychiatrist at Perryville emailed Defendant Ryan and other prison officials about the "dire situation" at the Florence prison, as it was the last day a psychiatric provider would be on staff. As a result of the staff shortage, she said she was contacted by nursing staff at the Florence prison, asking her to prescribe or renew medications for patients she had never examined, and who were housed at a prison 90 miles away from where she worked. The psychiatrist told Defendants that

> These are patients I have never met or treated. The liability for treating patients without evaluating and monitoring them is not one I am willing to undertake. It is unreasonable for administration to expect that its (very few) providers that it has left to carry the burden of treating patients unseen. In the past, I have been willing to fill meds for a day or two until the patient could be seen by the facility psych provider, but I am not willing to prescribe meds for long periods of time without seeing the inmate. …I hope for the sake of the patients and the staff at Florence that

you will drop everything else you are doing and work on getting a provider for them.

78. Defendant Ryan's response was "[y]our concerns are not falling on 'deaf ears'." Yet the problem the psychiatrist raised in June continues. According to ADC staffing reports, as of November 2011, four of the six prisons designated by Defendants for Level MH-4 seriously mentally ill prisoners – Eyman, Florence, Lewis, and Tucson – do not have a single psychiatrist on staff; it is therefore unclear who is writing or renewing prescriptions for psychotropic medication at those complexes. The Phoenix facility, which is located on the grounds of the Arizona State Hospital and is designated for the highest two levels of prisoners in need of inpatient mental health care, has only one psychiatrist on staff. As of February 28, 2012, 197 prisoners were housed in these mental health units at Phoenix.

79. Because prisoners on psychotropic medications rarely if ever see a psychiatrist due to staffing shortages, there is little or no follow-up to evaluate the efficacy of prescribed medications, to ensure that dosages are adjusted properly to achieve therapeutic levels, or to evaluate prisoners for possible adverse side effects. For example, Plaintiffs Parsons, Polson, and Gamez did not have their blood regularly drawn to test for dangerous side effects of medication. Similarly, without any documentation of the basis for their decisions, mental health staff prescribed Plaintiff Rodriguez high doses of Haldol, an old medication that carries a much greater risk than newer medications of side effects and long QTc syndrome, which puts a person at risk of heart arrhythmias. Ms. Rodriguez had a history of long QTc measurements, and exhibited symptoms including

lack of spontaneous speech, muscle and jaw stiffness, involuntary movements, and grimacing. Ms. Rodriguez finally started to refuse Haldol because of the side effects, aggravating her symptoms of mental illness. While housed in Eyman and Lewis prisons, Plaintiff Brislan demonstrated ongoing self-harming behaviors and dangerous side effects from multiple psychotropic medications, but he was rarely evaluated by a psychiatrist to see if medication adjustments might be helpful for his symptoms. Psychiatrists renewed the prescriptions, but the clinical notes did not indicate that the psychiatrist had ever seen Brislan, a clear violation of the applicable standard of care.

80. Defendants have a policy and practice of allowing ongoing monitoring of prisoners on psychotropic medication by LPNs, psychology assistants, or medication assistants who hand out the medications. These lower level mental health staff are not qualified to adequately convey a prisoner's concerns to a psychiatrist. Furthermore, staff at this level should not be ordering or authorizing the dispensation of medication. Plaintiff Swartz saw only lower level mental health staff at his cell front and did not see a psychiatrist for over a year, even though he had multiple suicide attempts and was put on a variety of psychotropic medication, and the dosages were regularly changed. Similarly, in June 2008, Plaintiff Smith was prescribed Celexa, but did not receive it for nearly a year. He was also prescribed lithium; however, despite the need for close monitoring for side effects from the lithium, he was not seen by a doctor for three months. His lithium was renewed without Mr. Smith having seen a doctor for six months. In November 2009, Mr. Smith submitted a HNR reporting that he was vomiting when given lithium without

food. He was given Tums and was not seen by a doctor. When he reported continuing symptoms in January 2010, he was told to submit another HNR and was not seen by a doctor until March 2010, four months after first reporting symptoms. Plaintiff Verduzco goes months without seeing the Perryville psychiatrist, despite demonstrating multiple symptoms of severe psychological distress including hallucinations and acts of self-harm.

81. According to Defendants' own records, approximately 1,350 ADC prisoners are "severely mentally ill." Some of these prisoners suffer from psychosis, a disorder that is marked by loss of contact with reality and disorganized thinking. Persons suffering from psychosis may have perceptual disturbances such as hallucinations, paranoia, delusional beliefs, and bizarre behaviors. Some of these very mentally ill prisoners require an inpatient level of care – a structured program of psychosocial rehabilitation services coupled with individual therapy and appropriate medication management – but they do not receive it. Defendants have failed to reliably provide inpatient mental health care to those prisoners whose serious mental health needs require it. Plaintiffs Brislan, Rodriguez, and Verduzco are among those who require but have not received inpatient mental health care.

2. Defendants Deprive Suicidal and Self-Harming Prisoners of Basic Mental Health Care

82. Defendants have a policy and practice of housing prisoners with serious mental health needs in unsafe conditions that heighten their risk of suicide. In FY 2011, there were 13 suicides in ADC prisons, out of a population that averaged 34,000 during that time. That is a rate of 38 suicides per 100,000 prisoners per year, more than double

the national average suicide rate in state prisons of 16.67 per 100,000. Three prisoners committed suicide in one week in late January 2012, including a 19-year-old woman.

83. One factor responsible for such a high suicide rate is Defendants' policy and practice of maintaining suicide watch facilities that offer no meaningful treatment. Usually the only people who interact with prisoners on suicide watch are correctional officers who check on them periodically, medication assistants who dispense pills, or psychology assistants who talk to them through the front of their cell. Plaintiff Swartz did not receive psychotherapy for more than two months in the summer of 2011 while on suicide watch at the Lewis facility. After he swallowed glass and was taken to an outside hospital, the hospital psychiatrist recommended that he be taken to an inpatient mental health unit. These units are in the Phoenix complex. Instead, Mr. Swartz remained at Lewis where he continued to harm himself. He finally was moved to the Phoenix inpatient unit almost three months after the hospital psychiatrist had made that recommendation, but after a short period of time he was again returned to Lewis. Plaintiff Thomas did not see a psychiatrist for 11 months despite being placed on suicide watch multiple times.

84. Defendants also have a policy and practice of holding suicidal and mentally ill prisoners in conditions that violate all notions of minimally adequate mental health care and basic human dignity, and are not compatible with civilized standards of humanity and decency. Suicide watch cells are often filthy, with walls and food slots smeared with other prisoners' blood and feces, reeking of human waste. Mental health staff show a lack

of professionalism and little compassion for prisoners enduring these conditions: for example, prisoners in suicide cells are taunted for being in "the feces cells." When Plaintiff Swartz complained to a LPN about the unhygienic conditions of the suicide cell at Lewis, the LPN described him in the mental health notes from the encounter as "bitching about cleanliness – germs and disease."

85. Defendants have a policy and practice of keeping suicide watch cells at very cold temperatures. Prisoners are stripped of all clothing and given only a stiff suicide smock and a thin blanket, making the extreme cold even harder to tolerate. Plaintiffs Rodriguez and Verduzco report that the suicide smock used in Perryville barely comes to the top of female prisoners' thighs, so both their legs and arms are exposed to cold air. Many prisoners are also deprived of mattresses and as a result must sleep on bare steel bed frames, or on the floor made filthy with the bodily fluids of prior inhabitants. Plaintiff Brislan spent several weeks in a frigid suicide cell with no mattress.

86. Defendants have a policy and practice of exposing prisoners on suicide watch to gratuitously harsh, degrading, and damaging conditions of confinement. Prisoners are given only two cold meals a day, and are denied the opportunity to go outside, brush their teeth, or take showers. The only monitoring prisoners receive in suicide watch is when correctional officers force them awake every ten to 30 minutes, around the clock, ostensibly to check on their safety. In some suicide cells, bright lights are left on 24 hours a day. The resulting inability to sleep aggravates the prisoners' psychological distress.

87. Mentally ill prisoners on suicide watch complain of correctional staff behavior that interferes with any therapeutic effect of being on suicide watch, including harassment, insults and taunts, and the excessive and practically sporting use of pepper spray. Prisoners at the Perryville suicide watch units, including Plaintiff Verduzco, have jerked awake when awoken by staff on the "safety checks," and are pepper sprayed for allegedly attempting to assault the officers. Guards in the Perryville suicide watch units also frequently pepper spray female prisoners in their eyes and throats when they are delusional or hallucinating. Plaintiffs Rodriguez and Verduzco have asthma and rely upon inhalers, and they have had asthma attacks from the regular use of pepper spray in the women's suicide watch unit. On multiple occasions after she was pepper sprayed in the eyes, nose, and mouth, Ms. Verduzco was dragged to a shower, stripped naked, and sprayed with extremely cold water to rinse away the pepper spray; she was then left naked to wait for a new vest and blanket. A prisoner in the Florence prison's suicide watch unit reports that while there he was handed razor blades to swallow by other prisoners, and told "just die right away." He started to swallow the blades, and security staff pepper sprayed him while he coughed up blood, and did not provide other emergency response.

88. Defendants' policy and practice of holding suicidal prisoners in excessively harsh conditions does not prevent but rather promotes self-injurious behavior. Plaintiff Brislan has cut himself numerous times with razors and pieces of metal while on suicide watch at multiple prisons, including Tucson, Lewis, and Eyman's SMU 1 and Browning units. At the Tucson prison, staff put him on suicide watch in a cell with broken glass on

the floor which he used to cut himself. During another stay in suicide watch, Mr. Brislan was given a razor blade that he used to deeply lacerate both of his thighs. While on suicide watch in the Lewis prison during the summer of 2011, Plaintiff Swartz, on separate occasions, swallowed multiple foreign objects, including two large staples, plastic wrap, a piece of glass, a lead-head concrete nail, a spork, two pens, sharpened paper clips, a metal spring, a steel bolt, and two copper wires. As with Plaintiff Brislan, Mr. Swartz's repeated suicidal gestures and ability to access dangerous objects while on suicide watch confirms that he was not being properly monitored and that any mental health treatment he might have been receiving was inadequate.

89. Defendants also have a policy and practice of improperly using the suicide watch cells to punish prisoners for alleged disciplinary infractions. An Eyman prisoner who went on a hunger strike to protest prison policies, but did not display signs of mental illness or distress, was put in a suicide watch cell for several weeks and was told by a mental health provider, "If you weren't on this hunger strike, you wouldn't have to live in the feces cell."

III. Defendants Subject Prisoners in Isolation to Unconstitutional Conditions

90. Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, and Polson, Plaintiff Arizona Center for Disability Law, and the Isolation Subclass allege the following. Defendants have a policy and practice of confining thousands of prisoners in isolation (defined as confinement in a cell for 22 hours or more each day or confinement in Eyman – SMU 1, Eyman – Browning Unit, Florence – Central Unit, or

Perryville – Lumley Unit Special Management Area (SMA)), in conditions of enforced idleness, social isolation, and sensory deprivation, and are deliberately indifferent to the resulting substantial risk of serious physical and psychiatric harm.

91. The large majority of prisoners in isolation are held in four facilities: two SMUs at the Eyman prison (SMU 1 and Browning Units); the Florence complex's Central Unit; and the Perryville complex's Lumley SMA for female prisoners. However, other prisoners are held in isolation in Complex Detention Units (CDUs) and other restricted housing units throughout ADC.

92. Prisoners in isolation leave their cells no more than three times a week, for a brief shower and no more than two hours of "exercise" in the "rec pen" – a barren, windowless concrete cell with high walls that is not much larger than the cells in which prisoners live, with no exercise equipment. Many prisoners refuse to go to the rec pen, because it is so small that it does not allow meaningful exercise, and because prisoners are placed in restraints and strip-searched when going to and returning from the rec pen. In addition, prisoners sometimes are not allowed to take water to the rec pen, even at the height of Arizona's summer heat. For those prisoners who do wish to go to the rec pen, even this brief respite is often denied: exercise is sometimes cancelled due to staffing shortages. Prisoners in Florence's Central Unit, including Plaintiff Gamez, are not allowed to go to recreation if they are not clean-shaven, but are often deprived of shaving supplies and are thus denied exercise. Some prisoners in isolation receive no outdoor exercise at all for months or years on end; others receive insufficient exercise to preserve

their physical and mental health.

93. Conditions of isolation are designed to minimize human contact and environmental stimulation. Most or all of these prisoners are held in cells with a solid steel door and no window to the outside. Some prisoners have no means of telling the time and become disoriented and confused, not knowing the date or whether it is day or night. The cells are often illuminated 24 hours a day, making sleep difficult and further contributing to prisoners' disorientation and mental deterioration. Chronic sleep deprivation is common. Plaintiff Thomas reported an inability to sleep and requested Ambien, but was not prescribed a sleep aid. Property is extremely limited. Many prisoners have no radio or television, and many are illiterate or have difficulty reading, leaving them in a state of enforced idleness with nothing to do but sleep, sit, or pace in their cells.

94. Prisoners in isolation often go months or years without any meaningful human interaction. Unless they are fortunate enough to receive a brief medical or legal appointment or a visit, prisoners are isolated from virtually all human contact. Their only regular interaction with another human being occurs when officers deliver their food trays, or place them in restraints and strip-search them while taking them to or from the rec pen.

95. Defendants have a policy and practice of denying prisoners in isolation adequate nutrition, which Defendants justify on the basis that, because these prisoners receive virtually no exercise, they burn fewer calories and therefore need less food. Some

prisoners in isolation receive only two meals per day, which do not meet their minimal nutritional needs. Prisoners experience constant hunger pangs and some lose significant weight as a result of Defendants' policy of providing inadequate nutrition. Plaintiff Thomas lost 30 pounds while in isolation. Plaintiff Smith, who is in isolation supposedly for his own protection after leaving a gang, often cannot eat the limited amount of food he is given, as it is tampered with by the prisoner kitchen workers who target him for retaliation. He has complained to prison staff, to no avail.

96. The devastating effects of these conditions of extreme social isolation and environmental deprivation are well known to Defendants. An abundant psychiatric literature spanning nearly two hundred years has documented the adverse mental health effects of isolation, and Arizona prisoners are no exception. Even prisoners who have no mental illness when first placed in isolation often experience a dramatic deterioration in their mental health, developing symptoms such as paranoia, anxiety, depression, and post-traumatic stress disorder. For example, Mr. Thomas did not suffer from suicidal ideation when he was put in isolation, but as time went on, his mental and physical state deteriorated. He developed suicidal ideation and physically harmed himself several times. Plaintiff Smith's file notes that on January 5, 2010, he reported mental health problems while housed in isolation, but he could not be seen due to a "psych RN shortage." Even those prisoners who withstand isolation better than most are subjected to intolerable conditions, as they are forced to endure the hallucinations and screaming of prisoners suffering the debilitating effects of isolation.

97. Isolation is even more predictably damaging to prisoners with a pre-existing mental illness. For these prisoners, isolation poses a grave risk of exacerbation of mental health symptoms, psychiatric injury such as PTSD, self-harm, and suicide. Deprived of the social interaction that is essential to keep them grounded in reality, many prisoners with mental illness experience catastrophic and often irreversible psychiatric deterioration. Unlike prison officials in many states, Defendants' policy and practice allows the isolation of prisoners with mental illness, and Defendants knowingly hold prisoners designated as seriously mentally ill in isolation.

98. The harm to prisoners in isolation is exacerbated by the policy and practice of Defendants of failing to provide adequate mental health care staffing and treatment. In addition, the harsh regime and severe limits on human contact in isolation render appropriate mental health treatment effectively impossible. Prisoners in isolation do not receive regular contact with psychiatrists or mental health clinicians, nor do they receive the limited group therapy that is sometimes provided to prisoners in other ADC facilities. Defendants stated in response to a public records request that they keep no records of the mental health programming provided to prisoners in isolation. These prisoners' rare interactions with mental health staff usually consist of "cellfront" contacts in which the staff member shouts through the cell door, within earshot of both officers and other prisoners. There is currently no psychiatrist on staff at Eyman, which has two SMUs.

99. The most common form of mental health treatment for prisoners in isolation is the administration of powerful psychotropic medications, with little or no supervision

by a psychiatrist. For example, Plaintiff Gamez was not seen by a psychiatrist from 2007 through 2011 despite worsening mental health symptoms. His mental health deteriorated extensively while held in isolation from 2009 through 2011, yet he did not see a psychiatrist or receive psychotherapy despite filing multiple HNRs detailing his symptoms. Similarly, Plaintiffs Brislan and Swartz had psychotropic medications renewed without any contact with a psychiatrist, despite increasing incidents of self-harming behavior and side effects while in isolation. Prisoners who require an inpatient level of mental health care, like Plaintiffs Brislan and Verduzco, do not receive it, and are instead left in isolation where their condition worsens.

100. The predictable outcomes of these cruel conditions of isolation are psychiatric deterioration, self-injury, and death. Plaintiffs Swartz and Brislan attempted to commit suicide on multiple occasions while in isolation. Recently a prisoner with depression who was housed in isolation at Florence-Central Unit repeatedly asked custodial staff and medical staff passing by if he could be seen by mental health because he was suicidal. Nothing was done for him, and he committed suicide by hanging on January 28, 2012.

CLASS ACTION ALLEGATIONS

Plaintiff Class

101. All prisoner Plaintiffs bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of all prisoners who are now, or will in the future be, subjected to the medical,

mental health, and dental care (collectively "health care") policies and practices of the ADC (the "Plaintiff Class").

Numerosity: Fed. R. Civ. P. 23(a)(1)

102. The class is so numerous that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). As of March 1, 2012, there are approximately 33,100 prisoners in the custody of ADC's prisons, all of whom are dependent entirely on Defendants for the provision of health care. Due to Defendants' policies and practices, all ADC prisoners, numbering tens of thousands annually, receive or are at risk of receiving inadequate health care while in ADC prisons.[3]

103. The Plaintiff Class members are identifiable using records maintained in the ordinary course of business by the ADC.

Commonality: Fed. R. Civ. P. 23(a)(2)

104. There are questions of law and fact common to the members of the class. Such questions include, but are not limited to:

(a) whether Defendants' failure to operate a health care system providing minimally adequate health care violates the Cruel and Unusual Punishments Clause of the Eighth Amendment,

(b) whether Defendants have been deliberately indifferent to the serious health care needs of class members.

Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

[3] This proposed class does not include the approximately 6,400 Arizona prisoners housed in private for-profit prisons pursuant to contracts with ADC.

Typicality: Fed. R. Civ. P. 23(a)(3)

105. The claims of the Plaintiffs are typical of those of the Plaintiff Class, as their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the class's claims.

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Adequacy: Fed. R. Civ. P. 23(a)(4)

106. Plaintiffs are capable of fairly and adequately protecting the interests of the Plaintiff class because Plaintiffs do not have any interests antagonistic to the class. Plaintiffs, as well as the Plaintiff class members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

107. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(1) because the number of class members is approximately 33,100, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants Ryan and Pratt. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

Fed. R. Civ. P. 23(b)(2)

108. This action is also maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) because Defendants' policies, practices, actions, and omissions that form the basis of this complaint are common to and apply generally to all members of the class, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the class. All state-wide health care policies are centrally promulgated, disseminated, and enforced from the central headquarters of ADC by Defendants Ryan and Pratt. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Plaintiff class.

Medical Subclass

109. Plaintiffs Jensen, Swartz, Chisholm, Licci, Hefner, Polson, and Wells bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass of all prisoners (hereinafter "Medical Subclass") who are now, or will in the future be, subjected to the medical care policies and practices of the ADC. "Medical care" includes care related to hearing and vision.

Numerosity: Fed. R. Civ. P. 23(a)(1)

110. The Medical Subclass is so numerous that joinder of all members is impracticable. As of March 1, 2012, there are approximately 33,100 prisoners in the custody of ADC's prisons, all of whom are dependent entirely on Defendants for the provision of medical care. Due to Defendants' policies and practices, all ADC prisoners, numbering tens of thousands annually, receive or are at risk of receiving inadequate

medical care while in ADC prisons.

111. The Medical Subclass members are identifiable using records maintained in the ordinary course of business by the ADC.

Commonality: Fed. R. Civ. P. 23(a)(2)

112. There are questions of law and fact common to the members of the Medical Subclass. Such questions include, but are not limited to:

(a) whether Defendants' failure to operate a medical care system providing minimally adequate medical care violates the Cruel and Unusual Punishments Clause of the Eighth Amendment,

(b) whether Defendants have been deliberately indifferent to the resulting harm and risk of harm to Medical Subclass members who are deprived of minimally adequate medical care.

Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

113. The claims of the Plaintiffs are typical of those of the Medical Subclass, because their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the subclass's claims.

Adequacy: Fed. R. Civ. P. 23(a)(4)

114. Plaintiffs are capable of fairly and adequately protecting the interests of the Medical Subclass because Plaintiffs do not have any interests antagonistic to the subclass. Plaintiffs, as well as the Medical Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. The Plaintiffs are represented by counsel experienced in civil

rights litigation, prisoners' rights litigation, and complex class action litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

115. Since the number of Medical Subclass members is so large, the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants Ryan and Pratt.

116. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

Fed. R. Civ. P. 23(b)(2)

117. Defendants' policies, practices, actions, and omissions that form the basis of the claims of the Medical Subclass are common to and apply generally to all members of the subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass. All state-wide medical policies are centrally promulgated, disseminated, and enforced from the central headquarters of ADC by Defendants Ryan and Pratt. The injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass.

Dental Subclass

118. Plaintiffs Swartz, Parsons, Chisholm, Polson, and Wells bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass of all prisoners (hereinafter "Dental Subclass")

who are now, or will in the future be, subjected to the dental care policies and practices of the ADC.

Numerosity: Fed. R. Civ. P. 23(a)(1)

119. The Dental Subclass is so numerous that joinder of all members is impracticable. As of March 1, 2012, there are approximately 33,100 prisoners in the custody of ADC's prisons, all of whom are dependent entirely on Defendants for the provision of dental care. Due to Defendants' policies and practices, all ADC prisoners, numbering tens of thousands annually, receive or are at risk of receiving inadequate dental care while in ADC prisons.

120. The Dental Subclass members are identifiable using records maintained in the ordinary course of business by the ADC.

Commonality: Fed. R. Civ. P. 23(a)(2)

121. There are questions of law and fact common to the members of the Dental Subclass. Such questions include, but are not limited to:

(a) whether Defendants' failure to operate a dental care system providing minimally adequate dental care violates the Cruel and Unusual Punishments Clause of the Eighth Amendment,

(b) whether Defendants have been deliberately indifferent to the resulting harm and risk of harm to Dental Subclass members who are deprived of minimally adequate dental care.

Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

122. The claims of the Plaintiffs are typical of those of the Dental Subclass, because their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the subclass's claims.

Adequacy: Fed. R. Civ. P. 23(a)(4)

123. Plaintiffs are capable of fairly and adequately protecting the interests of the Dental Subclass because Plaintiffs do not have any interests antagonistic to the subclass. Plaintiffs, as well as the Dental Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

124. Since the number of Dental Subclass members is so large, the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants Ryan and Pratt. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

Fed. R. Civ. P. 23(b)(2)

125. Defendants' policies, practices, actions, and omissions that form the basis of the claims of the Dental Subclass are common to and apply generally to all members of the subclass, and the injunctive and declaratory relief sought is appropriate and will apply

to all members of the subclass. All state-wide dental policies are centrally promulgated, disseminated, and enforced from the central headquarters of ADC by Defendants Ryan and Pratt. The injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass.

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Mental Health Subclass

126. Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Smith, Parsons, Chisholm, and Polson, bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass of all prisoners (hereinafter "Mental Health Subclass") who are now, or will in the future be, subjected to the mental health care policies and practices of the ADC.

Numerosity: Fed. R. Civ. P. 23(a)(1)

127. The Mental Health Subclass is so numerous that joinder of all members is impracticable. As of March 1, 2012, there are approximately 33,100 prisoners in the custody of ADC's prisons, all of whom are dependent entirely on Defendants for the provision of mental health care. Due to Defendants' policies and practices, all ADC prisoners, numbering tens of thousands annually, receive or are at risk of receiving inadequate mental health care while in ADC prisons. The Mental Health Subclass members are identifiable using records maintained in the ordinary course of business by the ADC.

Commonality: Fed. R. Civ. P. 23(a)(2)

128. There are questions of law and fact common to the members of the Mental Health Subclass. Such questions include, but are not limited to:

(a) whether Defendants' failure to operate a mental health care system providing minimally adequate mental health care violates the Cruel and Unusual Punishments Clause of the Eighth Amendment,

(b) whether Defendants have been deliberately indifferent to the resulting harm and risk of harm to Mental Health Subclass members who are deprived of minimally adequate mental health care.

Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

129. The claims of the Plaintiffs are typical of those of the Mental Health Subclass, because their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the subclass's claims.

Adequacy: Fed. R. Civ. P. 23(a)(4)

130. Plaintiffs are capable of fairly and adequately protecting the interests of the Mental Health Subclass because Plaintiffs do not have any interests antagonistic to the subclass. Plaintiffs, as well as the Mental Health Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

131. Since the number of Mental Health Subclass members is so large, the

prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants Ryan and Pratt. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

Fed. R. Civ. P. 23(b)(2)

132. Defendants' policies, practices, actions, and omissions that form the basis of the claims of the Mental Health Subclass are common to and apply generally to all members of the subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass. All state-wide mental health policies are centrally promulgated, disseminated, and enforced from the central headquarters of ADC by Defendants Ryan and Pratt. The injunctive and declaratory relief sought is appropriate and will apply to all members of the subclasses.

Isolation Subclass

133. Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, and Polson bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, against Defendants Ryan and Pratt on behalf of a subclass of all prisoners (hereinafter "Isolation Subclass") who are now, or will in the future be, subject by the ADC to isolation, defined as confinement in a cell for 22 hours or more each day or confinement in Eyman - SMU 1, Eyman - Browning Unit,

Florence - Central Unit, or Perryville - Lumley Unit Special Management Area (SMA).

Numerosity: Fed. R. Civ. P. 23(a)(1)

134. The Isolation Subclass is so numerous that joinder of all members is impracticable. Each year approximately 3,000 prisoners are subjected to Defendants' policies and practices of denying minimally adequate conditions of confinement while in isolation. The Isolation Subclass members are identifiable using records maintained in the ordinary course of business by the ADC.

Commonality: Fed. R. Civ. P. 23(a)(2)

135. There are questions of law and fact common to the members of the Isolation Subclass. Such questions include, but are not limited to:

(a) whether Defendants' policy and practice of not providing a housing environment free of debilitating isolation and inhumane conditions to prisoners subjected to isolation violates the Cruel and Unusual Punishments Clause of the Eighth Amendment,

(b) whether Defendants have been deliberately indifferent to the Isolation Subclass members' risk of injury and harm from the debilitating isolation and inhumane conditions to which they are subjected.

Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

136. The claims of the Plaintiffs are typical of those of the Isolation Subclass, because their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the subclass's claims.

Adequacy: Fed. R. Civ. P. 23(a)(4)

137. Plaintiffs are capable of fairly and adequately protecting the interests of the Isolation Subclass because Plaintiffs do not have any interests antagonistic to the subclass. Plaintiffs, as well as the Isolation Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

138. Since the number of Isolation Subclass members is approximately 3,000, the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants Ryan and Pratt. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

Fed. R. Civ. P. 23(b)(2)

139. Defendants' policies, practices, actions, and omissions that form the basis of the claims of the Isolation Subclass are common to and apply generally to all members of the subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass. All state-wide policies on the conditions of isolation are centrally promulgated, disseminated, and enforced from the central headquarters of ADC by Defendants Ryan and Pratt. The injunctive and declaratory relief sought is appropriate

and will apply to all members of the subclass.

CLAIMS FOR RELIEF

First Cause of Action
(All Prisoner Plaintiffs and the Plaintiff Class v. Defendants Ryan and Pratt)
(42 U.S.C. § 1983; Eighth Amendment)

140. By their policies and practices described herein, Defendants subject all prisoner Plaintiffs and the Plaintiff class to a substantial risk of serious harm and injury from inadequate health care. These policies and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs' and the Plaintiff Class's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

141. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

Second Cause of Action
(Plaintiffs Jensen, Swartz, Chisholm, Licci, Hefner, Polson, and Wells; and Medical Subclass v. Defendants Ryan and Pratt)
(42 U.S.C. § 1983; Eighth Amendment)

142. By their policies and practices described herein, Defendants subject Plaintiffs Jensen, Swartz, Chisholm, Licci, Hefner, Polson, and Wells, and the Medical Subclass to a substantial risk of serious harm and injury from inadequate medical care. These policies and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs'

and the Medical Subclass's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

143. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

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Third Cause of Action
(Plaintiffs Swartz, Parsons, Chisholm, Polson, and Wells; and
Dental Subclass v. Defendants Ryan and Pratt)
(42 U.S.C. § 1983; Eighth Amendment)

144. By their policies and practices described herein, Defendants subject Plaintiffs Swartz, Parsons, Chisholm, Polson, and Wells, and the Dental Subclass to a substantial risk of serious harm and injury from inadequate dental care. These policies and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs' and the Dental Subclass's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

145. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

Fourth Cause of Action
(Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, Parsons,
Chisholm, and Polson; Plaintiff Arizona Center for Disability Law; and
Mental Health Subclass v. Defendants Ryan and Pratt)
(42 U.S.C. § 1983; Eighth Amendment)

146. By their policies and practices described herein, Defendants subject

Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, Parsons, Chisholm, and Polson, and the Mental Health Subclass to a substantial risk of serious harm and injury from inadequate mental health care. These policies and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs' and the Mental Health Subclass's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

147. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

Fifth Cause of Action
(Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, and Polson; and Plaintiff Arizona Center for Disability Law; and Isolation Subclass v. Defendants Ryan and Pratt)
(42 U.S.C. § 1983; Eighth Amendment)

148. By their policies and practices described herein, Defendants subject Plaintiffs Gamez, Swartz, Brislan, Rodriguez, Verduzco, Thomas, Smith, and Polson, and the Isolation Subclass to a substantial risk of serious harm and injury from inadequate physical exercise, inadequate nutrition, inadequate mental health treatment, and conditions of extreme social isolation and environmental deprivation. These policies and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs' and the Isolation

Subclass's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

149. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

///

PRAYER FOR RELIEF

150. Plaintiffs and the classes they represent have no adequate remedy at law to redress the wrongs suffered as set forth in this complaint. Plaintiffs have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of Defendants Ryan and Pratt, as alleged herein, unless Plaintiffs and the classes they represent are granted the relief they request. The need for relief is critical because the rights at issue are paramount under the United States Constitution and the laws of the United States.

151. WHEREFORE, the named plaintiffs and the classes they represent request that this Court grant them the following relief:

A. Declare that the suit is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(1) and (2);

B. Adjudge and declare that the acts, omissions, policies, and practices of Defendants, and their agents, employees, officials, and all persons acting in concert with them under color of state law or otherwise, described herein are in violation of the rights of prisoner Plaintiffs and the classes they represent under the Cruel and Unusual

Punishments Clause of the Eighth Amendment, which grants constitutional protection to the Plaintiffs and the class they represent;

C. Preliminarily and permanently enjoin Defendants, their agents, employees, officials, and all persons acting in concert with them under color of state law, from subjecting prisoner Plaintiffs and the Plaintiff Class to the illegal and unconstitutional conditions, acts, omissions, policies, and practices set forth above.

D. Order Defendants and their agents, employees, officials, and all persons acting in concert with them under color of state law, to develop and implement, as soon as practical, a plan to eliminate the substantial risk of serious harm that prisoner Plaintiffs and members of the Plaintiff Class suffer due to Defendants' inadequate medical, mental health, and dental care, and due to Defendants' isolation policies. Defendants' plan shall include at a minimum the following:

1. Staffing: Staffing shall be sufficient to provide prisoner Plaintiffs and the Plaintiff Class with timely access to qualified and competent clinicians who can provide routine, urgent, emergent, and specialty health care;

2. Access: Policies and practices that provide timely access to health care;

3. Screening: Policies and practices that reliably screen for medical, dental, and mental health conditions that need treatment;

4. Emergency Response: Timely and competent responses to health care emergencies;

5. Medication and Supplies: Timely prescription and distribution of medications and supplies necessary for medically adequate care;

6. Chronic Care: Timely access to competent care for chronic diseases;

7. Environmental Conditions: Basic sanitary conditions that do not promote the spread or exacerbation of diseases or infections, including but not limited to a smoke-free environment;

8. Mental Health Treatment: Timely access to necessary treatment for serious mental illness, including medication, therapy, inpatient treatment, suicide prevention, and suicide watch;

9. Quality Assurance: A regular assessment of health care staff, services, procedures, and activities designed to improve outcomes, and to identify and correct errors or systemic deficiencies;

10. Isolation: Prohibition of confinement of prisoner Plaintiffs and the Isolation Subclass under conditions of social isolation and sensory deprivation that put prisoners at substantial risk of serious physical and mental harm. Providing prisoner Plaintiffs and the Isolation Subclass with necessary nutrition and regular outdoor exercise to preserve their physical and mental health.

E. Award Plaintiffs the costs of this suit, and reasonable attorneys' fees and litigation expenses pursuant to 42 U.S.C. § 1988, and other applicable law;

F. Retain jurisdiction of this case until Defendants have fully complied with the orders of this Court, and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction; and

G. Award such other and further relief as the Court deems just and proper.

Dated: March 22, 2012

ACLU FOUNDATION OF ARIZONA

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CERTIFICATE OF SERVICE

☒ I hereby certify that on March 22, 2012, I electronically transmitted the attached documents to the Clerk's Office using the CM/ECF System.

/s/ Gloria Torres

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DJH

STIPULATION

Plaintiffs and Defendants (collectively, "the Parties") hereby stipulate as follows:

I. INTRODUCTION AND PROCEDURAL PROVISIONS

1. Plaintiffs are prisoners in the custody of the Arizona Department of Corrections ("ADC"), an agency of the State of Arizona, who are incarcerated at one of the state facilities located in the State of Arizona, and the Arizona Center for Disability Law ("ACDL").

2. Defendants are Charles Ryan, Director of ADC, and Richard Pratt, Interim Division Director, Division of Health Services of ADC. Both Defendants are sued in their official capacities.

3. The Court has certified this case as a class action. The class is defined as "All prisoners who are now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the ADC." The subclass is defined as "All prisoners who are now, or will in the future be, subjected by the ADC to isolation, defined as confinement in a cell for 22 hours or more each day or confinement in the following housing units: Eyman–SMU 1; Eyman–Browning Unit; Florence–Central Unit; Florence–Kasson Unit; or Perryville–Lumley Special Management Area."

4. The purpose of this Stipulation to settle the above captioned case. This Stipulation governs or applies to the 10 ADC complexes: Douglas, Eyman, Florence, Lewis, Perryville, Phoenix, Safford, Tucson, Winslow and Yuma. This Stipulation does not apply to occurrences or incidents that happen to class members while they do not reside at one of the 10 ADC complexes.

5. Defendants deny all the allegations in the Complaint filed in this case. This Stipulation does not constitute and shall not be construed or interpreted as an admission of any wrongdoing or liability by any party.

6. Attached to this Stipulation as Exhibit A is a list of definitions of terms used herein and in the performance measures used to evaluate compliance with the Stipulation.

II. SUBSTANTIVE PROVISIONS

A. Health Care.

7. Defendants shall request that the Arizona Legislature approve a budget to allow ADC and its contracted health services vendor to modify the health services contract to increase staffing of medical and mental health positions. This provision shall not be construed as an agreement by Plaintiffs that this budgetary request is sufficient to comply with the terms of this Stipulation.

8. Defendants shall comply with the health care performance measures set forth in Exhibit B. Clinicians who exhibit a pattern and practice of substantially departing from the standard of care shall be subject to corrective action.

9. **Measurement and reporting of performance measures:** Compliance with the performance measures set forth in Exhibit B shall be measured and reported monthly at each of ADC's ten (10) complexes as follows.

a. The performance measures analyzed to determine ADC substantial compliance with the health care provisions of this Stipulation shall be governed by ADC's MGAR format. Current MGAR performance compliance thresholds used to measure contract compliance by the contracted vendor shall be modified pursuant to a contract amendment to reflect the compliance measures and definitions set forth in Exhibit B.

b. The parties shall agree on a protocol to be used for each performance measure, attached as Exhibit C. If the parties cannot agree on a protocol, the matter shall be submitted for mediation or resolution by the District Court.

10. The measurement and reporting process for performance measures, as described in Paragraph 9, will determine (1) whether ADC has complied with particular performance measures at particular complexes, (2) whether the health care provisions of this Stipulation may terminate as to particular performance measures at particular

complexes, as set forth in the following sub-paragraphs.

a. **Determining substantial compliance with a particular performance measure at a particular facility:** Compliance with a particular performance measure identified in Exhibit B at a particular complex shall be defined as follows:

i. For the first twelve months after the effective date of this Stipulation, meeting or exceeding a seventy-five percent (75%) threshold for the particular performance measure that applies to a specific complex, determined under the procedures set forth in Paragraph 9;

ii. For the second twelve months after the effective date of this Stipulation, meeting or exceeding an eighty percent (80%) threshold for the particular performance measure that applies to a specific complex, determined under the procedures set forth in Paragraph 9;

iii. After the first twenty four months after the effective date of this Stipulation, meeting or exceeding an eighty-five percent (85%) threshold for the particular performance measure that applies to a specific complex, determined under the procedures set forth in Paragraph 9.

b. **Termination of the duty to measure and report on a particular performance measure:** ADC's duty to measure and report on a particular performance measure, as described in Paragraph 9, terminates if:

i. The particular performance measure that applies to a specific complex is in compliance, as defined in sub-paragraph A of this Paragraph, for eighteen months out of a twenty-four month period; and

ii. The particular performance measure has not been out of compliance, as defined in sub-paragraph A of this Paragraph, for three or more consecutive months within the past 18- month period.

c. The duty to measure and report on any performance measure for a given complex shall continue for the life of this Stipulation unless terminated pursuant to sub-paragraph B of this Paragraph.

11. Defendants or their contracted vendor(s) will approve or deny all requests for specialty health care services using InterQual or another equivalent industry standard utilization management program. Any override of the recommendation must be documented in the prisoner's health care chart, including the reason for the override.

12. Defendants or their contracted vendor(s) will ensure that:

a. All prisoners will be offered an annual influenza vaccination.

b. All prisoners with chronic diseases will be offered the required immunizations as established by the Centers for Disease Control.

c. All prisoners ages 50 to 75 will be offered annual colorectal cancer screening.

d. All female prisoners age 50 and older will be offered a baseline mammogram screening at age 50, then every 24 months thereafter unless more frequent screening is clinically indicated.

13. Defendants or their contracted vendor(s) will implement a training program taught by Dr. Brian Hanstad, or another dentist if Dr. Hanstad is unavailable, to train dental assistants at ADC facilities about how to triage HNRs into routine or urgent care lines as appropriate and to train dentists to evaluate the accuracy and skill of dental assistants under their supervision.

14. For prisoners who are not fluent in English, language interpretation for healthcare encounters shall be provided by a qualified health care practitioner who is proficient in the prisoner's language, or by a language line interpretation service.

15. If a prisoner who is taking psychotropic medication suffers a heat intolerance reaction, all reasonably available steps will be taken to prevent heat injury or illness. If all other steps have failed to abate the heat intolerance reaction, the prisoner will be transferred to a housing area where the cell temperature does not exceed 85 degrees Fahrenheit.

16. Psychological autopsies shall be provided to the monitoring bureau within thirty (30) days of the prisoner's death and shall be finalized by the monitoring bureau within fourteen (14) days of receipt. When a toxicology report is required, the psychological autopsy shall be provided to the monitoring bureau within thirty (30) days of receipt of the medical examiner's report. Psychological autopsies and mortality reviews shall identify and refer deficiencies to appropriate managers and supervisors including the CQI committee. If deficiencies are identified, corrective action will be taken.

B. Maximum Custody Prisoners.

17. Defendants shall request that the Arizona Legislature approve a budget to allow ADC to implement DI 326 for all eligible prisoners. This provision shall not be construed as an agreement by Plaintiffs that this budget request is sufficient to comply with the terms of this Stipulation.

18. Defendants shall comply with the maximum custody performance measures set forth in Exhibit D.

19. **Measurement and reporting of performance measures:** Compliance with the performance measures set forth in Exhibit D shall be measured and reported monthly as follows.

a. The performance measures analyzed to determine ADC substantial compliance with the Maximum Custody provisions of this Stipulation

shall be governed by the protocol used for each performance measure attached as Exhibit E. If the parties cannot agree on a protocol, the matter shall be submitted for mediation or resolution by the District Court.

20. The measurement and reporting process for performance measures, as described in Paragraph 19, will determine (1) whether ADC has complied with particular performance measures at particular units, (2) whether the Maximum Custody provisions of this Stipulation may terminate as to particular performance measures at particular units, as set forth in the following sub-paragraphs.

a. **Determining substantial compliance with a particular performance measure at a particular unit:** Compliance with a particular performance measure identified in Exhibit D at a particular unit shall be defined as follows:

i. For the first twelve months after the effective date of this Stipulation, meeting or exceeding a seventy-five percent (75%) threshold for the particular performance measure that applies to a specific unit, determined under the procedures set forth in Paragraph 19;

ii. For the second twelve months after the effective date of this Stipulation, meeting or exceeding an eighty percent (80%) threshold for the particular performance measure that applies to a specific unit, determined under the procedures set forth in Paragraph 19;

iii. After the first twenty four months after the effective date of this Stipulation, meeting or exceeding an eighty-five percent (85%) threshold for the particular performance measure that

applies to a specific unit, determined under the procedures set forth in Paragraph 19.

b. **Termination of the duty to measure and report on a particular performance measure:** ADC's duty to measure and report on a particular performance measure, as described in Paragraph 19, terminates if:

i. The particular performance measure that applies to a specific unit is in compliance, as defined in sub-paragraph A of this Paragraph, for eighteen months out of a twenty-four month period; and

ii. The particular performance measure has not been out of compliance, as defined in sub-paragraph A of this Paragraph, for three or more consecutive months within the past eighteen-month period.

c. The duty to measure and report on any performance measure for a given unit shall continue for the life of this Stipulation unless terminated pursuant to sub-paragraph B of this Paragraph.

21. Seriously Mentally Ill (SMI) prisoners are defined as those prisoners who have been determined to be seriously mentally ill according to the criteria set forth in the ADC SMI Determination Form (Form 1103-13, 12/19/12), which is attached hereto as Exhibit F and is incorporated by reference as if fully set forth herein. For purposes of this Stipulation, "intellectual disabilities," as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), shall be added to the list of qualifying diagnoses on Form 1103.13. This definition shall govern this Stipulation notwithstanding any future modification of Form 1103.13 or ADC's definition of "Seriously Mentally Ill." All prisoners determined to be SMI in the community shall also be designated as SMI by ADC.

22. ADC maximum custody prisoners housed at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) units, shall be offered out of cell time, incentives, programs and property consistent with DI 326 and the Step Program Matrix, but in no event shall be offered less than 6 hours per week of out-of-cell exercise. Defendants shall implement DI 326 and the Step Program Matrix for all eligible prisoners and shall maintain them in their current form for the duration of this Stipulation. In the event that Defendants intend to modify DI 326 and the Step Program Matrix they shall provide Plaintiffs' counsel with thirty (30) days' notice. In the event that the parties do not agree on the proposed modifications, the dispute shall be submitted to Magistrate Judge David Duncan who shall determine whether the modifications effectuate the intent of the relevant provisions of the Stipulation.

23. Prisoners who are MH3 or higher shall not be housed in Florence Central-CB5 or CB7 unless the cell fronts are substantially modified to increase visibility.

24. All prisoners eligible for participation in DI 326 shall be offered at least 7.5 hours of out-of-cell time per week. All prisoners at Step II shall be offered at least 8.5 hours of out-of-cell time per week, and all prisoners at Step III shall be offered at least 9.5 hours of out-of-cell time per week. The out of cell time set forth in this paragraph is inclusive of the six hours of exercise time referenced in Paragraph 22. Defendants shall ensure that prisoners at Step II and Step III of DI 326 are participating in least one hour of out-of-cell group programming per week.

25. In addition to the out of cell time, incentives, programs and property offered pursuant to DI 326 and the Step Program Matrix for prisoners housed at maximum custody units specified in ¶ 24 above, ADC maximum custody prisoners designated as SMI pursuant to ¶ 21 above, shall be offered an additional ten hours of unstructured of out of cell time per week; an additional one hour of out-of-cell mental health programming per week; one hour of additional out of cell pyschoeducational programming per week;

and one hour of additional out of cell programming per week. Time spent out of cell for exercise, showers, medical care, classification hearings or visiting shall not count toward the additional ten hours of out of cell time per week specified in this Paragraph. All prisoners received in maximum custody will receive an evaluation for program placement within 72 hours of their transfer into maximum custody, including to properly identify all SMI prisoners.

26. If out of cell time offered pursuant to ¶¶ 24 or 25 above is limited or cancelled for legitimate operational or safety and security reasons such as an unexpected staffing shortage, inclement weather or facility emergency lockdown, Defendants shall make every reasonable effort to ensure that amount of out of cell time shall be made up for those prisoners who missed out of cell time. The out of cell time provided pursuant to paragraph 24 above, may be limited or canceled for an individual prisoner if the Warden, or his/her designee if the Warden is not available, certifies in writing that allowing that prisoner such out of cell time would pose a significant security risk. Such certification shall expire after thirty (30) days unless renewed in writing by the Warden or his/her designee.

27. Defendants shall maintain the following restrictions on the use of pepper spray and other chemical agents on any maximum custody prisoner classified as SMI, and in the following housing areas: Florence-CB-1 and CB-4; Florence-Kasson (Wings 1 and 2); Eyman-SMU I (BMU); Perryville-Lumley SMA; and Phoenix (Baker, Flamenco, and MTU).

a. Chemical agents shall be used only in case of imminent threat. An imminent threat is any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat. Some examples include, but are not limited to: an attempt to escape, on-going physical harm or active physical resistance. A decision to use chemical agents shall be based on

more than passive resistance to placement in restraints or refusal to follow orders. If the inmate has not responded to staff for an extended period of time, and it appears that the inmate does not present an imminent physical threat, additional consideration and evaluation should occur before the use of chemical agents is authorized.

b. All controlled uses of force shall be preceded by a cool down period to allow the inmate an opportunity to comply with custody staff orders. The cool down period shall include clinical intervention (attempts to verbally counsel and persuade the inmate to voluntarily exit the area) by a mental health clinician, if the incident occurs on a weekday between 8:00 a.m. and 4:00 p.m. At all other times, a qualified health care professional (other than a LPN) shall provide such clinical intervention. This cool down period may include similar attempts by custody staff.

c. If it is determined the inmate does not have the ability to understand orders, chemical agents shall not be used without authorization from the Warden, or if the Warden is unavailable, the administrative duty officer.

d. If it is determined an inmate has the ability to understand orders but has difficulty complying due to mental health issues, or when a mental health clinician believes the inmate's mental health issues are such that the controlled use of force could lead to a substantial risk of decompensation, a mental health clinician shall propose reasonable strategies to employ in an effort to gain compliance, if the incident occurs on a weekday between 8:00 a.m. and 4:00 p.m. At all other times, a qualified health care professional (other than a LPN) shall propose such reasonable strategies.

e. The cool down period may also include use of other available resources/options such as dialogue via religious leaders, correctional

counselors, correctional officers and other custody and non-custody staff that have established rapport with the inmate.

28. All maximum custody prisoners shall receive meals equivalent in caloric and nutritional content to the meals received by other ADC prisoners.

III. MONITORING AND ENFORCEMENT

29. Plaintiffs' counsel and their experts shall have reasonable access to the institutions, staff, contractors, prisoners and documents necessary to properly evaluate whether Defendants are complying with the performance measures and other provisions of this Stipulation. The parties shall cooperate so that plaintiffs' counsel has reasonable access to information reasonably necessary to perform their responsibilities required by this Stipulation without unduly burdening defendants. If the parties fail to agree, either party may submit the dispute for binding resolution by Magistrate Judge David Duncan. Defendants shall also provide, on a monthly basis during the pendency of the Stipulation, copies of a maximum of ten (10) individual Class Members' health care records, and a maximum of five (5) individual Subclass Members' health care and institutional records, such records to be selected by Plaintiffs' counsel. The health care records shall include: treatment for a twelve (12) month period of time from the date the records are copied. Upon request, Defendants shall provide the health care records for the twelve months before those originally produced. In addition, Defendants shall provide to Plaintiffs on a monthly basis a copy of all health care records of Class Members who died during their confinement at any state operated facility (whether death takes place at the facility or at a medical facility following transfer), and all mortality reviews and psychological autopsies for such prisoners. The records provided shall include treatment for a twelve (12) month period prior to the death of the prisoner. Upon request, Defendants shall provide the health care records for the twelve months before those originally produced. The parties will meet and confer about the limit on the records that Plaintiffs can request once the ADC electronic medical records system is fully implemented.

30. In the event that counsel for Plaintiffs alleges that Defendants have failed to substantially comply in some significant respect with this Stipulation, Plaintiffs' counsel shall provide Defendants with a written statement describing the alleged non-compliance ("Notice of Substantial Non-Compliance"). Defendants shall provide a written statement responding to the Notice of Substantial Non-Compliance within thirty (30) calendar days from receipt of the Notice of Substantial Non-Compliance and, within thirty (30) calendar days of receipt of Defendants' written response, counsel for the parties shall meet and confer in a good faith effort to resolve their dispute informally.

31. In the event that a Notice of Substantial Non-Compliance pursuant to ¶ 30 of this Stipulation cannot be resolved informally, counsel for the parties shall request that Magistrate Judge John Buttrick mediate the dispute. In the event that Magistrate Judge Buttrick is no longer available to mediate disputes in this case, the parties shall jointly request the assignment of another Magistrate Judge, or if the parties are unable to agree, the District Judge shall appoint a Magistrate Judge. If the dispute has not been resolved through mediation in conformity with this Stipulation within sixty (60) calendar days, either party may file a motion to enforce the Stipulation in the District Court.

32. Plaintiffs' counsel and their experts shall have the opportunity to conduct no more than twenty (20) tour days per year of ADC prison complexes. A "tour day" is any day on which one or more of plaintiffs' counsel and experts are present at a given complex. A tour day shall last no more than eight hours. No complex will be toured more than once per quarter. Tours shall be scheduled with at least two weeks' advance notice to defendants. Defendants shall make reasonable efforts to make available for brief interview ADC employees and any employees of any contractor that have direct or indirect duties related to the requirements of this Stipulation. The interviews shall not unreasonably interfere with the performance of their duties. Plaintiffs' counsel and their experts shall be able to have confidential, out-of-cell interviews with prisoners during these tours. Plaintiffs' counsel and their experts shall be able to review health and other

records of class members, and records of mental health and other programming, during the tours. Plaintiffs' counsel and their experts shall be able to review any documents that form the basis of the MGAR reports and be able to interview the ADC monitors who prepared those reports.

33. With the agreement of both parties, Plaintiffs may conduct confidential interviews with prisoners, and interviews of ADC employees or employees of ADC's contractors, by telephone.

34. Defendants shall notify the Ninth Circuit Court of Appeals of the settlement of this case and of their intention to withdraw the petition for rehearing en banc in case number 13-16396, upon final approval of the Stipulation by the District Court. Defendants agree not to file a petition for writ of certiorari with the United States Supreme Court seeking review of the Ninth Circuit's judgment in case number 13-16396.

IV. RESERVATION OF JURISDICTION

35. The parties consent to the reservation and exercise of jurisdiction by the District Court over all disputes between and among the parties arising out of this Stipulation. The parties agree that this Stipulation shall not be construed as a consent decree.

36. Based upon the entire record, the parties stipulate and jointly request that the Court find that this Stipulation satisfies the requirements of 18 U.S.C. § 3626(a)(1)(A) in that it is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right of the Plaintiffs. In the event the Court finds that Defendants have not complied with the Stipulation, it shall in the first instance require Defendants to submit a plan approved by the Court to remedy the deficiencies identified by the Court. In the event the Court subsequently determines that the Defendants' plan did not remedy the deficiencies, the Court shall retain the power to enforce this Stipulation through all remedies provided by law, except that the Court shall not have the authority to order Defendants to construct a new prison or to hire a

specific number or type of staff unless Defendants propose to do so as part of a plan to remedy a failure to comply with any provision of this Stipulation. In determining the subsequent remedies the Court shall consider whether to require Defendants to submit a revised plan.

V. TERMINATION OF THE AGREEMENT.

37. To allow time for the remedial measures set forth in this Stipulation to be fully implemented, the parties shall not move to terminate this Stipulation for a period of four years from the date of its approval by the Court. Defendants shall not move to decertify the class for the duration of this Stipulation.

VI. MISCELLANEOUS PROVISIONS

38. Information produced pursuant to this Stipulation shall be governed by the Amended Protective Order (Doc. 454).

39. This Stipulation constitutes the entire agreement among the parties as to all claims raised by Plaintiffs in this action, and supersedes all prior agreements, representations, statements, promises, and understandings, whether oral or written, express or implied, with respect to this Stipulation. Each Party represents, warranties and covenants that it has the full legal authority necessary to enter into this Stipulation and to perform the duties and obligations arising under this Stipulation.

40. This is an integrated agreement and may not be altered or modified, except by a writing signed by all representatives of all parties at the time of modification.

41. This Stipulation shall be binding on all successors, assignees, employees, agents, and all others working for or on behalf of Defendants and Plaintiffs.

42. Defendants agree to pay attorneys' fees and costs incurred in the underlying litigation of the subject lawsuit in the total amount of $ 4.9 million. Defendants agree to deliver payment of $ 1 million within 14 days of the effective date of the Stipulation, and $ 3.9 million by July 15, 2015. The parties agree that payment of these fees and costs

represents full satisfaction of all claims for fees and costs incurred through the effective date of the Stipulation.

43. In the event that Plaintiffs move to enforce any aspect of this Stipulation and the Plaintiffs are the prevailing party with respect to the dispute, the Defendants agree that they will pay reasonable attorneys' fees and costs, including expert costs, to be determined by the Court. The parties agree that the hourly rate of attorneys' fees is governed by 42 U.S.C. § 1997e(d).

44. Plaintiffs' counsel shall be compensated for work reasonably performed or costs incurred to monitor or enforce the relief set forth in this Stipulation up to $ 250,000 per calendar year. In exchange for Plaintiffs' agreement to a cap on the amount of fees, Defendants shall not dispute the amount sought unless there is an obvious reason to believe that the work was unreasonable or the bill is incorrect. The amount of $ 250,000 will be prorated for the portion of the calendar year between the effective date of the Stipulation and the start of the next calendar year. Plaintiffs' counsel shall submit an invoice for payment quarterly along with itemized time records and expenses. Defendants shall pay the invoice within thirty (30) days of receipt. This limitation on fees and costs shall not apply to any work performed in mediating disputes before the Magistrate pursuant to paragraphs 22, 29, and 31 above, or to any work performed before the District Court to enforce or defend this Stipulation.

Dated this 9TH day of OCTOBER, 2014.

APPROVED:

Charles Ryan,
Director, Arizona Department of Corrections

Date: 10.9.14

Richard Pratt
Interim Division Director, Division of Health Services,
Arizona Department of Corrections

Date: 10/9/14

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CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2014, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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Index of Exhibits to Stipulation

Exhibit A:	Definitions of Terms
Exhibit B:	Health Care Performance Measures
Exhibit C:	Health Care Performance Measures Protocol
Exhibit D:	Maximum Custody Performance Measures
Exhibit E:	Maximum Custody Performance Measures Protocol
Exhibit F:	ADC SMI Determination Form

EXHIBIT A

For purposes of the performance measures, the following definitions will be used:

TERM	DEFINITION
Active labor & delivery	Contractions lasting 45-60 seconds and being 3 to 4 minutes apart
ASPC	Arizona State Prison Complex. ASPC- Safford includes Ft Grant. ASPC-Florence includes Globe. ASPC-Winslow includes Apache.
ATP	Alternate Treatment Plan
Chronic Disease	Chronic diseases include the following: • diabetes • HIV/AIDs • cancer • hypertension • Respiratory disease (for example, COPD / asthma / cystic fibrosis) • Seizure Disorder • heart disease • sickle cell disease • Hepatitis C • Tuberculosis • Neurological disorders (Parkinson's, multiple sclerosis, myasthenia gravis, etc.) • Cocci (Valley Fever) • End-Stage Liver Disease • Hyperlipidemia • Renal Diseases • Blood Diseases (including those on anticoagulants (or long term >six months)) • Rheumatological Diseases (including lupus, rheumatoid arthritis) • Hyperthyroidism • Crohn's Disease
Contracted Vendor	For purposes of this agreement, contracted vendor refers directly to Corizon Health and its subcontractors, or any successor contractor/subcontractor.
CQI	Continuous Quality Improvement
Diagnostic Service	Lab draws and specimen collections, X-rays, vision testing, and hearing testing
DOT	Direct-observation therapy (watch-swallow) (medications)

TERM	DEFINITION
Effective date of the Stipulation	The date on which the Court grants final approval to the Stipulation.
Encounter	Interaction between a patient and a qualified healthcare provider that involves a treatment and/or exchange of confidential information.
Healthcare staff	Includes QHCPs as well as administrative and support staff (e.g. health record administrators, lab techs, nursing and medical assistants and clerical workers).
HNR	Health Needs Request
HSCMB	ADC's Health Services Compliance Monitoring Bureau
IPC	Inpatient Component / Infirmary beds
IR	Incident Report
KOP	Keep-on-person (medications)
Licensed	Healthcare staff who hold an active and unrestricted license in the State of Arizona in the relevant professional discipline.
MAR	Medication Administration Record
Medical Provider	Physician, Dentist, Nurse Practitioner, Physician's Assistant-C. Any health care practitioner who has been duly empowered by the State of Arizona to write prescriptions.
Mental Health Clinician	Psychologist, Psychology Associate
Mental Health Provider	Psychiatrist, Psychiatry Nurse Practitioner
Mental Health Staff	Includes QHCP's who have received instruction and supervision in identifying and interacting with individuals in need of mental health services.
MH-1 (Mental Health 1)	Inmates who have no history of mental health issue or treatment
MH-2 (Mental Health 2)	Inmates who do not currently have mental health needs and are not currently in treatment but have had treatment in the past
MH-3 (Mental Health 3)	Inmates with Mental Health needs, who require current outpatient treatment. Inmates meeting this criterion will be divided into four (4) categories. These categories may change during each interaction with the inmate as their condition warrants.
MH-3A (Mental Health 3A)	Inmates in acute distress who may require substantial intervention in order to remain stable. Inmates classified as SMI in ADC and/or the community will remain a Category MH-3A (or MH-4 or MH-5 if in specialized mental health program).
MH-3B (Mental Health 3B)	Inmates who may need regular intervention but are generally stable and participate with psychiatric and psychological interventions.

TERM	DEFINITION
MH-3C (Mental Health 3C)	Inmates who need infrequent intervention and have adequate coping skills to manage their mental illness effectively and independently. These inmates participate in psychiatric interventions only.
MH-3D (Mental Health 3D)	Inmates who have been recently taken off of psychotropic medications and require follow up to ensure stability over time.
MH-4 (Mental Health 4)	Inmates who are admitted to a specialized mental health program as identified in the Mental Health Technical Manual outside of inpatient treatment areas.
MH-5 (Mental Health 5)	Inmates with mental health needs who are admitted to an inpatient psychiatric treatment program (Baker Ward and Flamenco).
Prenatal screening tests	GA/Preg, RPR, HIV, HEP, B & C, CBC, CMP (standardized lab panel), Urine, Rubella, ABO RH & Antibody
Psychology Associate	A mental health clinician who has a master's or doctoral-level degree in a mental health discipline, but is not a licensed psychologist.
Qualified Health Care Professional (QHCP)	Physicians, Physician Assistants, Dentists, nurses, nurse practitioners, dentists, mental health professionals, and others, who by virtue of their education, credentials/license, and experience are permitted by law to evaluate and care for patients.
Regular Business Hours	Monday through Friday, 0800 am -1600 pm or similar 8-hour time frame; excluding weekends and holidays.
"Seeing a provider"/ seen/ "seen by"	Interaction between a patient and a Medical Provider, Mental Health Provider or Mental Health Clinician that involves a treatment and/or exchange of information in a confidential setting. With respect to Mental Health staff, means an encounter that takes place in a confidential setting outside the prisoner's cell, unless the prisoner refuses to exit his or her cell for the encounter
SMI	According to a licensed mental health clinician or provider, possessing a qualifying mental health diagnosis as indicated on the SMI Determination Form (#1103.13) as well as a severe functional impairment directly relating to the mental illness. All inmates determined to be SMI in the community shall also be designated as SMI in ADC. All inmates designated SMI (as defined in MHTM Chapter 2, Section 2.0) will be designated a MH-3A, MH-4, or MH-5 based on their current program placement.
SNO	Special Needs Order

TERM	DEFINITION
Specialized Medical Housing	Infirmary beds (IPC)

EXHIBIT B

HEALTH CARE OUTCOME MEASURES

Category	Measure #	Final Measure
Staffing	1	Each ASPC will maintain, at a minimum, one RN onsite 24/7, 7 days/week.
Staffing	2	Each ASPC will maintain, at a minimum, one Medical Provider (not to include a dentist) onsite during regular business hour and on-call at all other times.
Staffing	3	Dental staffing will be maintained at current contract levels – 30 dentists.
Staffing	4	Infirmary staffing will be maintained with a minimum staffing level of 2 RNs on duty in the infirmary at all times at Tucson & Florence infirmaries and a minimum of one RN on duty in the infirmary at all times at Perryville and Lewis infirmaries
Medical Records	5	Medical Records will be accurate, chronologically maintained, and scanned or filed in the patient's chart within two business days, with all documents filed in their designated location.
Medical Records	6	Provider orders will be noted daily with time, date, and name of person taking the orders off.
Medical Records	7	Medical record entries will be legible, and complete with time, name stamp and signature present.
Medical Records	8	Nursing protocols/NETS will be utilized by nurses for sick call.
Medical Records	9	SOAPE format will be utilized in the medical record for encounters.
Medical Records	10	Each patient's medical record will include an up-to-date Master Problem list.
Pharmacy	11	Newly prescribed provider-ordered formulary medications will be provided to the inmate within 2 business days after prescribed, or on the same day, if prescribed STAT.
Pharmacy	12	Medical record will contain documentation of refusals or "no shows."
Pharmacy	13	Chronic care and psychotropic medication renewals will be completed in a manner such that there is no interruption or lapse in medication.
Pharmacy	14	Any refill for a chronic care or psychotropic medication that is requested by a prisoner between three and seven business days prior to the prescription running out will be completed in a manner such that there is no interruption or lapse in medication.

Category	Measure #	Final Measure
Pharmacy	15	Inmates who refuse prescribed medication (or no show) will be counseled by a QHCP after three consecutive refusals.
Pharmacy	16	Perpetual inventory medication logs will be maintained on each yard.
Pharmacy	17	The Medication Administration Record (MAR) will reflect dose, frequency, start date and nurse's signature.
Pharmacy	18	Daily delivery manifests will be kept in binders located in medication rooms on each yard/complex and will be reviewed and initialed daily by an LPN or RN.
Pharmacy	19	Perpetual inventory medications will be signed off on the Inmate's individual MAR.
Pharmacy	20	Medical AIMs entries are accurately completed within 3 business days from the entry in the medical record.
Pharmacy	21	Inmates who are paroled or released from ASPCs will receive a 30-day supply of all medications currently prescribed by the ADC contracted vendor.
Pharmacy	22	Non-formulary requests are reviewed and approved, disapproved, or designated for an alternate treatment plan (ATP) within two business days of the prescriber's order.
Equipment	23	Automated External Defibrillators (AEDs) will be maintained and readily accessible to Health Care Staff.
Equipment	24	Emergency medical response bags are checked daily, inventoried monthly, and contain all required essential items.
Emergency Response	25	A first responder trained in Basic Life Support responds and adequately provides care within three minutes of an emergency.
Quality Improvement	26	Responses to health care grievances will be completed within 15 working days of receipt (by health care staff) of the grievance.
Quality Improvement	27	Each ASPC facility will conduct monthly CQI meetings, in accordance with NCCHC Standard P-A-06
Quality Improvement	28	Every medical provider will undergo peer reviews annually with reviews and recommended actions documented.
Quality Improvement	29	Each ASPC facility Director of Nursing or designee will conduct and document annual clinical performance reviews of nursing staff as recommended by NCCHC standard P-C-02.
Quality Improvement	30	The initial mortality review of an inmate's death will be completed within 10 working days of death.

Category	Measure #	Final Measure
Quality Improvement	31	Mortality reviews will identify and refer deficiencies to appropriate managers and supervisors, including CQI committee, and corrective action will be taken.
Quality Improvement	32	A final independent clinical mortality review will be completed by the Health Services Contract Monitoring Bureau for all mortalities within 10 business days of receipt of the medical examiner's findings.
Intake facility	33	All inmates will receive a health screening by an LPN or RN within one day of arrival at the intake facility.
Intake facility	34	A physical examination including a history will be completed by a Medical Provider (not a dentist) by the end of the second full day of an intake inmate's arrival at the intake facility.
Intersystem Transfers	35	All inmate medications (KOP and DOT) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption.
Access to care	36	A LPN or RN will screen HNRs within 24 hours of receipt.
Access to care	37	Sick call inmates will be seen by an RN within 24 hours after an HNR is received (or immediately if identified with an emergent need, or on the same day if identified as having an urgent need).
Access to care	38	Vital signs, to include weight, will be checked and documented in the medical record each time an inmate is seen during sick call.
Access to care	39	Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointments will be seen within fourteen calendar days of the referral.
Access to care	40	Urgent provider referrals are seen by a Medical Provider within 24 hours of the referral.
Access to care	41	Emergent provider referrals are seen immediately by a Medical Provider.
Access to care	42	A follow-up sick call encounter will occur within the time frame specified by the Medical or Mental Health Provider.
Access to care	43	Inmates returning from an inpatient hospital stay or ER transport will be returned to the medical unit and be assessed by a RN or LPN on duty there.

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Access to care	44	Inmates returning from an inpatient hospital stay or ER transport with discharge recommendations from the hospital shall have the hospital's treatment recommendations reviewed and acted upon by a medical provider within 24 hours.
Diagnostic Services	45	On-site diagnostic services will be provided the same day if ordered STAT or urgent, or within 14 calendar days if routine
Diagnostic Services	46	A Medical Provider will review the diagnostic report, including pathology reports, and act upon reports with abnormal values within five calendar days of receiving the report at the prison.
Diagnostic Services	47	A Medical Provider will communicate the results of the diagnostic study to the inmate upon request and within seven calendar days of the date of the request.
Specialty care	48	Documentation, including the reason(s) for the denial, of Utilization Management denials of requests for specialty services will be sent to the requesting Provider in writing within fourteen calendar days, and placed in the patient's medical record.
Specialty care	49	Patients for whom a provider's request for specialty services is denied are told of the denial by a Medical Provider at the patient's next scheduled appointment, no more than 30 days after the denial, and the Provider documents in the patient's medical record the Provider's follow-up to the denial.
Specialty care	50	Urgent specialty consultations and urgent specialty diagnostic services will be scheduled and completed within 30 calendar days of the consultation being requested by the provider.
Specialty care	51	Routine specialty consultations will be scheduled and completed within 60 calendar days of the consultation being requested by the provider.
Specialty care	52	Specialty consultation reports will be reviewed and acted on by a Provider within seven calendar days of receiving the report.
Chronic care	53	Treatment plans will be developed and documented in the medical record by a provider within 30 calendar days of identification that the inmate has a chronic disease.
Chronic care	54	Chronic disease inmates will be seen by the provider as specified in the inmate's treatment plan, no less than every 180 days unless the provider documents a reason why a longer time frame can be in place.

Category	Measure #	Final Measure
Chronic care	55	Disease management guidelines will be implemented for chronic diseases.
Chronic care	56	Inmates with a chronic disease will be provided education about their condition/disease which will be documented in the medical record.
Prenatal Services	57	A Medical Provider will order prenatal vitamins and diet for a pregnant inmate at the inmate's initial intake physical examination.
Prenatal Services	58	Results of an inmate's prenatal screening tests will be documented in the medical record.
Preventative Services	59	Inmates will be screened for TB on an annual basis.
Preventative Services	60	All female inmates ages 21 to 65 will be offered a Pap smear at the inmate's initial intake physical examination.
Preventative Services	61	All female inmates ages 21 to 65 will be offered a Pap smear , every 36 months after initial intake, unless more frequent screening is clinically recommended.
Preventative Services	62	All prisoners are screened for tuberculosis upon intake.
Infirmary Care	63	In an IPC, an initial health assessment will be completed by a Registered Nurse on the date of admission.
Infirmary Care	64	In an IPC, a Medical Provider evaluation and plan will occur within the next business day after admission.
Infirmary Care	65	In an IPC, a written history and physical examination will be completed by a medical provider within 72 hours of admission.
Infirmary Care	66	In an IPC, a Medical Provider encounters will occur at a minimum every 72 hours.
Infirmary Care	67	In an IPC, Registered nurses will conduct and document an assessment at least once every shift. Graveyard shift assessments can be welfare checks.
Infirmary Care	68	In an IPC, Inmate health records will include admission orders and documentation of care and treatment given.
Infirmary Care	69	In an IPC, nursing care plans will be reviewed weekly documented with a date and signature.
Infirmary Care	70	All IPC patients have properly working call buttons, and if not, health care staff perform and document 30-minute patient welfare checks.

Category	Measure #	Final Measure
Medical Diets	71	Inmates with diagnosed and documented diseases or conditions that necessitate a special diet will be provided the diet, if clinically indicated. When prescribing the special diet, the provider will include the type of diet, duration for which it is to be provided, and any special instructions.
Medical Diets	72	Inmates who refuse prescribed diets for more than 3 consecutive days will receive follow-up nutritional counseling by a QHCP.
Mental Health	73	All MH-3 minor prisoners shall be seen by a licensed mental health clinician a minimum of every 30 days.
Mental Health	74	All female prisoners shall be seen by a licensed mental health clinician within five working days of return from a hospital post-partum.
Mental Health	75	A mental health assessment of a prisoner during initial intake shall be completed by mental health staff by the end of the second full day after the prisoner's arrival into ADC.
Mental Health	76	If the initial mental health assessment of a prisoner during initial intake is not performed by licensed mental health staff, the prisoner shall be seen by a mental health clinician within fourteen days of his or her arrival into ADC.
Mental Health	77	Mental health treatment plans shall be updated a minimum of every 90 days for MH-3A, MH-4, and MH-5 prisoners, and a minimum of every 12 months for all other MH-3 prisoners.
Mental Health	78	All mental health treatment plan updates shall be done after a face-to-face clinical encounter between the prisoner and the mental health provider or mental health clinician.
Mental Health	79	If a prisoner's mental health treatment plan includes psychotropic medication, the mental health provider shall indicate in each progress note that he or she has reviewed the treatment plan.
Mental Health	80	MH-3A prisoners shall be seen a minimum of every 30 days by a mental health clinician.
Mental Health	81	MH-3A prisoners who are prescribed psychotropic medications shall be seen a minimum of every 90 days by a mental health provider.
Mental Health	82	MH-3B prisoners shall be seen a minimum of every 90 days by a mental health clinician.

Category	Measure #	Final Measure
Mental Health	83	MH-3B prisoners who are prescribed psychotropic medications shall be seen a minimum of every 180 days by a mental health provider. MH-3B prisoners who are prescribed psychotropic medications for psychotic disorders, bipolar disorder, or major depression shall be seen by a mental health provider a minimum of every 90 days.
Mental Health	84	MH-3C prisoners shall be seen a minimum of every 180 days by a mental health provider.
Mental Health	85	MH-3D prisoners shall be seen by a mental health provider within 30 days of discontinuing medications.
Mental Health	86	MH-3D prisoners shall be seen a minimum of every 90 days by a mental health clinician for a minimum of six months after discontinuing medication.
Mental Health	87	MH-4 prisoners shall be seen by a mental health clinician for a 1:1 session a minimum of every 30 days.
Mental Health	88	MH-4 prisoners who are prescribed psychotropic medications shall be seen by a mental health provider a minimum of every 90 days.
Mental Health	89	MH-5 prisoners shall be seen by a mental health clinician for a 1:1 session a minimum of every seven days.
Mental Health	90	MH-5 prisoners who are prescribed psychotropic medications, shall be seen by a mental health provider a minimum of every 30 days.
Mental Health	91	MH-5 prisoners who are actively psychotic or actively suicidal shall be seen by a mental health clinician or mental health provider daily.
Mental Health	92	MH-3 and above prisoners who are housed in maximum custody shall be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days.
Mental Health	93	Mental health staff (not to include LPNs) shall make weekly rounds on all MH-3 and above prisoners who are housed in maximum custody.
Mental Health	94	All prisoners on a suicide or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays, by a registered nurse.

Category	Measure #	Final Measure
Mental Health	95	Only licensed mental health staff may remove a prisoner from a suicide or mental health watch. Any prisoner discontinued from a suicide or mental health watch shall be seen by a mental health provider, mental health clinician, or psychiatric registered nurse between 24 and 72 hours after discontinuation, between seven and ten days after discontinuation, and between 21 and 24 days after discontinuation of the watch.
Mental Health	96	A reentry/discharge plan shall be established no later than 30 days prior to release from ADC for all prisoners who are MH-3 or above.
Mental Health	97	A mental health provider treating a prisoner via telepsychiatry shall be provided, in advance of the telepsychiatry session, the prisoner's intake assessment, most recent mental health treatment plan, laboratory reports (if applicable), physician orders, problem list, and progress notes from the prisoner's two most recent contacts with a mental health provider.
Mental Health	98	Mental health HNRs shall be responded to within the timeframes set forth in the Mental Health Technical Manual (MHTM) (rev. 4/18/14), Chapter 2, Section 5.0.
Mental Health	99	Peer reviews shall be conducted as set forth in the MHTM (rev. 4/18/14), Chapter 1, Section 3.0.
Dental	100	Prisoners on the routine dental care list will not be removed from the list if they are seen for urgent care or pain appointments that do not resolve their routine care issues or needs.
Dental	101	Dental assistants will take inmate histories and vital signs and dental radiographs (as ordered) by the Dentist.
Dental	102	Routine dental care wait times will be no more than 90 days from the date the HNR was received.
Dental	103	Urgent dental care wait times, as determined by the contracted vendor, shall be no more than 72 hours from the date the HNR was received.

EXHIBIT C

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Staffing	1	Each ASPC will maintain, at a minimum, one RN onsite 24/7, 7 days/week.	Monthly staffing report and Weekly staffing schedule. Any changes to the weekly staffing schedule will be documented and provided to monitors.	Contracted Vendor.
Staffing	2	Each ASPC will maintain, at a minimum, one Medical Provider (not to include a dentist) onsite during regular business hour and on-call at all other times.	Monthly staffing report and Weekly staffing schedule. Any changes to the weekly staffing schedule will be documented and provided to monitors.	Contracted Vendor.
Staffing	3	Dental staffing will be maintained at current contract levels – 30 dentists.	Monthly staffing report and Weekly staffing schedule.	Contracted Vendor.
Staffing	4	Infirmary staffing will be maintained with a minimum staffing level of 2 RNs on duty in the infirmary at all times at Tucson & Florence infirmaries and a minimum of one RN on duty in the infirmary at all times at Perryville and Lewis infirmaries	Monthly staffing report and Weekly staffing schedule. Any changes to the weekly staffing schedule will be documented and provided to monitors.	Contracted Vendor.
Medical Records	5	Medical Records will be accurate, chronologically maintained, and scanned or filed in the patient's chart within two business days, with all documents filed in their designated location.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Nursing and Provider lines from the preceding 30 days.
Medical Records	6	Provider orders will be noted daily with time, date, and name of person taking the orders off.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Provider lines from the preceding 30 days.
Medical Records	7	Medical record entries will be legible, and complete with time, name stamp and signature present.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Nursing and Provider lines from the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Medical Records	8	Nursing protocols/NETS will be utilized by nurses for sick call.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Nurse lines from the preceding 30 days.
Medical Records	9	SOAPE format will be utilized in the medical record for encounters.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Nursing and Provider lines from the preceding 30 days.
Medical Records	10	Each patient's medical record will include an up-to-date Master Problem list.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Scheduled Provider lines from the preceding 30 days.
Pharmacy	11	Newly prescribed provider-ordered formulary medications will be provided to the inmate within 2 business days after prescribed, or on the same day, if prescribed STAT.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Contracted vendor to provide list of NF medications ordered from the preceding 30 days. Follow up and confirmation of receipt of medications will be made through review of MAR's and eOmis.	Contracted vendor to provide list of NF medications ordered from the preceding 30 days, and MAR's and eOmis.
Pharmacy	12	Medical record will contain documentation of refusals or “no shows.”	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	MAR's and eOmis from preceding 30 days.
Pharmacy	13	Chronic care and psychotropic medication renewals will be completed in a manner such that there is no interruption or lapse in medication.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Contracted vendor Medication Expiration Reports and medication manifests from preceding 30 days will be reviewed, and corresponding MAR's will be reviewed to determine any lapses in medication.	Contracted vendor Medication Expiration Reports and medication manifests from preceding 30 days, and MAR's.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Pharmacy	14	Any refill for a chronic care or psychotropic medication that is requested by a prisoner between three and seven business days prior to the prescription running out will be completed in a manner such that there is no interruption or lapse in medication.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Contracted vendor HNR logs from preceding 30 days will be reviewed to identify medication refills, and corresponding MAR's will be reviewed to determine any lapses in medication.	Contracted vendor HNR logs from preceding 30 days and MAR's.
Pharmacy	15	Inmates who refuse prescribed medication (or no show) will be counseled by a QHCP after three consecutive refusals.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	MAR's from preceding 30 days will be reviewed for refusals and no shows, and medical records will be reviewed for follow up counseling.
Pharmacy	16	Perpetual inventory medication logs will be maintained on each yard.	Review of Perpetual Inventory Logs are to be confirmed in use on each yard.	Perpetual Inventory Logs from the preceding 30 days.
Pharmacy	17	The Medication Administration Record (MAR) will reflect dose, frequency, start date and nurse's signature.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	MAR's from the preceding 30 days.
Pharmacy	18	Daily delivery manifests will be kept in binders located in medication rooms on each yard/complex and will be reviewed and initialed daily by an LPN or RN.	Review of daily delivery manifests will be reviewed for appropriate signatures on each yard/complex.	Daily manifests from the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Pharmacy	19	Perpetual inventory medications will be signed off on the Inmate's individual MAR.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Medications documented in the perpetual inventory lists for individual patient use during the preceding 30 days will be followed up for appropriate documentation in the individual inmate's MAR.	Perpetual Inventory Logs and MAR's from the preceding 30 days.
Pharmacy	20	Medical AIMs entries are accurately completed within 3 business days from the entry in the medical record.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Any SNO's identified in the Provider's notes will be confirmed as a timely AIMS entry.	Scheduled Provider lines from the preceding 30 days.
Pharmacy	21	Inmates who are paroled or released from ASPCs will receive a 30-day supply of all medications currently prescribed by the ADC contracted vendor.	At each facility, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. The Released Inmate Medication report from the contracted vendor from the preceding 30 days will be compared to an ADC report with inmate signature documenting receipt of appropriate medications.	The Released Inmate Medication report from the contracted vendor from the preceding 30 days and an ADC report with inmate signature documenting receipt of appropriate medications.
Pharmacy	22	Non-formulary requests are reviewed and approved, disapproved, or designated for an alternate treatment plan (ATP) within two business days of the prescriber's order.	At each facility, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Non-formulary request / tracking log from the preceding 30 days will be provided by the contracted vendor.	Non-formulary request / tracking log from the preceding 30 days.
Equipment	23	Automated External Defibrillators (AEDs) will be maintained and readily accessible to Health Care Staff.	At each facility, a monthly physical inspection of all AED's will occur.	All AED's and Checklist Binder.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Equipment	24	Emergency medical response bags are checked daily, inventoried monthly, and contain all required essential items.	At each facility, a monthly physical inspection of all medical response bags will occur. Contents of bag will match inventory list.	All Emergency response bags.
Emergency Response	25	A first responder trained in Basic Life Support responds and adequately provides care within three minutes of an emergency.	At each facility, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. SIR's will be reviewed and compared with medical chart documenting the emergency response	Appropriate and pertinent SIR's.
Quality Improvement	26	Responses to health care grievances will be completed within 15 working days of receipt (by health care staff) of the grievance.	At each facility, a minimum of 10 grievances per month are randomly selected from the grievance logs. Grievances received during the preceding 30 days will be reviewed for timeliness of responses.	Grievance logs maintained by security staff (COIII-IV) at each yard.
Quality Improvement	27	Each ASPC facility will conduct monthly CQI meetings, in accordance with NCCHC Standard P-A-06	Monthly CQI meeting minutes. Monthly CQI minutes will be provided by the contracted vendor.	Monthly CQI minutes.
Quality Improvement	28	Every medical provider will undergo peer reviews annually with reviews and recommended actions documented.	Annual peer reviews will be documented for every medical provider who has been employed for at least one year. Documentation of required annual peer reviews will be provided by the contracted vendor.	Annual peer review.
Quality Improvement	29	Each ASPC facility Director of Nursing or designee will conduct and document annual clinical performance reviews of nursing staff as recommended by NCCHC standard P-C-02.	Annual clinical performance reviews will be documented for every nurse who has been employed for at least one year. Documentation of required annual clinical performance reviews will be provided by the contracted vendor.	Annual clinical performance review.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Quality Improvement	30	The initial mortality review of an inmate's death will be completed within 10 working days of death.	At each facility, all deaths that occurred in the preceding month are reviewed. Dates of completion of stages in the mortality review will determine compliance.	Mortality reviews for inmate deaths in the preceding month.
Quality Improvement	31	Mortality reviews will identify and refer deficiencies to appropriate managers and supervisors, including CQI committee, and corrective action will be taken.	At each facility, all mortalities from the preceding month will be identified, and deficiencies identified in any mortalities where the final review has been completed will be documented in the minutes. Monthly CQI minutes will be provided by the contracted vendor.	Monthly CQI minutes.
Quality Improvement	32	A final independent clinical mortality review will be completed by the Health Services Contract Monitoring Bureau for all mortalities within 10 business days of receipt of the medical examiner's findings.	All final mortality reviews completed in the previous month are reviewed. Dates of completion of stages in the mortality review will determine compliance.	Health Services Contract Monitoring Bureau signed and dated mortality review.
Intake facility	33	All inmates will receive a health screening by an LPN or RN within one day of arrival at the intake facility.	Minimum 10 records per month randomly selected per reception center. Records from reception center at ASPC Phoenix (male), ASPC Perryville (female), and if applicable, ASPC Tucson (minor males).	Medical records from inmates received during the preceding 30 days.
Intake facility	34	A physical examination including a history will be completed by a Medical Provider (not a dentist) by the end of the second full day of an intake inmate's arrival at the intake facility.	Minimum 10 records per month randomly selected per reception center. Records from reception center at ASPC Phoenix (male), ASPC Perryville (female), and if applicable, ASPC Tucson (minor males).	Medical records from inmates received during the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Intersystem Transfers	35	All inmate medications (KOP and DOT) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Transfer logs (arrival departure) at each facility, and transfer screening form in the medical record will be reviewed for compliance.	Transfer logs (arrival departure) at each facility, and transfer screening form in the medical record from the preceding 30 days.
Access to care	36	A LPN or RN will screen HNRs within 24 hours of receipt.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. HNR date and time stamps will be reviewed for compliance.	HNR log from the preceding 30 days.
Access to care	37	Sick call inmates will be seen by an RN within 24 hours after an HNR is received (or immediately if identified with an emergent need, or on the same day if identified as having an urgent need).	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Nurse line and eOmis from the preceding 30 days.
Access to care	38	Vital signs, to include weight, will be checked and documented in the medical record each time an inmate is seen during sick call.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure.	Nurse line and eOmis from the preceding 30 days.
Access to care	39	Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointment will be seen within fourteen calendar days of the referral.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Nurse line, Provider line, and eOmis from the preceding 30 days.
Access to care	40	Urgent provider referrals are seen by a Medical Provider within 24 hours of the referral.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Nurse line, Provider line, and eOmis from the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Access to care	41	Emergent provider referrals are seen immediately by a Medical Provider.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Nurse line, Provider line, and eOmis from the preceding 30 days.
Access to care	42	A follow-up sick call encounter will occur within the time frame specified by the Medical or Mental Health Provider.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Nurse line, Provider line, and eOmis from the preceding 30 days.
Access to care	43	Inmates returning from an inpatient hospital stay or ER transport will be returned to the medical unit and be assessed by a RN or LPN on duty there.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Inmates identified in either the field briefing report or the hospital report will be reviewed for documentation upon return from the transport.	Field Briefing Report (ADC), hospital report, and eOmis.
Access to care	44	Inmates returning from an inpatient hospital stay or ER transport with discharge recommendations from the hospital shall have the hospital's treatment recommendations reviewed and acted upon by a medical provider within 24 hours.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Inmates identified in either the field briefing report or the hospital report will be reviewed for documentation upon return from the transport. Physician acknowledgement/action will be reviewed for timeliness.	Field Briefing Report (ADC), hospital report, and eOmis.
Diagnostic Services	45	On-site diagnostic services will be provided the same day if ordered STAT or urgent, or within 14 calendar days if routine	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Radiology, vision, lab lines appointments within the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Diagnostic Services	46	A Medical Provider will review the diagnostic report, including pathology reports, and act upon reports with abnormal values within five calendar days of receiving the report at the prison.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	Radiology, vision, lab lines appointments within the preceding 30 days and eOmis records.
Diagnostic Services	47	A Medical Provider will communicate the results of the diagnostic study to the inmate upon request and within seven calendar days of the date of the request.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Appropriate HNR's will be tracked for completion.	HNR log from the preceding 30 days, Provider line, eOmis.
Specialty care	48	Documentation, including the reason(s) for the denial, of Utilization Management denials of requests for specialty services will be sent to the requesting Provider in writing within fourteen calendar days, and placed in the patient's medical record.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. ORC requests are documented in ORC, and will be followed for appropriate handling and documentation.	ORC and eOmis.
Specialty care	49	Patients for whom a provider's request for specialty services is denied are told of the denial by a Medical Provider at the patient's next scheduled appointment, no more than 30 days after the denial, and the Provider documents in the patient's medical record the Provider's follow-up to the denial.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. ORC requests will be followed for appropriate handling and documentation.	ORC, eOmis, and provider lines.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Specialty care	50	Urgent specialty consultations and urgent specialty diagnostic services will be scheduled and completed within 30 calendar days of the consultation being requested by the provider.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. ORC requests are documented in ORC, and will be followed for appropriate handling and documentation.	ORC, eOmis, and provider lines.
Specialty care	51	Routine specialty consultations will be scheduled and completed within 60 calendar days of the consultation being requested by the provider.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. ORC requests are documented in ORC, and will be followed for appropriate handling and documentation.	ORC, eOmis, and provider lines.
Specialty care	52	Specialty consultation reports will be reviewed and acted on by a Provider within seven calendar days of receiving the report.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. ORC requests are documented in ORC, and will be followed for appropriate handling and documentation.	ORC, eOmis, and provider lines.
Chronic care	53	Treatment plans will be developed and documented in the medical record by a provider within 30 calendar days of identification that the inmate has a chronic disease.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Chronic care logs and forms will be used in the review process.	Chronic care logs and eOmis.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Chronic care	54	Chronic disease inmates will be seen by the provider as specified in the inmate's treatment plan, no less than every 180 days unless the provider documents a reason why a longer time frame can be in place.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Chronic care logs and forms will be used in the review process.	Chronic care logs and eOmis.
Chronic care	55	Disease management guidelines will be implemented for chronic diseases.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Chronic care logs and forms will be used in the review process.	Chronic care logs and eOmis.
Chronic care	56	Inmates with a chronic disease will be provided education about their condition/disease which will be documented in the medical record.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Chronic care logs and forms will be used in the review process.	Chronic care logs and eOmis.
Prenatal Services	57	A Medical Provider will order prenatal vitamins and diet for a pregnant inmate at the inmate's initial intake physical examination.	This is specific to Perryville intake inmates. At the facility, all pregnant prisoners' files from all intakes in the previous month are reviewed to confirm that vitamins are ordered.	Pregnant inmate list from Perryville within the preceding 30 days, Intake arrival logs and eOmis.
Prenatal Services	58	Results of an inmate's prenatal screening tests will be documented in the medical record.	This is specific to Perryville intake inmates. At the facility, all pregnant prisoners' files from all intakes in the previous month are reviewed to confirm that the tests were conducted.	Intake arrival logs and eOmis within the preceding 30 days.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Preventative Services	59	Inmates will be screened for TB on an annual basis.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Review for PPD history or appropriate signs and symptom follow up will be reviewed to determine timeliness.	eOmis.
Preventative Services	60	All female inmates ages 21 to 65 will be offered a Pap smear at the inmate's initial intake physical examination, and every 36 months thereafter unless more frequent screening is clinically recommended.	This is specific to Perryville. At the facility, 10 records per month are randomly selected from all intakes in the previous month.	eOmis.
Preventative Services	61	All female inmates ages 21 to 65 will be offered a Pap smear every 36 months after initial intake, unless more frequent screening is clinically recommended.	At each yard, 10 records per month are randomly selected to review the frequency with which subsequent Pap smears have been conducted. Chart review will determine compliance.	Medical records.
Preventative Services	62	All prisoners are screened for tuberculosis upon intake.	Minimum 10 records per month randomly selected from each reception center. Records from reception center at ASPC Phoenix (male), ASPC Tucson (minor males) and ASPC Perryville (female). Chart review will determine compliance.	Medical records from inmates received at intake during the preceding 30 days.
Infirmary Care	63	In an IPC, an initial health assessment will be completed by a Registered Nurse on the date of admission.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	64	In an IPC, a Medical Provider evaluation and plan will occur within the next business day after admission.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Infirmary Care	65	In an IPC, a written history and physical examination will be completed by a medical provider within 72 hours of admission.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	66	In an IPC, a Medical Provider encounters will occur at a minimum every 72 hours.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	67	In an IPC, Registered nurses will conduct and document an assessment at least once every shift. Graveyard shift assessments can be welfare checks.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	68	In an IPC, Inmate health records will include admission orders and documentation of care and treatment given.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	69	In an IPC, nursing care plans will be reviewed weekly documented with a date and signature.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness.	IPC Census and eOmis.
Infirmary Care	70	All IPC patients have properly working call buttons, and if not, health care staff perform and document 30-minute patient welfare checks.	This is specific to Perryville, Florence, Tucson, and Lewis IPC inmates. At each IPC, 10 records per month are randomly selected for documentation and timeliness. Monitor will walk through IPC once a month to confirm that all call buttons are working, and if the monitor discovers any nonfunctioning call buttons, will also review the medical records of the patient housed in that room. Patient welfare checks will be shown when required through a separate log.	IPC Census and eOmis.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Medical Diets	71	Inmates with diagnosed and documented diseases or conditions that necessitate a special diet will be provided the diet, if clinically indicated. When prescribing the special diet, the provider will include the type of diet, duration for which it is to be provided, and any special instructions.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate documentation will be determined upon review.	Diet Roster and eOmis.
Medical Diets	72	Inmates who refuse prescribed diets for more than 3 consecutive days will receive follow-up nutritional counseling by a QHCP.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Dietary liaison will advise regarding non-compliance, which will be followed up with nutritional counseling. Appropriate documentation will be determined upon review.	ADC dietary liaison and eOmis.
Mental Health	73	All MH-3 minor prisoners shall be seen by a licensed mental health clinician a minimum of every 30 days.	An AIMS report will be run monthly by the HSCMB MH staff of all MH-3 minor prisoners. 10 records will be randomly selected from the report for review.	AIMS Report
Mental Health	74	All female prisoners shall be seen by a licensed mental health clinician within five working days of return from a hospital post-partum.	The HSCMB MH staff will review the hospital reports and review the records of all post-partum women from the previous 30 days.	Hospital Report
Mental Health	75	A mental health assessment of a prisoner during initial intake shall be completed by mental health staff by the end of the second full day after the prisoner's arrival into ADC.	An AIMS report will be run for the Phoenix and Perryville reception centers, and if applicable, the Tucson minor males reception center. 10 records (if available) will be reviewed from each reception center for compliance with this performance measure.	AIMS Report

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Mental Health	76	If the initial mental health assessment of a prisoner during initial intake is not performed by licensed mental health staff, the prisoner shall be seen by a mental health clinician within fourteen days of his or her arrival into ADC.	Of the records reviewed in #74, if any of the initial MH evaluation was not completed by a licensed MH staff, then the record will be re-reviewed in 20 days for compliance with this performance measure.	AIMS Report
Mental Health	77	Mental health treatment plans shall be updated a minimum of every 90 days for MH-3A, MH-4, and MH-5 prisoners, and a minimum of every 12 months for all other MH-3 prisoners.	An AIMS report will be run for all MH-3 and above prisoners at each Complex. 10 records will be reviewed per yard for compliance with the treatment plan time frames.	AIMS Report
Mental Health	78	All mental health treatment plan updates shall be done after a face-to-face clinical encounter between the prisoner and the mental health provider or mental health clinician.	Each record that is reviewed for treatment plan compliance will also be reviewed for a face-to-face SOAPE note dated the same date.	AIMS Report
Mental Health	79	If a prisoner's mental health treatment plan includes psychotropic medication, the mental health provider shall indicate in each progress note that he or she has reviewed the treatment plan.	For all records reviewed for inmates on medications, it will be determined if this performance measure was complied with.	AIMS Report
Mental Health	80	MH-3A prisoners shall be seen a minimum of every 30 days by a mental health clinician.	An AIMS report will be run for all MH-3A prisoners at each Complex. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Mental Health	81	MH3-A prisoners who are prescribed psychotropic medications shall be seen a minimum of every 90 days by a mental health provider.	The records reviewed for performance measure #80 will also be reviewed for compliance if they are on medications.	AIMS Report
Mental Health	82	MH-3B prisoners shall be seen a minimum of every 90 days by a mental health clinician.	An AIMS report will be run for all MH-3B prisoners at each Complex. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	83	MH-3B prisoners who are prescribed psychotropic medications shall be seen a minimum of every 180 days by a mental health provider. MH-3B prisoners who are prescribed psychotropic medications for psychotic disorders, bipolar disorder, or major depression shall be seen by a mental health provider a minimum of every 90 days.	The records reviewed for performance measure #82 will also be reviewed for compliance if they are on medications.	AIMS Report
Mental Health	84	MH-3C prisoners shall be seen a minimum of every 180 days by a mental health provider.	An AIMS report will be run for all MH-3C prisoners at each Complex. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	85	MH-3D prisoners shall be seen by a mental health provider within 30 days of discontinuing medications.	An AIMS report will be run for all MH-3D prisoners at each Complex. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	86	MH-3D prisoners shall be seen a minimum of every 90 days by a mental health clinician for a minimum of six months after discontinuing medication	The Records reviewed for Performance Measure #85 will also be reviewed for compliance with this performance measure.	AIMS Report

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Mental Health	87	MH-4 prisoners shall be seen by a mental health clinician for a 1:1 session a minimum of every 30 days.	An AIMS report will be run for all complexes that have MH-4 prisoners. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	88	MH-4 prisoners who are prescribed psychotropic medications shall be seen by a mental health provider a minimum of every 90 days.	The Records reviewed for Performance Measure #87 will also be reviewed for compliance with this performance measure.	AIMS Report
Mental Health	89	MH-5 prisoners shall be seen by a mental health clinician for a 1:1 session a minimum of every seven days.	An AIMS report will be run for the Phoenix Complex (MH-5 inmates). 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	90	MH-5 prisoners who are prescribed psychotropic medications shall be seen by a mental health provider a minimum of every 30 days.	The Records reviewed for Performance Measure #89 will also be reviewed for compliance with this performance measure.	AIMS Report
Mental Health	91	MH-5 prisoners who are actively psychotic or actively suicidal shall be seen by a mental health clinician or mental health provider daily.	The Records reviewed for Performance Measure #89 will also be reviewed for compliance with this performance measure.	AIMS Report
Mental Health	92	MH-3 and above prisoners who are housed in maximum custody shall be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days.	An MH-3 report will be run for all maximum custody yards. 10 records (if available) will be reviewed per yard for compliance.	AIMS Report
Mental Health	93	Mental health staff (not to include LPNs) shall make weekly rounds on all MH-3 and above prisoners who are housed in maximum custody.	The Records reviewed for Performance Measure #92 will also be reviewed for compliance with this performance measure.	AIMS Report

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Mental Health	94	All prisoners on a suicide or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays, by a registered nurse.	The Contractor will develop and provide to HSCMB MH Staff a log weekly of all inmates currently on watch. A minimum of 10 records (if available) per Complex will be reviewed, except ASPC Eyman, where 20 records will be reviewed.	Suicide Watch Log
Mental Health	95	Only licensed mental health staff may remove a prisoner from a suicide or mental health watch. Any prisoner discontinued from a suicide or mental health watch shall be seen by a mental health provider, mental health clinician, or psychiatric registered nurse between 24 and 72 hours after discontinuation, between seven and ten days after discontinuation, and between 21 and 24 days after discontinuation of the watch.	The Contractor will develop and provide to HSCMB MH Staff a log weekly of all inmates discontinued off watch. A minimum of 10 records (if available) per Complex will be reviewed, except ASPC Eyman, where 20 records will be reviewed.	Suicide Watch Log
Mental Health	96	A reentry/discharge plan shall be established no later than 30 days prior to release from ADC for all prisoners who are MH-3 or above.	An AIMS report will be run for those inmates releasing in the next 30 days. 10 records (if available) per yard will be reviewed.	AIMS Report

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Mental Health	97	A mental health provider treating a prisoner via telepsychiatry shall be provided, in advance of the telepsychiatry session, the prisoner's intake assessment, most recent mental health treatment plan, laboratory reports (if applicable), physician orders, problem list, and progress notes from the prisoner's two most recent contacts with a mental health provider.	The Contracted Vendor will supply the Appointment Logs for the previous 30 days to the HSCMB MH staff. 10 records (if available) from each yard utilizing telepsychiatry will be reviewed for compliance with this performance measure.	Provider Line Appointment Logs
Mental Health	98	Mental health HNRs shall be responded to within the timeframes set forth in the Mental Health Technical Manual (MHTM) (rev. 4/18/14), Chapter 2, Section 5.0.	The Contracted Vendor will provide each week an HNR log for each Complex. 10 records (if available) from each yard will be reviewed for compliance with this performance measure.	HNR Log
Mental Health	99	Peer reviews shall be conducted as set forth in the MHTM (rev. 4/18/14), Chapter 1, Section 3.0.	The Contracted Vendor will provide a report on all required peer reviews for the Psychiatrists, Psychiatric Nurse Practitioners, and Psychologists to the HSCMB.	Contracted vendor report.
Dental	100	Prisoners on the routine dental care list will not be removed from the list if they are seen for urgent care or pain appointments that do not resolve their routine care issues or needs.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Dental HNR's will be reviewed and compared with medical record to identify any conflict or non-compliance.	Dental medical records and Dental HNR's.

Category	Measure #	Final Measure	Protocol	Source of Records / Review
Dental	101	Dental assistants will take inmate histories and vital signs and dental radiographs (as ordered) by the Dentist.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review.	eOmis.
Dental	102	Routine dental care wait times will be no more than 90 days from the date the HNR was received.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Dental HNR's will be reviewed and compared with medical record to identify any conflict or non-compliance.	Dental medical records and Dental HNR's.
Dental	103	Urgent care wait times, as determined by the contracted vendor, shall be no more than 72 hours from the date the HNR was received.	At each yard, a minimum 10 records per month are randomly selected, if qualified under this Performance Measure. Appropriate handling and timeliness will be determined upon review. Dental HNR's will be reviewed and compared with medical record to identify any conflict or non-compliance.	Dental medical records and Dental HNR's.

For any performance measure requiring a review of a minimum of 10 records per month per yard, in the event of an insufficient sample size of less than 10 records, the sample will be drawn from the entire complex.

Monitoring for medical, mental health and dental Outcome Measures specified herein will be conducted by ADC's Monitoring Bureau.

EXHIBIT D

MAXIMUM CUSTODY OUTCOME MEASURES

Measure #	Outcome Measure
1	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) who are eligible for participation in DI 326 are offered a minimum of 7.5 hours out-of-cell time per week. Those at Step II are offered a minimum of 8.5 hours out-of-cell time per week, and those at Step III are offered a minimum of 9.5 hours out-of-cell time per week.
2	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) who are eligible for participation in DI 326 are offered at least one hour of out-of-cell group programming a week at Step II and Step III.
3	All out-of-cell time that is limited or cancelled is properly documented and justified in accordance with the terms of the Stipulation.
4	All maximum custody prisoners receive meals with the same caloric and nutritional content as meals served to other ADC prisoners.
5	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) are offered a minimum of 6 hours of out-of-cell exercise time a week.
6	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30), who are eligible for participation in DI 326 are offered out-of-cell time, incentives, programs and property consistent with their Step Level and housing assignment under the DI 326 policy.
7	No prisoners with a mental health classification of MH3 or higher are housed in Florence Central-CB 5 or CB-7 unless the cell fronts are substantially modified to increase visibility.

Measure #	Outcome Measure
8	In addition to the general privileges and incentives afforded to prisoners under DI 326, all SMI prisoners in maximum custody receive: • 10 hours of unstructured out-of-cell time per week • 1 hour of additional out-of-cell mental health programming per week • 1 hour of additional out-of-cell psycho-educational programming per week • 1 hour of additional out-of-cell programming per week
9	All use of force incidents involving prisoners who are designated SMI or housed in Florence-CB-1 or CB-4; Florence-Kasson (Wings 1 and 2); Eyman-SMU I (BMU); Perryville-Lumley SMA; or Phoenix (Baker, Flamenco, or MTU) conform to the policies for use of force set forth in ¶ 27 (a)-(e) of the Stipulation.

EXHIBIT E

MAXIMUM CUSTODY OUTCOME MEASURE PROTOCOL

Final Measure #	Outcome Measure	Protocol	Source of Records/Review
1	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) who are eligible for participation in DI 326 are offered a minimum of 7.5 hours out-of-cell time per week. Those at Step II are offered a minimum of 8.5 hours out-of-cell time per week, and those at Step III are offered a minimum of 9.5 hours out-of-cell time per week.	At each designated location, Max Custody Monthly Activity Schedule Calendars are selected for each monitored month. At each designated location, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners.	Max Custody Monthly Activity Schedule Max Custody Daily Out of Cell Time Tracking Form
2	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) who are eligible for participation in DI 326 are offered at least one hour of out-of-cell group programming a week at Step II and Step III.	At each designated location, Max Custody Monthly Activity Schedule Calendars are selected for each monitored month. At each designated location, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners. At each designated location, DI 326 Programming Attendance/Sign In Sheets	Max Custody Monthly Activity Schedule Max Custody Daily Out of Cell Time Tracking Form Program Attendance/ Sign In Sheets

Final Measure #	Outcome Measure	Protocol	Source of Records/Review
		for Step II and III are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners.	(containing prisoner signature)
3	All out-of-cell time specified in Outcome Measures 1, 2, 8 that is limited or cancelled is properly documented and justified in accordance with the terms of the Stipulation as set forth in ¶26 of the Stipulation.	At each designated location, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners.	Max Custody Daily Out of Cell Time Tracking Form Warden Certification of individual security risk necessitating limitation or cancellation where applicable to randomly selected prisoner
4	All maximum custody prisoners receive meals with the same caloric and nutritional content as meals served to other ADC prisoners.	At each designated location, Monthly Max Custody Prisoner Food Services Menus are selected for each monitored month.	Max Custody Monthly Prisoner Meal Food Services Menu
5	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30) are offered a minimum of 6 hours of out-of-cell exercise time a week.	At each designated location, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners.	Max Custody Daily Out of Cell Time Tracking Form

Final Measure #	Outcome Measure	Protocol	Source of Records/Review
6	All maximum custody prisoners at Eyman-Browning, Eyman-SMU I, Florence Central, Florence-Kasson, and Perryville-Lumley Special Management Area (Yard 30), who are eligible for participation in DI 326 are offered out-of-cell time, incentives, programs and property consistent with their Step Level and housing assignment under the DI 326 policy.	At each designated location, Max Custody Monthly Activity Schedule Calendars are selected for each monitored month. At each designated location, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners. At each designated location, DI 326 Programming Attendance/Sign In Sheets are reviewed for one randomly selected week for each monitored month, for 10 randomly selected prisoners. At each designated location, a minimum of 10 Prisoner Property Files are randomly selected and reviewed to identify access to allowable property consistent with Step Level under DI 326 for each monitored month.	Max Custody Monthly Activity Schedule Max Custody Daily Out of Cell Time Tracking Form Program Attendance/Sign In Sheets (containing prisoner signature) Prisoner Property Files
7	No prisoners with a mental health classification of MH3 or higher are housed in Florence Central-CB 5 or CB-7 unless the cell fronts are substantially	At each designated location, the Housing Assignment Log for maximum custody prisoners with mental health classification of MH3 or higher is reviewed for one	Housing Assignment Log for maximum custody prisoners with mental health

Final Measure #	Outcome Measure	Protocol	Source of Records/Review
	modified to increase visibility.	randomly selected day of each monitored month and reviewed for: 1) any housing assignments in CB-5 and CB-7; and 2) if so housed, whether prisoner is housed in a cell with modified cell front.	classification of MH3 or higher
8	In addition to the general privileges and incentives afforded to prisoners under DI 326, all SMI prisoners in maximum custody receive: • 10 hours of unstructured out-of-cell time per week • 1 hour of additional out-of-cell mental health programming per week • 1 hour of additional out-of-cell psycho-educational programming per week • 1 hour of additional out-of-cell programming per week	At each maximum custody unit where SMI prisoners are housed, Max Custody Monthly Activity Schedule Calendars are selected for each monitored month. At each maximum custody unit where SMI prisoners are housed, Max Custody Daily Out of Cell Time Tracking Forms are reviewed for one randomly selected week of each monitored month, for 10 randomly selected prisoners. At each maximum custody unit where SMI prisoners are housed, DI 326 Programming Attendance/Sign In Sheets are reviewed for one randomly selected week of each monitored month, for 10 randomly selected prisoners. At each maximum custody unit where SMI prisoners are housed, Mental Health Programming Attendance/Sign In Sheets are reviewed for one randomly selected	Max Custody Monthly Activity Schedule Max Custody Daily Out of Cell Time Tracking Form DI 326 Program Attendance/Sign In Sheets (containing prisoner signature) Mental Health Program Attendance/Sign In Sheets (containing prisoner signature)

Final Measure #	Outcome Measure	Protocol	Source of Records/Review
		week of each monitored month, for 10 randomly selected prisoners.	
9	All use of force incidents involving maximum custody prisoners classified as SMI, and in the following housing areas: Florence-CB-1 and CB-4; Florence-Kasson (Wings 1 and 2); Eyman-SMU I (BMU); Perryville-Lumley SMA; and Phoenix (Baker, Flamenco, and MTU), conform to the policies for use of force set forth in ¶ 27 (a)-(e) of the Stipulation.	At each designated location, Use of Force SIRs/Use of Force Review Packets (if applicable) are selected for each monitored month for maximum custody SMI prisoners where force utilized involved chemical agents and incident is reviewed for compliance with the procedures for use of force set forth in ¶ 27 (a)-(e) of the Stipulation	SIR Packet; Use of Force Review Packet (if applicable); incident video (if applicable)

Monitoring for maximum custody Outcome Measures will be conducted by designated ADC staff at each location specified herein.

EXHIBIT F

ARIZONA DEPARTMENT OF CORRECTIONS

Mental Health Seriously Mentally Illness (SMI) Determination

Inmates with a Mental Health Score of 3 or greater will be assessed as clinically indicated to determine if the criteria for SMI is met. To be considered SMI in ADC the inmate must have a qualifying diagnosis [as indicated below] and present with at least one identified level of the severe functional impairment as the result of the mental illness [Reference MHTM 4-5.0].

☐ **Anxiety Disorders**
300.00 Anxiety Disorder NOS; 300.01 Panic Disorder without Agoraphobia; 300.02 Generalized Anxiety Disorder; 300.14 Dissociative Identity Disorder; 300.21 Panic Disorder with Agoraphobia, and 300.22 Agoraphobia without History of Panic Disorder, 300.03 Obsessive Compulsive Disorder; and 309.81 Post -Traumatic Stress Disorder.

☐ **Bipolar Disorder**
296.0x Bipolar 1 Single Manic Episode, 296.4x Bipolar I Most Recent Episode Manic, 296.5x Bipolar I Most Recent Episode Depressed, 296.6x Bipolar I Most Recent Episode Mixed, 296.7 Bipolar I Most Recent Episode Unspecified, 296.80 Bipolar Disorder NOS, and 296.89 Bipolar II Disorder.

☐ **Depressive Disorders**
296.2x Major Depressive Disorder, Single Episode; 296.3x Major Depressive Disorder, Recurrent; 296.90 Mood Disorder NOS; 300.4 Dys

☐ **Psychotic Disorders**
295.10, Schizophrenia Disorganized Type, 295.20 Schizophrenia Catatonic Type, 295.30 Schizophrenia Paranoid Type, 295.60 Schizophrenia Residual Type, 295.90 Schizophrenia Undifferentiated, 295.70 Schizoaffective Disorder, 297.1 Delusional Disorder, and 298.9 Psychotic Disorder NOS.

☐ **Personality Disorders**
301.0 Paranoid Personality Disorder, 302.20 Schizoid Personality Disorder, 301.22 Schizotypal Personality Disorder, 301.4 Obsessive-Compulsive Disorder, 301.50 Histrionic Personality Disorder, 301.6 Dependent Personality Disorder, 301.81 Narcissistic Personality Disorder; 301.82 Avoidant Personality Disorder; 301.83 Borderline Personality Disorder; and 301.9 Personality Disorder NOS.

_____ The inmate does not meet any criteria listed above. The inmate is not eligible for SMI status.

The inmate posses a severe functional impairment as evidenced by [check as appropriate]:

☐ A serious and persistent inability to perform developmentally appropriate occupational or school functioning.
☐ Inability to live in General Population without supervision (self-care-basic needs): Impairment in the inmate's ability to function independently including the capacity to provide or arrance for needs such as food, personal hygiene, clothing, medical, dental and mental health care.
☐ Risk of harm to self or others.
☐ Risk of Deterioration: The individual does not currently meet any of the above functional criteria, 1 through 3, but may be expected to deteriorate to such a level without treatment. If the reviewer concurs with this statement, please document the reason below.

- ◯ Diagnostic Category I diagnosis with probable chronic, relapsing and remitting course
- ◯ Co-morbidities (like mental retardation, substance dependence, personality disorder)
- ◯ Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization).
- ◯ Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated; care is complicated and requires multiple providers.)

_____ Inmate does not meet any of the criteria for functional impairment. The inmate is not eligible for SMI status.

_____ Inmate meets the SMI diagnostic and functional impairment criteria above. The inmate is SMI in ADC.

Mental Health Staff Name/Stamp	Mental Health Staff Signature	Date

Inmate Name *(Last, First M.I.)*	ADC Number
Date of Birth	Facility/Unit

1103-13
12/19/12

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
CIVIL MINUTES - GENERAL

Phoenix Division

CV-12-0601-PHX-DKD DATE: February 18, 2015

Title: Parsons et al vs. Ryan et al
Plaintiffs Defendants

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HON: David K. Duncan Judge # 70BL/DKD

Caryn Smith Gary Moll
Deputy Clerk Court Reporter

APPEARANCES:
Donald Specter, David Fathi and Corene Kendrick for plaintiffs
Daniel Struck, Timothy Bojanowski, Nicholas Acedo and Michael Gottfried for defendants

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PROCEEDINGS: **X Open Court** **Chambers** **Other**

This is the time set for Fairness Hearing.

Argument is heard.

Defendants' objection to allow members of the gallery to make statements to the Court is overruled.

Donna Firello, Donna Leone-Hamm, Tricia Borden, James Neuman, James Hamm, Dawn Bigelow-Ingram and Patty Jones address the Court.

The Court FINDS that settlement is fair, adequate and reasonable for the reasons stated on the record and will issue a supplementing written Order. The Court will also sign the proposed order at [1185-2] and ORDERS attorneys' fees be paid. Further, the Court will identify and exclude those members from the settlement who have requested to be excluded.

Additionally, the Court ORDERS a transcript of this proceeding will be prepared and made available to the Class Plaintiffs confined at the Arizona Department of Corrections at the prison libraries in the same manner the parties' settlement agreement was made available.

Time in court: 1 hr 2 min (1:32 PM – 2:34 PM)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al., Plaintiffs, v. Charles L. Ryan, et al., Defendants.	No. CV-12-0601-PHX-DKD **ORDER**

This Order supplements the findings made on the record during the February 18, 2015 Fairness Hearing. At the Fairness Hearing, which occurred after the notice required by Rule 23(e)(1) of the Federal Rules of Civil Procedure, the Court ruled that the parties' settlement set forth in their signed Stipulation (Doc. 1185) was fair, adequate and reasonable. The Court set forth on the record its findings as required by Rule 23(e)(2) of the Federal Rules of Civil Procedure and applicable Ninth Circuit authority. The law of the Circuit instructs the District Court to conduct a balancing of several factors which may include:

1. The strength of the Plaintiffs' case;
2. The risk, expense, complexity, and likely duration of further litigation;
3. The risk of maintaining class action status during trial;
4. The amount offered in settlement;
5. The extent of discovery completed and the stage of the proceedings;

6. The experience and views of counsel;

7. The presence of a governmental participant; and

8. The reaction of the class members to the proposed settlement.

Linney v. Cellular Alaska Partnership, 151 F.3d 1234, 1242 (9th Cir. 1998). The Court made findings on the record on each of these factors at the conclusion of the Fairness Hearing except that it did not specifically address factor No. 7, the presence of a government participant.

The Court believes it is appropriate for the Court to further comment on the objections. Although the Circuit does not require that the Court individually respond to each of the objections, the Court did review each of the objections. As stated on the record, many of the objections addressed contentions of inadequate medical care and conditions of confinement in the isolation units – the very issues which the proposed settlement seeks to address. Thus it seems incorrect to fault a proposed settlement for failing to correct perceived deficiencies which existed prior to implementation of the settlement. It appears to the Court that it is both parties' views that the settlement will address many of the circumstances of the objections and this is a reasonable conclusion in light of the specific measures and benchmarks delineated in the Stipulation (Doc. 1185). This said, however, it is also reasonable to conclude that not every perceived deficiency will be resolved by the settlement. Some matters raised in the objections are beyond the scope of this lawsuit or address matters not subject to constitutional protection. Moreover, the Stipulation allows for graduated benchmarks that contemplate some margin of noncompliance. Nevertheless, the Stipulation includes the parties' agreement to adopt substantial measures designed to address the provision of medical care and other conditions of confinement. No settlement is perfect. A compromise of hotly contested issues will leave each side wanting, receiving something less than their highest and best expectations. But those highest expectations can only be achieved with a complete litigation victory both at the trial court and before the court of appeals. And in light of the fact that neither plaintiffs nor defendants could say that such victories were a "sure

thing" in this case, the compromise which produced the "sure thing" of more limited results can still look wise and prudent. Both parties came to this understandable conclusion and reached a settlement that the Court can say, beyond any reasonable doubt, is fair, reasonable and adequate in light of the circumstances.

Finally the Court emphasizes a significant virtue of this settlement: it addresses many of the Class Plaintiffs' goals in a vastly more expeditious period of time. The benchmarks and performance standards and substantive changes in policy set forth in the Stipulation as well as the Class Plaintiffs' counsels' monitoring and the Court's supervision will start now, not two to three years hence, assuming Plaintiffs could have prevailed through trial and appeal.

Accordingly, the Court has determined that the Stipulation which seeks to resolve the litigation is fair, reasonable and adequate. The Court directed that the Stipulation be accepted as of February 18, 2015, and that as of that date the Parties' Proposed Order was approved and shall be placed upon the docket of this case in the form set forth in Attachment 1 to this Order.

The parties' Stipulation also addressed payment of Class Plaintiffs' attorneys' fees. The notice of the proposed settlement included the provisions in the Stipulation which addressed attorneys' fees and the Court's notice provided for class members to comment on the fee award. A number of comments addressed the subject of attorneys' fees (Plaintiffs' counsel set the total number at 37, not all of which object to the fee award).[1]

Plaintiffs' counsels' motion for fees and Defendants' response to the fee motion explain that the parties agreed to the amount of the fee award in their Stipulation. The agreed upon fee award is substantially less than the total fees Plaintiffs' counsel incurred. The Court's review of the lodestar calculation set forth in counsel's affidavit evidences

[1] It is noted that one of the objections includes the signatures of 105 other class members who object to the fee award as premature. They believe a fee award should be made only after the Stipulation has been performed. The Court disagrees because these fees and costs have already been incurred and they produced the settlement which resulted in the Stipulation.

that the fee requested is substantially less than the fees incurred based upon the number of hours reasonably expended multiplied by a reasonable hourly rate (in this case the hourly rate is set by Congressional command). Plaintiffs' counsel avowed that "[t]he amount of time and money actually expended by Plaintiffs' counsel in litigating this case far exceeds the amount Defendants have agreed to pay." Spector Affidavit at p. 7 (Doc. 1207). Dividing the agreed upon fee award by the statutory hourly rate produces a quotient of 20,814 hours of attorney time. There can be no rational suggestion that these hours are excessive in light of the three-year history of this class action with 33,000 class members with its extensive discovery, motion practice and interlocutory appellate course. The Court is also aware that the $4.9 million agreement was reached in part because this amount nearly matches the amount Defendants spent in payments to outside counsel in defending the case. Although such parity between what the two sides in a case spend on attorney time does not necessarily define a fair and reasonable fee – especially where the plaintiff carries the burden and where part of the defense of the case was performed by defendants' in-house counsel who did not bill their time – it is a benchmark which strongly suggests that Plaintiffs' fee award is reasonable. Accordingly,

IT IS ORDERED granting the Motion to Approve Stipulation (Doc. 1448) and to enter the proposed order tendered to the Clerk at the Fairness Hearing (which superseded the proposed order referenced at Doc. 1448). See Attachment 1 to this Order.

IT IS FURTHER ORDERED APPROVING $4.9 million in attorneys' fees as fair, adequate and reasonable and **GRANTING** the motion for fees (Doc. 1206).

IT IS FURTHER ORDERED that Defendants shall pay $4.9 million in attorneys' fees and non-taxable costs and up to $250,000 per year in monitoring fees and expenses, consistent with the requirements of the parties' Stipulation.

IT IS FURTHER NOTED that the class members Zeke Floyd Smith #193241 and James D. Jarrell #066219, sought exclusion from the class (Docs. 1224, 1451).[2] The Motion to Withdraw is **DENIED** (Doc. 1224).

[2] As this case was certified as a class action pursuant to Rule 23(b)(2), the Rules of

IT IS FURTHER ORDERED that this Order and the transcript of the Fairness Hearing, attached as Attachment 2 to this Order, be distributed at the prison libraries so that it may be reviewed by the Class Plaintiffs.

IT IS FURTHER ORDERED denying Plaintiff Gomez' Motion for Court-Ordered Accommodations Providing Class Members Reasonable Notice of Proposed Settlement (Doc. 1195), as moot.

IT IS FURTHER ORDERED that the Request for Production of Documents (Doc. 1452) is **DENIED**.

IT IS FURTHER ORDERED that the Clerk shall close this case subject to the Court maintaining jurisdiction to supervise the enforcement of the settlement as provided in the parties' Stipulation.

Dated this 24th day of February, 2015.

David K. Duncan
United States Magistrate Judge

Civil Procedure do not provide an "opt out" provision. *Ticor Title Ins. v. Brown*, 511 U.S. 117, 121, 114 S.Ct. 1359, 1361 (1994) (writ dismissed as improvidently granted).

Attachment 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER RE: SETTLEMENT

Based upon the entire record in this case and the parties' Stipulation (Doc. 1185), the Court hereby finds that the relief set forth therein is narrowly drawn, extends no further than necessary to correct the violations of the Federal right, and is the least intrusive means necessary to correct the violations of the Federal right of the Plaintiffs.

The Court shall retain the power to enforce this Stipulation through all remedies provided by law, except that the Court shall not have the authority to order Defendants to construct a new prison or to hire a specific number or type of staff unless Defendants propose to do so as part of a plan to remedy a failure to comply with any provision of this Stipulation.

Dated this 18th day of February, 2015.

David K. Duncan
United States Magistrate Judge

Attachment 2

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law, Plaintiffs, vs. Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Assistant Director, Health Services Contract Monitoring Bureau, Arizona Department of Corrections, in their official capacities, Defendants.	No. CV 12-601-PHX-DKD Phoenix, Arizona February 18, 2015 1:34 p.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

BEFORE U.S. MAGISTRATE JUDGE DAVID K. DUNCAN

(Fairness Hearing)

Court Reporter: Gary Moll
401 W. Washington Street, SPC #38
Phoenix, Arizona 85003
(602) 322-7263

Proceedings taken by stenographic court reporter
Transcript prepared by computer-aided transcription

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P R O C E E D I N G S

THE CLERK: Civil case number 12-601, Parsons, et al., versus Ryan, et al., on for fairness hearing.

THE COURT: Would counsel please state their appearances for the record. 13:33:54

MR. SPECTER: Certainly. Donald Specter from the prison law office, and with me is my colleagues David Fathi, Corene Kendrick, and other folks, a multitude of other lawyers.

THE COURT: Unnamed individuals, but for the record, they certainly are noted. 13:34:12

MR. STRUCK: Your Honor, Dan Struck, Tim Bojanowski, Nick Acedo, from Struck Wieneke & Love, and Mike Gottfried from the Attorney General's Office, and we also have some folks, other folks here. 13:34:27

THE COURT: All right. Thank you very much.

So this matter has been set pursuant to a stipulated agreement between the parties in this action to resolve it. The Court set a timetable for the consideration of comments on the settlement and has received many, many comments, all of which I have read through. I've also read what the -- what the parties have submitted throughout most of this litigation, especially after the time that I became involved in it. And I think I should take just a moment to comment about that fact, that the judge who was originally the settlement judge, or the 13:34:43 13:35:10

mediator in the case, is now, by the parties' consent, the presiding judge in the case.

I think at one level one could question whether or not a judge who had participated in the settlement could be the appropriate person to consider the fairness of the settlement. 13:35:32

There is, I think, an argument that could be made that perhaps somebody who was involved in the process would have a vested interest in the settlement. I hear sometimes that comment. I do conduct a large number of settlement conferences and I sometimes hear people say, "Well, Judge, you're just invested 13:35:55 in the settlement."

The truth of it is I'm not invested. I get paid the same whether I settle the case or not. But almost always what is evident in any kind of mediation is that settlement is in both parties' interests, and so that reality seems to override 13:36:14 that other concern.

The other aspect that overrides this concern of a judge being vested in it is I think that something that has certainly become clear to me over the almost 14 years that I have done this is that judging well is not accidental. You 13:36:36 just don't avoid problems by staying out of places where you might run into problems. In fact, it's just the opposite. You have to be studied and careful to make sure that you follow the rules, the canons that apply to judges with respect to their ethical conduct, and that you make sure that you comport with 13:36:52

expectations of due process and fairness.

In the consideration of whether or not a settlement meets the standard for a class action, whether it is fair to all of the parties, it's the same kind of studied process. There are factors that the Ninth Circuit has enumerated that 13:37:14
the Court must consider in deciding whether or not the settlement is fair, and those criteria can be applied in a careful and explained way such that a reviewing court could see whether or not the standard had been complied with and could see whether or not there was an unreasonable application of 13:37:35
decision-making in the process.

I have also had the benefit of the comments in my process of applying the law, the factors that the Ninth Circuit has told me that a judge should apply in considering the fairness of a settlement. I have my ability to read the 13:37:59
applicable law and to look at the elements of the settlement and to consider the situation that is before me, in part greatly informed by the fact that I participated in the mediation process. I learned many things about the relative status of the respective views of the case because of my 13:38:24
participation in that process that I believe better equips me, actually, to decide whether or not the settlement is fair.

But even if I had not had that benefit, what I do also have the benefit is the comments that have been produced by many of the -- by the class of plaintiffs which inform me about 13:38:49

their views on the settlement, and allow me to have the benefit of what they think that I should be thinking about in case I wasn't thinking about those things because of some reason. And I think that that, combined with the knowledge that I had in the mediation process, reduces any untoward risk that there would be some kind of participant bias that would vest me in finding that the settlement was fair without applying the standard. 13:39:11

I do actually think it's the opposite. I think I am in a better position because of the fortuity of the parties deciding to consent to have the mediating judge preside in the case, and I have the benefit of that knowledge that I acquired, and so as a preamble I make that statement. 13:39:28

The next step here will be that I will turn to the lawyers with respect to anything that they would like to say on the record, and also give anyone here in the courtroom who would like to address the Court on the subject of the settlement an opportunity to do that, but first I'll turn to the lawyers. 13:39:48

Mr. Struck? 13:40:02

I'm sorry, misspoke. It's because you all are at the wrong tables.

MR. SPECTER: My opposing counsel pointed that out to me.

THE COURT: Is it a California rule, or something like 13:40:14

that?

MR. SPECTER: This is Donald Specter for the plaintiffs. Most of what we believe is true is set forth in our moving papers so I won't belabor this proceeding by repeating all of those arguments. I just wanted to make a few brief comments, and then it will be followed by my colleague and co-counsel, Mr. Fathi, will address some of the issues in the case. 13:40:39

So the first question the Court has to answer is whether under Rule 23 the stipulation is fair, adequate, and reasonable, and plaintiffs and their counsel submit that that's the case, that this stipulation is abundantly fair, adequate, and reasonable. So we are going to ask the Court, if it so concludes, to sign the proposed order that the parties agreed to as well, which is found in docket 1185-2. 13:40:55 13:41:18

The second question before the Court is whether the Court should grant plaintiffs' motion for attorney fees, and we believe the Court should grant that motion, and Mr. Fathi will explain why briefly after I get done.

As far as the stipulation goes, the stipulation represents a compromise reached by the parties. It's a comprehensive document that aims to cure what plaintiffs believe and were prepared to prove were unconstitutional conditions of confinement. It has six separate parts. 13:41:40

The first one provides over a hundred different 13:42:02

performance measures that the ADC and its contractor, Corizon, must meet, and it also provides restrictions on the use of force and improvements in the conditions in the isolation units. Mr. Fathi will address those last two measures in more detail. 13:42:22

The performance measures are very comprehensive. They address staffing, medical records, pharmacy, medication, medical equipment, emergency response, timely access to diagnostic services, specialty care, clinician quality, chronic disease; the whole panoply, essentially, of what a 13:42:39 health care -- medical health care system must have in order to perform its functions and reduce the risk of harm which we believe is now present in the Arizona Department of Corrections' facilities.

It's my belief, and our belief as plaintiffs' counsel, 13:42:55 that any fair review of these performance measures must conclude that they are detailed, comprehensive, and if properly implemented, will substantially improve the quality and the amount of care that the class members receive.

The second part of the stipulation provides a detailed 13:43:15 mechanism for determining whether in fact these performance measures are being met by ADC's contractor, Corizon, and ADC itself.

The third part is it sets -- the stipulation sets a threshold for compliance, which increases gradually as 13:43:35

the three years go by.

Fourth, to ensure that these improvements are being implemented, or to determine if they're not, the stipulation provides for plaintiffs' counsel to monitor ADC's performance and to tour the prisons to view the conditions in the units. 13:43:57

Fifth, it provides that for dispute resolution, in the event that the parties disagree about whether the ADC or its contractor are in compliance with the provisions of the decree.

And finally, and perhaps most importantly in the long run for its prophylactic effect and, if needed, for other -- 13:44:20
for enforcement purposes, it provides that the disputes that can't be resolved by the parties are able to be resolved through the Court, and the Court retains jurisdiction to enforce the provisions of the stipulation in all respects provided by law, with two discrete exceptions, which are set 13:44:42
forth in the stipulation.

So we believe, if implemented in good faith by the ADC and Corizon, the stipulation will provide the plaintiff class and the subclass with very substantial benefit, and in a very relatively short time frame compared to what would have 13:45:02
happened if the case had gone to trial. And if the stipulation doesn't do that with the good faith efforts by the ADC and Corizon, then we will take all needed and legally sound efforts to enforce that compliance through the enforcement mechanisms of the decree. 13:45:29

As far as the comments go, the plaintiff class members submitted over 200 comments, as you well know. Even though it's less than 1 percent of the 33,000 prisoners, we believe that many of the comments represent a very accurate picture of the suffering that has gone on through the -- through the years 13:45:50
for prisoners in isolation; for prisoners who can't receive adequate medical, mental health, and dental care. And some of those comments describe with particular accuracy, and we believe credibly, the types of results that happen when -- and harm that occurs when prisoners have to live under those 13:46:15
conditions.

One of the reasons we believe the stipulation should be approved by the Court and is necessary to improve care is because of the fact that it would go into effect immediately upon approval by the Court. If this case had dragged out 13:46:37
through trial, the proceedings there would have taken many months.

For all we know, we would have still possibly been in trial; it would have taken many more months for the Court to issue findings of fact and conclusions of law; then there could 13:46:54
have been appeals and stays and development of plans and objections to those plans. So we believe that the stipulation has the ability to provide much quicker relief to our clients than if we had taken the litigation road in this case, and that's why we believe the Court should approve it. 13:47:19

And Mr. Fathi will now -- unless the Court has any questions, Mr. Fathi will now address some of the other subjects.

THE COURT: Thank you.

MR. FATHI: Good afternoon, Your Honor. 13:47:31

THE COURT: Good afternoon.

MR. FATHI: The Supreme Court has said that there is no Iron Curtain drawn between the Constitution and the prisons of this country. This case, and the settlement that is before the Court today, are an important reminder of that fundamental 13:47:50 truth.

Mr. Specter has discussed the medical and dental care provisions of the settlement. I will briefly review the provisions governing mental health care and conditions in ADC's isolation units. 13:48:08

Many of the medical care provisions -- for example, those governing medical records, pharmacy, and health care staffing -- will also improve the delivery of mental health care. But there are also a number of provisions specifically addressing mental health care, such as mental 13:48:23 health treatment plans, the frequency with which prisoners are seen by a mental health clinician, and access to individual and group therapy.

The settlement also includes several provisions aimed at preventing prisoner suicides. And these are particularly 13:48:37

critical in light of the fact that ADC continues to struggle with prisoner suicide, and, indeed, just last month experienced three suicides in a five-day period.

For prisoners in the isolation subclass, the settlement provides for additional out-of-cell time and access 13:48:57
to programming, it provides that those in isolation will receive food of the same nutritional value as other ADC prisoners, and it provides special protections for those with serious mental illness who are particularly vulnerable to the
damaging effects of isolated confinement. 13:49:16

Subclass members with serious mental illness are guaranteed a minimum of 19 hours out of cell per week, including at least three hours of out-of-cell programming. There are also restrictions on the use of chemical agents on
prisoners with serious mental health illness and in housing 13:49:33
units that hold the mentally ill.

Is the settlement perfect? Like any settlement, it is the offspring of compromise. But Mr. Specter and I agree that it is in the best interests of the plaintiff class and accords
our clients more relief and quicker relief than if we had gone 13:49:56
to trial and prevailed on all issues.

We believe that the defendants are genuinely committed to the improvements required by this settlement, but if they fall short for whatever reason, the Court retains the power and
the duty to enforce compliance. President Reagan famously 13:50:15

counseled that one should trust but verify. I can assure the Court that we, as counsel for the plaintiff class, will do both.

I'd like to briefly address the motion for attorney fees that is also before the Court today. As the Court is aware, the parties have agreed both on the amount of fees and on the schedule for payment. Under the case law, the parties' agreement is entitled to great weight, and the Court's task is simply to determine whether the negotiated fee is facially fair and reasonable. 13:50:34 13:50:53

In light of the extraordinary amount of work required to successfully represent this class of 34,000 over the three years of this litigation, and for all the other reasons set forth in our brief, the fee agreement is fair and reasonable and the motion should be granted. 13:51:10

Thank you, Your Honor. And again, we are, of course, happy to answer any questions the Court has.

THE COURT: Thank you.

Mr. Struck.

MR. STRUCK: Thank you, Your Honor. 13:51:20

The defendants also support the stipulation and request that the Court grant an order finding that the settlement is fair and reasonable.

We believe that the stipulation essentially codifies what was already in the policies and procedures at A DC with 13:51:44

respect to medical, mental health, and dental care, with a few exceptions. It's something that ADC has all along strived to do, to follow their policies and procedures and their technical manuals, and will continue to do.

With respect to the attorneys' fees motion, it's the defendants' position that the Court does not have to grant plaintiffs' motion for attorneys' fees. I think under Rule 23(h) the Court would be required to grant it if there was some operation of law which required it to do so. In this case, the Court simply has to find that the fees that are already -- have already been negotiated are fair and reasonable, and the parties agree and stipulate that the fees were fair and reasonable and a negotiated amount. 13:52:08 13:52:25

You had mentioned earlier at the beginning of the hearing that you were inviting members of the audience to speak. The defendants object to that unless -- we don't believe that there are any actual parties here. Typically, in fairness hearings parties are welcome to come up and testify with respect to that. We've already had 200 or plus comments that have been submitted to the Court with respect to -- from parties mostly with respect to the stipulation, and we don't believe that the individuals who are in the audience who might want to speak about the stipulation have any standing to do so. 13:52:42 13:53:02

Finally, we wanted to point out or let the Court know that the defendants are taking action even before the 13:53:26

settlement has been approved by the Court. There has been a request in the Legislature for 91 additional medical/mental health/dental positions within -- to include with the current contract with the -- with the provider, which is Corizon.

Thank you. 13:53:47

THE COURT: Thank you, Mr. Struck.

Regarding the objection to the ability of members of the gallery who may wish to address the Court, the objection's overruled because the matter is one that is of significant public concern. And because of the circumstances of the class 13:54:04 plaintiffs being confined, and the difficulty in arranging for them to have an ability to be present in open court, whether by physical means or electronic means, the comments, I think, do address the opportunity for the class plaintiffs to be heard, but with respect to an action that affects the 13:54:27 community in a larger sense, I do think it is appropriate to allow people to be heard if they wish.

And so we'll turn to that portion now, and I'll ask if there are those who would like to speak, if you'd raise your hand so that I could get a sense about how many people would 13:54:42 like to.

So I see one, two, three, four, five, looks to me to five hands.

And so, ma'am, if you would please approach the lectern -- yes, ma'am -- and state your name for the record. 13:54:54

You'll be next.

Thank you, ma'am. If you could just come forward to the lectern and give your name, and spell it also for the record.

MS. DONNA FIRRELLO: Donna Firrello, F-i-r-r-e-l-l-o. 13:55:11

THE COURT: Thank you.

MS. DONNA FIRRELLO: My husband is currently incarcerated in Lewis on the Barchey Unit, and the medical issues, I have -- I have to fight to get him care. He has to fight to get care. It's -- it's horrible. 13:55:29

He has multiple medical issues, and I have been in touch with Chuck Ryan, Mr. Pratt, Corizon, to no avail. It's -- he's possibly facing prostate cancer right now. This has been going on for a year that we've tried to get him treated for it. 13:55:52

He had possibly pneumonia and he put in an HNR two weeks ago, still has not seen a doctor. And he had a stroke while he was in prison, and we have been trying for two years to get him to a cardiologist, which that is supposed to happen this month, but whether it does or not. It's -- it's horrible 13:56:10 the care they're getting. They're treated worse than animals.

And it's just horrible that they have the lack of care, or possibly the lack of funds, I'm not sure what it is, or, you know, if it's just they don't care. And then the ones that are in -- you know, in confinement, that's -- it's even 13:56:31

worse. And I think something needs to be done. I really think something needs to be done.

And my husband is in there for nonviolent. He's bipolar and he was -- that's not getting treated. And the reason he's in there is because he was out of control for his bipolar. 13:56:50

And it's just a vicious battle that I have to fight on a daily basis with DOC and Corizon, and something needs to be done about the medical and mental issues with the prisoners, and that's all I have to say. 13:57:11

THE COURT: Thank you very much.

MS. DONNA FIRRELLO: Thank you.

(Pause in proceedings to clarify spellings for the court reporter.)

THE COURT: Thank you. Ma'am? 13:57:23

MS. DONNA LEONE HAMM: Good afternoon, Your Honor. My name is Donna Leone Hamm, and I'm the Executive Director of Middle Ground Prison Reform. Middle Ground is the oldest continuous prisoner rights organization in the state of Arizona. We've been here since 1983. 13:57:53

We had an opportunity to review the settlement offer when it was first published, and we certainly agree with both sides in this matter that it clearly has to be a matter of compromise. We are pleased that overall, there will clearly be some improvement in the delivery of medical services. The 13:58:19

treatment, the conditions of confinement for solitary confinement, the Department can call it whatever they want, but if you're in your cell the vast majority of hours per day seven days a week, that is solitary confinement. And we know that there are psychological studies which demonstrate the harm that comes for anyone who is subjected to those conditions, especially when you exacerbate the problem with a verified mental illness. 13:58:44

We did have some concerns about the threshold after three years being only at 85 percent -- we wish it could be 95 percent -- for compliance with the performance requirements. But we understand that whatever will happen, if in three years there is 85 percent compliance, that that, in itself, will be a tremendous improvement over what is occurring at present. 13:59:07

We also express concern -- and I think some of the inmates who've written to you, members of the class, may have done the same thing -- that the site inspections are required to have a two-week notice. We think that at least some of those inspections by the plaintiffs' lawyers should be unannounced, so that there can be an opportunity for them to see firsthand what is happening without advance notice and preparation by the Department for a visit. 13:59:34 14:00:01

I heard the lawyers for the Department make a remarkable comment today that really this settlement represents merely a codification of the policies that are already in 14:00:28

existence in the technical manuals, and I find that astounding, because what it tells me is this settlement is really the Kool-Aid of mandatory compliance that is needed to get these folks to be in compliance with their own written policies. That hasn't happened. That's why we're here. 14:00:54

So to echo what I think, and I hear from inmates' families or inmates themselves easily a dozen times a week about serious medical problems, we're not talking about sniffles or ingrown toenails. We're talking about cancer that has gone undiagnosed and untreated for months at a time; we're 14:01:24 talking about serious heart conditions, diabetes that's untreated properly.

So I think that most of the inmates, if they were here today, would tell you that any improvement, or anything that happens as a result of this settlement, is going to be an 14:01:43 improvement over what is currently happening.

THE COURT: Thank you, Ms. Hamm.

MS. DONNA LEONE HAMM: Thank you very much.

THE COURT: Please, sir.

Is it -- or, is it -- I'm sorry, ma'am, you may. Yes. 14:01:59

MS. PATRICIA BORDEN: Thank you for allowing me the time to -- to speak with you. I really don't want to waste your time, and the only reason that I'm coming up is because this gentleman said that they have already started doing things? 14:02:22

Well, my son is in the Cook unit, or was in the Cook unit --

THE COURT: Can I interrupt just for a moment --

MS. PATRICIA BORDEN: Sure.

THE COURT: -- so that you can state your name, and -- 14:02:28

MS. PATRICIA BORDEN: Oh.

THE COURT: -- spell it for the record --

MS. PATRICIA BORDEN: Okay.

THE COURT: -- too, please.

MS. PATRICIA BORDEN: It's Patricia Borden, 14:02:32
B-o-r-d-e-n.

THE COURT: Thank you. Please go ahead.

MS. PATRICIA BORDEN: I'm sorry. And so there has been no -- nothing in the past year has shown that they're moving in this direction. Hopefully now, with this signed, 14:02:43
there will be.

My son is now in a private prison so he's not entitled to the -- the same agreement that's in place. But I am a Registered Nurse, the Mayo Hospital, and I diagnosed one of his inmate -- one of his -- one of the inmates at the prison where 14:03:03
my son was with lymphoma, and it only took nine months for him to be seen by a doctor, finally then to have scans, and he didn't -- and to get a port was another couple of months, and then finally the chemo. And if he was a patient on the outside world he would have been diagnosed, the port would have been 14:03:25

placed, the chemo would have been started within 10 days, not within 14 months. So I thank you for allowing me to speak.

THE COURT: Thank you, ma'am.

Yes, sir.

MR. JAMES NEUMAN: Good afternoon, Your Honor. 14:03:50

THE COURT: Good afternoon.

MR. JAMES NEUMAN: My name is James Neuman. Neuman is spelled N-e-u-m-a-n, for the record. I was not planning on speaking today so bear with me in that regard.

I'm here on behalf of my father, who is incarcerated currently, and some of the personal experiences I have. He has a pain pump that was installed prior to his incarceration that ran empty while he was incarcerated. This caused his blood pressure to skyrocket to nearly fatal levels, and since that time Corizon, the DOC, have done nothing to refill this pain pump or remove it, both of which could have serious ramifications. 14:04:01 14:04:22

I've written Corizon and the DOC almost on a weekly basis now just advocating and lobbying for basic health care in the meantime for prescriptions that he needs, and coming here today and seeing all these folks that are here supporting this I realize that I'm definitely not alone in this struggle, and I know that there's other individuals here that would probably like to get up and speak and maybe don't have the courage to do so. 14:04:42 14:04:58

I hope that you will take into account all of the hard work that these attorneys have done and Mrs. Hamm and everybody else that's worked hard to try and get more successful health care for the inmates there, not just for my father but for everybody. You know, nonviolent, violent, I don't think that matters; what I think matters is that we treat them humanely. And as one of the -- the ladies said earlier, it is worse than animals in some regard, and it's a shame. 14:05:13

So, you know, I really hope that you'd look at all the facts that are presented to you, and I want to thank you for the opportunity to speak here today, so thank you. 14:05:31

THE COURT: Thank you, Mr. Neuman.

Yes, sir.

MR. JAMES HAMM: Good afternoon, Your Honor. My name is James Hamm, H-a-m-m. I don't really have anything to add to what other people have said on the subjects, but I'd like to say something about the Court's role in the future, because there are a couple of issues that I think are hidden underneath this settlement. 14:05:53

One of them has to do with long-term confinement in isolation. We all know that the current state of affairs in terms of our understanding of what happens is in a state of flux. There are new reports that are coming out all the time. So when we settle things today with regard to how long people are going to be in there, what's going to happen while they are 14:06:09 14:06:29

in there, how many hours they're going to be out of their cell, whether they get medication and whether they get treatment, we are putting a band-aid on something that we don't really understand today.

And so I just want to caution us all that the state of affairs is going to change and we are learning that there are long-term almost irreversible effects from this sort of confinement. 14:06:43

And in the ADC we have this confinement on multiple levels. We have it because people are mentally ill and they are unable to conform to the rules and so they get written up and their classification changes and eventually they get to the highest possible custody; we get it because they have been involved in security threat group activities, and so they're classified to these kinds of situations, and they stay there essentially for an exceedingly long time unless they are willing to put their lives at risk by informing on other inmates, and this creates a question where the -- a situation where the person has to either put his own life at danger in order to obtain some kind of relief from the confinement that he subjected to. 14:06:57 14:07:15 14:07:34

We also have a question about medication when it is given to people in long-term confinement, because what we are learning from medical professionals is that many of the medications that are given for things like mental health and 14:07:49

depression, including clinical depression, really have effects that we don't really understand today, and that what's happening today is that beneath the surface of these medications, which are masking the problems, there are more serious long-term mental health issues that are coming -- that are still being developed. 14:08:09

So although there's nothing that you can do about it and there's nothing that this settlement can do about it, we applaud the settlement in terms of it being quicker than litigation, better than litigation in many ways, and certainly a significant improvement. We just want to put it on the record that there are some issues involved in this settlement that really don't -- can't possibly be resolved between these two groups of people today by this Court, and that we may be back here dealing with these situations in the future. 14:08:24 14:08:44

And it isn't just a matter of settling things legally, because this type of confinement what is being learned is that it is a risk to public safety. Not everyone who goes into long-term confinement in the prison -- and I should say long-term, close custody, isolation custody, solitary confinement; that's the kind of confinement I'm talking about -- when those people are -- not all of those people are going to be there. It's just not natural life people who go there. It's not just death penalty people who go there. When those people are released, we are essentially creating 14:09:02 14:09:20

time bombs and then releasing them into the community. And there are other ways to deal with these problems, and I understand that the prison system has the right to make its own decisions about how it's going to manage its population.

But it still is worth putting on the record that this settlement still does not resolve some of the underlying more serious issues that are going to face us all with regard to how we're dealing with solitary confinement for a long time in the Department of Corrections regardless of medication; regardless of mental health; regardless of the reason why they're there. It is just the fact that they are there and for the length of time that they are there, and ultimately there needs to be some kind of resolution to that. 14:09:35 14:09:52

Obviously, all of the people who live in prison and who have serious medical conditions will be pleased if there is an improvement if it comes as a result of this, and all of us will be in support of both sides as they attempt to comply with this settlement as it is currently written. 14:10:07

But there is a -- there's still a -- there are still issues that are not resolved by this, and we just do -- we just want to put on the record that some of these things are of exceeding importance. Thank you. 14:10:26

THE COURT: Thank you, Mr. Hamm.

Yes, ma'am. Please.

MS. DAWN BIGELOW-INGRAM: My name is Dawn 14:10:46

Bigelow-Ingram, and my brother, Jimmy, was incarcerated and diagnosed -- he had a heart attack right after -- while he was still at Fourth Avenue Jail, and then he was diagnosed with liver failure.

Jimmy was learning disabled. He wasn't able to speak for himself or fill out papers. And with the help of Donna, I was able to get clemency for him, but before that happened it took a very long time. 14:11:01

Jimmy wasn't getting his medications in a timely manner, and because of that he was being taken by ambulance to the hospital. No one would let us know that Jimmy was in the hospital and that's why he wasn't calling. 14:11:24

Jimmy, because he was not receiving his medications in a timely manner, was sent to Housing Unit 9, and if you say that to any prisoner it strikes terror in their eyes. It is nothing more than solitary confinement. 14:11:47

Jimmie's risk level was almost nonexistent. He was placed in solitary confinement for no other reason than there wasn't enough staff to see to it that he got his medication around the clock. 14:12:09

Each time I would visit Jimmy -- and most of the time I went once a week at that stage -- his mental health deteriorated to the point where the last couple of visits I left sobbing. My brother would sit in a chair and say: "I'm going home today. I'm going home today." He was living in his 14:12:33

head.

He had a television set that he was allowed to bring with him, but during the move his headset, the earphones were lost. No one would get him another pair. They wouldn't let me buy him a pair, I couldn't bring him a pair. 14:12:49

So he was in this filthy cell with a bed, linens that had holes in it; cold; filthy plastic cup to drink out of with a TV set that just flickered pictures. It sounds like something out of Charles Dickens and it's happening down in Tucson. It's heartbreaking. My brother passed away three years ago. I did manage, he got clemency, but he didn't live for very long after. 14:13:17

Please, we can do more. These are human beings. Jimmy was learning disabled. He had an alcohol problem. He probably should have been programmed out, not sent to jail. 14:13:45

Thank you for hearing me.

(Pause in proceedings to clarify spellings for the court reporter.)

MS. DAWN BIGELOW-INGRAM: And thank you for hearing me. 14:14:10

THE COURT: Thank you, ma'am.

Is there anyone else who would like to speak?

I don't see -- oh, yes. Ma'am, please.

MS. PATTY JONES: Good afternoon, Your Honor.

THE COURT: Good afternoon. 14:14:33

MS. PATTY JONES: My name is Patty Jones. I'm the aunt to the late Anthony Clayton Lester -- "Tony" -- who lost his life on July 12th, 2010.

Tony was not able to be here because he was driven to sheer madness. Left in a detention cell. Could not fend for his own mental health needs. I was his advocate. I was his voice. I come here today after five -- almost five long, agonizing years, feeling a sense of justice and vindication from the settlement. 14:14:48

This has given everybody in Arizona a fight to fight through legislation to ensure that Tony's tragic story will never happen to any other severely mentally ill individual within the Department of Corrections. Thank you. 14:15:08

THE COURT: Thank you very much.

And any other hands? I don't see any. 14:15:26

Thank you all for your comments. And unless the lawyers have anything else to say, I'll speak for a moment about the matters that I need to address.

The fundamental question of whether or not the settlement is fair, adequate, and reasonable is one that, as I indicated earlier, is addressed by enumerated questions that need to be answered. And I will track through each one of those, but I will also start out by saying that one of the most compelling features of this settlement is that it provides for a rapid corrective action of problems that were identified by 14:15:47 14:16:14

the plaintiffs in a way that affords the opportunity for constructive relief.

The first question that the Court's required to analyze is the strength of the plaintiffs' case. It's fair to say that this was a hotly contested battle between two sides who believed that they had the law on each of their sides. 14:16:37

The plaintiffs presented compelling incidences of demonstrated harm. However, the defendants fought back with a belief that the law, as defined by the Eighth Amendment jurisprudence, would have meant that they would have succeeded at trial. 14:17:07

The difficulty that overlays every -- every prison health care case is that it's not the standard that is applicable to care that is afforded to people under the civil law outside of the arena of confinement. It's spoken in plain and very general terms. One comes to a notion of what is essentially malpractice and inappropriate conduct that would affect someone's rights such that you would think at the end of the day the jury would find in your favor if you brought this attention -- to the attention through the court process. 14:17:29 14:17:49

But that's not the standard that applies in a -- in a case necessarily that is in the court for the status of health care and issues of confinement. It's the standard as defined by the Eighth Amendment, and there are arguments about whether or not that's inclusive or exclusive of the common 14:18:11

notion that people have. But it's certainly an argument that the defendants could make, and it's an argument the defendants believed that would prevail at trial.

I cannot and do not have a crystal ball, so I can't foresee what would have happened at trial, but it's fair to say 14:18:28
that in this greatly contested battle there was litigation risk on both sides. And what that, I think, counseled the parties to consider seriously was the benefit of settlement, understanding that no one would accomplish their highest and best expectations for the case. 14:18:48

And in that compromise there was always one looming advantage to everyone who had an interest in this case. It would be a diversion from the litigation road to a road that would work toward addressing what is, I think, in everyone's interest on both sides of the case, and that is providing for 14:19:11
the needs of the people that are in custody in the State of Arizona's correction system.

And no one on the defendants' side would disagree with that. They had disagreements about exactly what was necessary to do. The plaintiffs had very strongly held views that the 14:19:31
defendant -- that the Arizona Department of Corrections was falling below the standard that was required.

But by diverting from this litigation track, we do focus on what is the principal attraction of the settlement, and that is addressing harms that can certainly be ameliorated 14:19:55

by the measures set forth in the stipulation; not only by the injunctive provisions that will be put in place pursuant to the parties' agreement and the Court's order, but also the monitoring mechanism that will ensure going forward that there is compliance with the stipulation, and in that monitoring 14:20:13
there will be identification of issues that will arise that in certain -- to a certain extent will be assisted by the mechanism that is in place because it is the hope of the stipulation, I think it's fair to say this, that the mechanism that will result in the monitoring will be one of cooperation 14:20:37
between the monitoring plaintiffs' counsel and the Department of Corrections staff with respect to identifying needs and working toward resolving those needs. And so the settlement does afford a more rapid redressing of these needs and an implementation of a monitoring program. 14:21:00

If the case were not settled, I think it's fair to say that the past record of litigation would be a fair prologue for what would be expected down the road, and that is a very hotly contested pretrial period even yet, the trial would likely have been offset in light of the change of judge, and the litigation 14:21:19
itself would consume a great number of resources.

Even in this very small way, it would divert people who are tasked with a very important job, and that is providing for the proper care of people within the custody of the Department of Corrections. If they are in court preparing to 14:21:42

testify or waiting to testify or testifying, they're not doing their job, and that takes away from the ultimate goal.

And then the resolution that would occur at the trial, if the past is the predictor, would not be the end. This case knows the way to the court of appeals, and it could travel that road again. If that happened, there would be further delay, and it is not unreasonable to conclude that this case that was started in March three years ago would be continuing for another two years past this time period. And so the settlement affords for a much more expeditious mechanism for addressing these needs. 14:22:04 14:22:25

The second point -- the first being the strength of the plaintiffs' case; the second being the risk, expense, complexity, and likely duration of further litigation -- is one that's so closely linked to the first point that you see that I've already alluded to many of the points that one would have to consider. 14:22:42

And that is that it is a hotly contested case, both sides with different views, expert opinions on both sides of the case, and a fair and reasonable expectation that it would take a long time to conclude; again, at each time expending more money on battle rather than redressing needs. 14:22:54

And that financial aspect of it is not one that can be lost on anybody who's aware of the circumstances in the state of Arizona just by reading the newspaper and what appears to be 14:23:18

the reality that the Arizona state budget is 10 to 20 percent off of where -- the revenue is 10 to 20 percent off of where they need to be to maintain the current budget. So what that means is dramatic cuts. And what that means is that there will be fewer dollars to do things that need to be done. 14:23:36

The litigation is expensive, and the settlement of the litigation means that those dollars can be used to redress the need. If the dollars are lost in litigation, it's reasonable to conclude that there are less dollars available to address what needs to be done. 14:23:56

The third factor, the risk of maintaining class status throughout the trial, is one that the plaintiffs, understandably, say in their memorandum is a low risk because the class status has already been before the court of appeals, but it is always a looming risk that something can happen at a trial where the -- the dissimilarities appear to predominate and -- and so that there is a risk I'll agree -- agree that it is -- is low. 14:24:13

The fourth factor, the consideration offered in settlement, this is one in which there is a plan that has been put in place to provide for particular benchmarks to be achieved, particular changes to be made, and for a monitoring program to enforce those first two. This is a remedy that some of the commentators objected to because of its limited -- limited scope, and perhaps because it did not provide any 14:24:29 14:24:56

financial relief to any of the individuals who believe they suffered damages associated with the conduct.

This has never been a case, though, about those issues. It's been a case that has been addressing substantive and systemic changes in the mechanism of providing for the care and confinement of the class plaintiffs. And so like many of the objections, they are a little bit off of what was even within the realm of this case. 14:25:16

And I will say also that some good number of the objections are ones that seem reasonable to be made in light of the circumstances that brought the case about, but are also the kinds of things that one would reasonably believe could be addressed by the stipulation and the compromise settlement. 14:25:39

It may well be that they are the kinds of things that -- that are objections that perhaps are -- are premature, because they may reflect a prior status that is hoped to be addressed by the settlement and that would only be fair to use as -- as criticisms of the settlement if they were indeed situations that arose during the time that the settlement was in place. And so I think it's fair to say that a good number of the -- of the objections do articulate that point, and it is my hope that the settlement will address those very concerns. 14:26:03 14:26:25

The fifth factor, the extent of discovery completed and the state of the proceedings, it's fair to say that this 14:26:46

case was, on the one hand, regrettably, completely discovered and prepared for trial, meaning that both sides' lawyers knew virtually every thing about what was to go forward.

And I say "regrettably" because that meant that a great deal of energy and resources and time were devoted to this. But on the other hand, perhaps it was necessary. Perhaps it was only in that climate where the lawyers could fully evaluate the respective cases and decide that a compromise was the best way to proceed. 14:27:07

The sixth factor is linked to this somewhat, the experience and views of counsel, because if you have a fully discovered case that provides this information, it's probably of limited use if you don't have people who are skilled and able to take in this information. 14:27:26

That's not the case we have here. We have accomplished counsel on both sides of the case. Both sides' counsel have national reputations with respect to litigating these kinds of cases, and have the experience of being able to evaluate the circumstances that were presented in this case against their backgrounds and experiences in other cases, and their backgrounds and experiences in other states. I think that that's helpful as they evaluated how best to proceed in this case. 14:27:46 14:28:03

The seventh factor, the reaction of the class to the proposed settlement, is set forth in the comments, which I -- 14:28:20

and I have considered, but I fundamentally believe that they do not suggest that this settlement should be deemed to not satisfy the standard that the Court must follow.

And I do that for two reasons. One, I've already mentioned, and that is I do believe that many of the objections are objections to the current status of affairs, not the status of affairs that we hope will be in place once this settlement and the stipulation is active. 14:28:41

The second point that is one that I would echo that was made by plaintiffs' counsel, and that is that the -- that the proportion of criticism is, although each of the opinions is important, the overall number against those for whom the notice was provided is low. It is 1 percent, and so it would seem that it is not fair to say that there was an overriding outcry of protest. It's fair to say that there are people with significant concerns who raised those concerns in a process that the Court provided. 14:29:01 14:29:31

I will also say that with respect to those who provided the information in the Spanish language, those were interpreted for the Court and I reviewed them after they were interpreted into English. 14:29:44

And so I think, taken together, all of these factors do establish that the settlement that the parties reached -- albeit, as Mr. Fathi said, no settlement is perfect -- it is, in light of the circumstances that were present, presented to 14:30:05

both of the parties in how best to proceed, one that for the class plaintiffs resulted in achievement of many measures that will resolve issues that have been identified in this lawsuit and have been presented.

And against the risk of going forward that they could lose the case, the compromise makes sense; and against the risk of even if the case could be won, the loss of perhaps life and injury and mental and physical damage that can occur to individuals over the life of the case as it worked its way through trial and through appeal, compellingly mandates that the settlement be approved, approved at this instant, so that the parties can move forward as expeditiously as possible, with no further delay interposed by the Court. 14:30:26 14:30:52

And so I will sign an order finding that the settlement is fair, adequate, and reasonable. I will provide written findings that will augment what I have said here on the record, but I do believe what I have said on the record does support the conclusion that the Court has made. I will sign the proposed order that is on the docket at 1185-2, and I will approve the motion for attorneys' fees. 14:31:12 14:31:33

The motion for attorneys' fees mirrors the agreement that the parties reached in the settlement, in the stipulation. It is a fair attorney fee amount in light of, I think, two overwhelming factors that evidence it.

One, the affidavit in support of it demonstrates that 14:31:55

it is a number about half the number that was expended by the plaintiffs in terms of costs and fees associated with the case. If the case had proceeded to trial, it would have even been a more robust figure.

And the other factor is that the amount of the fee award is approximately the same amount of money that the defendants expended to their outside counsel, even assisted by in-house counsel to a significant extent. 14:32:17

And so that benchmark seems to answer conclusively that this is a fair and reasonable attorneys' fees amount and also a necessary attorneys' fees amount, an attorneys' fees provision that the Congress has established because of its understanding that class plaintiffs can only oftentimes accomplish representation if there is a fee mechanism in place. 14:32:35

And so consistent with the congressional authority for the awarding of fees in a case like this and the parties' agreement to it, I will approve the attorneys' fees order. 14:32:54

Turning now to counsel, if there's anything else that I need to address I look first to you, Mr. Struck, since you're closer to the jury. 14:33:14

MR. STRUCK: No, Your Honor.

THE COURT: All right.

Anything further, Mr. Specter?

MR. SPECTER: The proposed order had a blank in it for the document number for the stipulation, so we had another 14:33:24

order prepared.

THE COURT: You can tender that to me now, if you please.

MR. SPECTER: Yes.

THE COURT: Thank you. 14:33:40

And then there's one final matter, two final matters that I would like to address. I will need to identify and exclude from the settlement those who indicated their wish to be excluded from the settlement. I believe that number is presently two, is that correct, counsel? 14:33:59

MR. SPECTER: Yes, Your Honor.

THE COURT: And so just so the record's clear, I want to make sure that that is noted here.

And then the second factor --

Mr. Struck, I'll turn to you, perhaps. 14:34:12

What I would like to do is arrange for the transcript of this proceeding to be made available at the prison libraries in a way that the settlement was also made available.

Is that possible to do?

MR. STRUCK: Yes, Your Honor. 14:34:26

THE COURT: Okay. So the transcript would be prepared and tendered to the State of Arizona for that purpose as well.

So the proposed order regarding the stipulation is no longer a proposed order, it will be entered on the docket as an order of this Court, and the stipulation will be approved as 14:34:44

well.

Anything further?

MR. SPECTER: No, Your Honor.

MR. STRUCK: No, Your Honor.

THE COURT: All right. Thank you all. 14:34:52

(Proceedings concluded at 2:34 p.m.)

C E R T I F I C A T E

I, GARY MOLL, do hereby certify that I am duly appointed and qualified to act as Official Court Reporter for the United States District Court for the District of Arizona.

I FURTHER CERTIFY that the foregoing pages constitute a full, true, and accurate transcript of all of that portion of the proceedings contained herein, had in the above-entitled cause on the date specified therein, and that said transcript was prepared under my direction and control.

DATED at Phoenix, Arizona, this 20th day of February, 2015.

s/Gary Moll

Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

B.K. by her next friend, MARGARET TINSLEY, *et al.*,
Plaintiffs/Appellees,
v.
GREGORY McKAY, *et al.*,
Defendants/Appellants.

On Appeal from the United States District Court
for the District of Arizona
No. 2:15-CV-00185-PHX-ROS
Hon. Roslyn O. Silver

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF ARIZONA, AND PRISON LAW OFFICE IN SUPPORT OF PLAINTIFFS/APPELLEES' OPPOSITION TO APPEAL OF CLASS CERTIFICATION ORDER APPENDIX, VOL. II

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VOLUME III

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UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF PABLO STEWART, M.D.

I, Pablo Stewart, M.D., Declare:

1. I am a physician licensed to practice in California and Hawaii, Board certified in psychiatry, with a specialty in clinical and forensic psychiatry.

2. I have been retained by counsel for plaintiffs in the present case to render an opinion on the quality of mental health care provided to Arizona state prisoners.

3. Attached hereto as Exhibit A is my Confidential Report, dated March 30, 2016. This document constitutes a true and correct report of my findings and opinions. I have personal knowledge of the matters set forth in this report and if called as a witness I could competently so testify.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 1ST day of APRIL, 2016, at San Francisco, California.

PABLO STEWART, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on April 11, 2016, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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Exhibit A

Expert Report of Pablo Stewart, M.D.

Parsons v. Ryan, No. 2:12-cv-00601-DKD (D. Ariz.)
March 30, 2016

INTRODUCTION AND QUALIFICATIONS

1. I am a physician licensed to practice in California and Hawaii, with a specialty in clinical and forensic psychiatry. A true and correct copy of my current *curriculum vitae* is attached hereto as **Exhibit 1**. My background and experience as relevant to my expert testimony in this proceeding are summarized briefly below, and set forth more fully in my November 8, 2013 report (Dkt. 1104-2).

2. In 1973, I earned a Bachelor of Science Degree at the United States Naval Academy in Annapolis, Maryland. In 1982, I received my Doctor of Medicine from the University of California, San Francisco School of Medicine.

3. Throughout my professional career, I have had extensive clinical, research, and academic experience in the diagnosis, treatment, and prevention of mental illnesses in correctional and other institutional contexts. I also have extensive experience managing, monitoring, and reforming correctional mental health systems.

4. Between August 1988 and December 1989, I served as the Director of Forensic Psychiatric Services for the City and County of San Francisco. In that capacity, I had administrative and clinical oversight responsibility for the psychiatric care provided to the inmate population in San Francisco at both the county jails and in the 12-bed locked inpatient treatment unit at the San Francisco General Hospital. At the time, mental health care in San Francisco's jails was subject to a consent decree in the case *Stone v. City and County of San Francisco*, 968 F.2d 850 (9th Cir. 1992).

5. I have also served as a psychiatric expert or consultant to various federal courts or other organizations implementing remedial decrees covering the provision of mental health care in correctional institutions. For ten years, between April 1990 and February of 2000, I served as court-appointed medical and psychiatric expert in the consent decree case *Gates v. Deukmejian*, E.D. Cal. Case No. CIV S-87-1636. Among other things, that case involved the provision of adequate psychiatric care to mentally ill inmates at the California Medical Facility (CMF) in Vacaville, California.

6. Between October 1996 and July 1997, I served as a psychiatric expert

for the United States District Court for the Northern District of California in the case of *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995), an omnibus case involving psychiatric care and other issues at Pelican Bay State Prison in Crescent City, California. In my work on the *Madrid* case, I gained first-hand knowledge of the severe impact of prolonged isolation on mentally ill inmates, as well as additional concrete understanding of the need for constant monitoring of both non-mentally ill and mentally ill inmates in isolation in order to prevent any further decompensation, since isolated confinement by itself sometimes causes, contributes to and/or intensifies psychiatric instability.

7. Between June of 2003 and December of 2004, I was hired by the State of New Mexico as an expert for the implementation phase of the psychiatric sections of the "Ayers Agreement" covering the New Mexico Corrections Department (NMCD). The Agreement was a settlement between a class of New Mexico prisoners and the NMCD concerning the provision of adequate psychiatric care for inmates in New Mexico's highest security facility. The Ayers Agreement concerned a mental health treatment program in a disciplinary detention unit similar to the Security Housing Unit (SHU) at Pelican Bay State Prison.

8. I have also worked as an expert consultant for the United States Department of Justice (USDOJ) on inspections and remedial work in connection with youth facilities in California and Michigan. In August and September of 2003, I was retained as a medical and psychiatric expert for the USDOJ in connection with an inspection of the N.A. Chaderjian Youth Correction Facility in Stockton, California. Between March of 2003 and the summer of 2006, I worked as an expert for the USDOJ in connection with inspections to identify and remedy various problems at the Maxey Training School, a youth facility with large medical and mental health treatment programs in Whitmore Lake, Michigan. The case involved the adequacy of medical and mental health care provided at the facility.

9. In 2007 and 2008, I prepared expert statements and testified before the

three-judge panel in the *Coleman/Plata* overcrowding litigation in California. My expert report in that case was cited twice in the United States Supreme Court decision upholding the three-judge court's imposition of an order requiring California to reduce overcrowding.

10. I have presented numerous papers before mental health professionals, prosecuting and defense attorneys, probation officers, and judges, and have published in professional and peer-reviewed journals on topics including prison mental health services, dual diagnosis, mental illness, alcohol and drug abuse, and the treatment of substance abuse. I am currently a Diplomat of, and have served as an Examiner for, the American Board of Psychiatry and Neurology.

11. Since 1986, I have held academic appointments as Clinical Instructor, Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor in the Department of Psychiatry, University of California, San Francisco, School of Medicine. I received the Henry J. Kaiser Award for Excellence in Teaching in 1987 and was selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic years 1988-1989, 1990-1991, and 1994-1995. I also coordinated a course on Prisoner Health at the University of California San Francisco School of Medicine between January 2002 and January 2004.

12. I have served as an expert witness and consultant to the plaintiffs in this case since 2012. In that capacity I have conducted on-site inspections of the Arizona State Prison Complexes at Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma. I have prepared the following expert reports:

- Expert Report of Pablo Stewart, M.D., November 8, 2013 (Dkt. 1104-2).
- Supplemental Expert Report of Pablo Stewart, M.D., December 9, 2013 (Dkt. 1104-6, Exhibit 8).
- Rebuttal Expert Report of Pablo Stewart, M.D., January 31, 2014 (Dkt. 1104-6, Exhibit 9).

- Second Supplemental Expert Report of Pablo Stewart, M.D., February 24, 2014 (Dkt. 1104-6, Exhibit 10).
- Third Supplemental Report of Pablo Stewart, M.D., August 29, 2014 (**Exhibit 2**)

13. The opinions expressed in this report are necessarily limited by the information available to me at this time. I reserve the right to modify or supplement these opinions as additional information becomes available.

FAILURE TO COMPLY WITH MENTAL HEALTH PERFORMANCE MEASURES

14. When settlement discussions began in this case in the fall of 2014, I consulted with plaintiffs' counsel in formulating the remedies they would seek regarding mental health care. Each of the mental health Performance Measures (PM) in the Stipulation is designed to protect prisoners with serious mental health needs from unnecessary risk of harm or death, and to ensure that they receive minimally adequate mental health care.[1]

15. I have reviewed the CGARs from February through December of 2015, as well as summary charts reflecting the CGAR results.[2] It is readily apparent that ADC has failed to comply with a number of critically important mental health performance measures. This failure has already harmed a number of ADC prisoners, as explained below; and it creates a substantial risk of serious future harm to others.

[1] The Performance Measures most directly relevant to mental health care are PM 73-99 (see Stipulation, Exhibit B, Dkt. 1185-1). Of course additional measures, such as those concerning the accuracy of medical records (PM 5-10) and the provision of prescribed medications (PM 11-22), also have a profound effect on the quality of mental health care received by patients.

[2] CGARs (the acronym stands for "Compliance: Green, Amber, Red") are documents reflecting ADC's monitoring of its compliance with the Performance Measures at each ADC prison complex. Under the Stipulation, ADC is required to reach 75% compliance on each measure at each prison during the first year; 80% during the second year; and 85% in subsequent years.

More generally, as set forth in greater detail below, many of the deficiencies in care I identified in my previous reports persist to this day.

16. At the outset, I must note that there is reason to question the accuracy of defendants' self-reported compliance. In the September 2015 CGAR for Phoenix, the monitor noted that multiple mental health contacts were listed as being done by a psychiatrist, when in fact the staff member in question was not a psychiatrist. (ADCM 197144). This also occurred in July (ADCM 135620-21). Because the majority of the mental health Performance Measures require contact by mental health staff with specified levels of training and qualifications, this finding casts doubt on the accuracy of defendants' reported compliance.[3]

INADEQUATE MENTAL HEALTH STAFFING

17. As I said in my November 2013 report:

> The provision of sufficient numbers of qualified mental health staff is the foundation of any minimally adequate prison mental health care system. Without a sufficient number of properly qualified mental health staff, it is impossible to provide adequate mental health treatment. In addition, shortages of other health care staff, such as nurses and medical records staff, can negatively affect the delivery of mental health services, even if those employees are not formally classified as mental health staff.

November 2013 report at 11. It appears that serious shortages in mental health staff continue, with predictable results.

18. The Arizona Department of Corrections, like any state prison system, incarcerates a large number of persons with serious mental health needs. Treatment of these persons requires sufficient numbers of adequately qualified staff. Throughout

[3] My discussion of noncompliance with specific Performance Measures below does not indicate that I have concluded that ADC is in compliance with other Measures not discussed.

my involvement in this case, from 2012 to the present, I have been struck by the extreme and chronic shortage of mental health staff in ADC. For example, in the ten full days I have spent inspecting mental health care in seven ADC prisons, I do not believe I have ever seen a psychiatrist. This is extraordinary and completely unprecedented in my professional experience. A recurrent theme in my review is that patients are not being seen by a psychiatrist as required by their clinical condition and by the Performance Measures.

19. I have also repeatedly noted the lack of professional preparation of many of the mental health staff that do exist in ADC prisons. For example, during my tour of Eyman in December 2015, I tried to engage a mental health staff member in a collegial discussion of the events leading up to the [redacted] suicide of [redacted]. As discussed below, this is a case in which ADC itself concluded the suicide was preventable, and that [redacted] was not offered adequate mental health care in the months leading up to his death. The staff member and I, however, were unable to have this collegial discussion due to his almost complete lack of basic understanding of psychopathology, appropriate modalities of treatment and the standard of care for patients suffering from serious mood disorders. I was frankly appalled by this staff member's lack of proper professional preparation. My concern was heightened by the fact that this particular staff member held a supervisorial position.

20. While it may be that there are other variables preventing the delivery of adequate mental health care in ADC, the problems I observed are consistent with a shortage of qualified mental health staff. In addition to failure to comply with critical Performance Measures, these include failure to see the patient at appropriate intervals; patient encounters that are insufficiently thorough (for example, failure to perform a mental status exam or a suicide risk assessment);[4] and inadequate documentation in the medical record.

[4] I saw one "individual counseling" session noted in the file of [redacted], [redacted], that took 47 seconds to complete.

21. Indeed, ADC records consistently show large backlogs of patients waiting for mental health care. A 12/18/15 letter from Shane L. Evans to Lucy Rand noted that "[t]he current statewide Mental Health appointment backlog is 377" and "[t]he current statewide Psychiatric appointment backlog is 1,385." Records from individual prison complexes tell the same story:[5]

Tucson:

- September 2015 CQI minutes ("we have a large psych backlog – close to 1000") (ADCM 197765)
- October 2015 CQI minutes ("psych backlog 650") (ADCM 197776)
- November 2015 CQI minutes ("Mental Health backlog MH 978 psych 283") (ADCM 197785)
- "Dr. Wolfe will provide Dr. Pastor with a backlog list of MH-3D prisoners to be scheduled for telepsychiatry within the required time frames." (PM 85) ADCM199655

Lewis:

- September 2015 CQI minutes ("psychiatry is very backlogged currently – with approx. 400 inmates") (ADCM225806).
- "Given the backlog of such individuals, those whose medications have been discontinued in the last 30 days will be scheduled first in order to reduce the expansion of the backlog." (PM 85) ADCM199455

Perryville:

- September 2015 CQI minutes ("back log noted at 43 at this time") (ADCM 225821).

Yuma:

- September 2015 CQI minutes ("Dr. Raza [psychiatrist] has backlog due to being sick and being pulled to work at other sites. Needs are greater at other

[5] Typographical and grammatical errors are as in the original.

sites for his assistance") (ADCM 225851).

Florence:

- November 2015 CQI minutes ("there were 283 backlogs for Psychiatry") (ADCM228120)
- "A backlog was allowed to develop and the clinicians failed to maintain a tracking mechanism to assure compliance." (PM 86) ADCM199489

22. ADC records similarly acknowledge chronic shortages of mental health staff, and explicitly link these shortages with ADC's failure to comply with the mental health Performance Measures. For example:

Eyman:

- "We actively recruiting for our vacant 1.0 FTE Psych NP and telepsych positions." ADCM 199347, 199348, 199349 (PM 83, 85, 86)

Florence:

- "Florence complex is currently short two [mental health] providers. … The conintued need to recruit additional providers is still in place and is a huge need." (PM 85) (ADCM 228309).
- "Provider being utilized from another complex starting 8/3/15 once to twice a week until backlog complete." (PM 81) ADCM199416
- October 2015 CQI minutes ("psychiatry backlog has increased due to lack of provider coverage") (ADCM 225864)
- September CQI minutes ("currently down a Psychiatrist, Psychologist and mid-level") (ADCM 225786)

Yuma:

- "Due to staffing shortage with nursing staff Mental health Associates will be coming in and doing [suicide] watches on the weekend and holidays until nuring can take over that duty. … This will ciontinue until addition RN coverage can be scheduled and an mental heatlh RN is hired." (PM 94)

(ADCM199401).

Tucson:

- "Mental Health backlog has increased since we have had a decrease in staff." (ADCM 197785).
- "Dr. Wolfe will compile a list of inmates who are past due for medications and those who are due soon to provide to Dr. Pastor for further planning due to psychiatry provider shortages." ADCM199654. (PM 81)
- "Dr. Wolfe will compile a list of past due and due soon prisoners to send to Dr. Pastor for further planning due to severe provider shortage." ADCM199656. (PM 85)

23. ADC's mental health staffing shortage has two aspects. First, there appears to be a chronic inability to hire and retain staff, resulting in critical positions often being vacant. A December 18, 2015 letter from Shane L. Evans, Senior Manager of Compliance, to Lucy Rand, Assistant Attorney General, states that the statewide fill rate for psychologists is 50%, and for psych associates it is 77% (p. 3). But even those figures significantly overstate ADC's mental health staffing, since they include contract staff, overtime, and agency or locums staff (p. 2).

24. A review of ADC's monthly staffing reports shows that these shortages are longstanding. The following are the contract fill rates for various mental health staff in recent months:

Psychologists: 52% (December 2015); **52%** (November 2015); **52%** (October 2015); **46%** (September 2015); **46%** (August 2015); 52% (July 2015); **52%** (June 2015); **52%** (May 2015); **52%** (April 2015).

Mental Health Nurse Practitioners: 49% (December 2015); **49%** (November 2015); **26%** (October 2015); **26%** (September 2015); **43%** (August 2015); **47%** (July 2015); **47%** (June 2015); **43%** (May 2015); **43%** (April 2015).

Psychiatric Director: 0% (December 2015); **0%** (November 2015); **0%** (October 2015); **0%** (September 2015); **0%** (August 2015); **0%** (July 2015); **0%** (June 2015); **0%** (May 2015); **0%** (April 2015). It appears that this position has been continuously vacant since the Stipulation became effective in February 2015.

ADCM 274691, 273945, 197358, 197347, 197336; 199719; 199708; 199697; 199686. ADC's current level of mental health staffing is dangerously low and is woefully inadequate to provide minimally adequate care to its prisoners.

25. Second, even if all authorized mental health staff positions were filled, staffing would likely still be inadequate. It is impossible to be completely certain about this, because as far as I can ascertain there has never been a time since the Stipulation went into effect when all authorized mental health staff positions were filled. But ADC's mental health staffing levels are below those of comparable state prison systems. To take one example, ADC has a total of 19.0 psychiatric provider positions (7.5 psychiatrists, 11.5 mental health nurse practitioners). According to the ADC website, on March 11, 2016, ADC had 35,366 prisoners in its state prisons, yielding a prisoner to psychiatric provider ratio of **1,861 to 1.** By contrast, the Colorado Department of Corrections has 26.375 psychiatric provider positions and 14,017 prisoners in its state prisons, yielding a ratio of **531 to 1.**[6]

[6] January 14, 2016 email from Adrienne Jacobson, Colorado Department of Corrections, to Rebecca Wallace; Colorado Department of Corrections, Monthly Population and Capacity Report, Feb. 29, 2016, available at https://drive.google.com/file/d/0B30yLl0I1yBRUVpNSndDeU1Bc1pwcmxGVUxsQV9NYlZ3OVIw/view.

SPECIFIC PERFORMANCE MEASURES

Inadequate monitoring of prisoners taking psychotropic medication

Performance Measure 81

26. As I wrote in my November 2013 report:

> Patients taking psychotropic medication need to be monitored by a psychiatrist. The frequency depends on the clinical situation, but in no cases should it be any less frequent than every 90 days.

11/8/13 report at 29. Accordingly, PM 81 requires that "MH-3A prisoners[7] who are prescribed psychotropic medications shall be a seen a minimum of every 90 days by a mental health provider."[8]

27. ADC is persistently noncompliant with PM 81 at multiple prisons. For example, Lewis was noncompliant every month from February through November; Tucson was noncompliant from June through December.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	88	69	77	77	64	79	83	84	69	79	89
Florence	92	79	92	67	65	77	81	69	90	74	66
Lewis	54	58	72	51	61	74	68	73	51	60	77
Perryville	98	100	100	96	91	92	85	87	94	92	91
Phoenix	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100	80	100
Tucson	85	88	90	77	74	63	69	64	61	68	69
Yuma	95	98	97	98	93	92	88	95	89	93	95

[7] ADC classifies prisoners according to their assessed mental health needs. Those classified MH-1 have the lowest needs; those classified MH-5 the highest. Those classified MH-3 are divided into four subcategories: A, B, C, and D. This classification system is described in the "Definition of Terms" section of the Stipulation (Exhibit A).

[8] The Stipulation defines "mental health provider" as a psychiatrist or psychiatric nurse practitioner. Stipulation, Exhibit A. "Seen" is defined as "Interaction between a patient and a Medical Provider, Mental Health Provider or Mental Health Clinician that involves a treatment and/or exchange of information in a confidential setting. With respect to Mental Health staff, means an encounter that takes place in a confidential setting outside the prisoner's cell, unless the prisoner refuses to exit his or her cell for the encounter." Stipulation, Exhibit A.

Performance Measure 85

28. I also wrote in my November 2013 report, "[i]t is … essential that a patient who discontinues psychotropic medication be closely followed by a psychiatrist in case the patient decompensates and medications need to be restarted." 11/8/13 Report at 31. In that report I identified patients who had not been adequately followed after discontinuing medications and had suffered harm as a result. 11/8/13 report at 31-32.

29. To avert such harm, PM 85 requires that "MH-3D prisoners shall be seen by a mental health provider within 30 days of discontinuing medication." Unfortunately, no prison has achieved compliance with this measure in a single month between February and November 2015. In December 2015, only Eyman was compliant. Some prisons had 0% compliance in multiple months; Lewis had 0% compliance in all but two months (in those two months its compliance rate was 5% and 9%). This chronic failure to monitor prisoners who are currently prescribed, or have recently discontinued, psychotropic medication presents a significant risk of serious harm. It is likely that this failure results at least in part from the extraordinarily high vacancy rates among mental health nurse practitioners, who constitute the large majority of mental health providers in ADC.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	0	0	14	0	20	25	20	33	0	0	80
Florence	0	17	22	17	8	17	0	15	8	8	13
Lewis	0	0	9	0	0	0	0	5	0	0	0
Perryville	50	43	69	24	55	33	0	43	57	50	67
Tucson	0	0	35	12	13	0	14	13	6	13	0
Yuma	20	43	0	0	18	29	20	60	20	50	29

Inadequate access to non-medication treatment modalities

Performance Measure 80

30. I wrote in my November 2013 report:

> An adequate correctional mental health care system must provide a full range of treatment modalities; a system that relies primarily or exclusively on medication does not provide an acceptable level of care. It is my opinion that the ADC mental health care system relies almost exclusively on medication (which it fails to provide reliably or appropriately), and does not provide an appropriate level of non-medication mental health programming.

(p. 37).[9]

31. Performance Measure 80 requires that "MH-3A prisoners shall be seen a minimum of every 30 days by a mental health clinician."[10] ADC has not complied with this measure, with several consecutive months of noncompliance at Eyman (7 months), Tucson (8 months), and Lewis (6 months). This is likely related to the fact that only about 50% of ADC's psychologist positions are filled.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	73	57	47	23	27	43	60	92	88	98	98
Florence	97	93	97	93	93	90	63	87	95	84	95
Lewis	62	79	93	40	67	69	59	64	62	80	75
Perryville	100	91	100	100	92	90	92	91	89	88	74
Phoenix	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80	100	100
Tucson	81	87	93	70	53	64	66	69	68	66	64
Yuma	94	98	98	82	84	84	90	92	94	84	84

Inadequate access to care

32. The Health Needs Request (HNR) form is the primary means by which ADC prisoners access non-routine mental health services. In my November 2013 report, I concluded that "It is clear that untimely handling of HNRs remains a serious

[9] I quoted the comment of Nicole Taylor, ADC Mental Health Monitor, that "I also have concerns that the inmates are receiving medication management and not other therapeutic interventions." 11/8/13 report, p. 39.

[10] "Mental Health Clinician" is defined in the Stipulation as a psychologist or psychology associate. Stipulation, Exhibit A.

problem" (p. 34). I noted that "I saw many records with HNRs pleading for mental health care, which were answered only after many days, or not at all" (pp. 35-36, citing examples).

Performance Measure 98

33. To ensure that prisoners are able to make their mental health needs known to mental health staff in a timely fashion, PM 98 requires that "mental health HNRs shall be responded to within the timeframes set forth in the [ADC] Mental Health Technical Manual (MHTM) (rev. 4/18/14), Chapter 2, Section 5.0." The relevant provision of the MHTM provides the following timeframes for response to mental health HNRs:

> 2.0 Inmates with emergency mental health issues will be seen by nursing staff immediately upon receipt of the HNR.
>
> 3.0 Inmates with urgent medication issues (e.g., serious medication side effects or lack of receiving prescribed medications) will be seen by nursing staff within twenty-four (24) hours of HNR triage.
>
> 4.0 Inmates with urgent non-medications issues describing serious mental health symptoms will be seen by either nursing or mental health staff within twenty-four (24) hours of receipt of the HNR.
>
> 4.0 Inmates with routine non-medication issues will be forwarded to appropriate mental health staff, and will be responded to within five (5) working days with a specific plan of action.
>
> 5.0 Inmates with routine medication issues will be referred to a P/PNP, and seen within fourteen (14) days.

ADC267409.

34. I am informed that defendants have decided to monitor only one of these five categories of HNRs: those raising "routine non-medication issues." This by itself presents a risk of serious harm, since absent monitoring there is no way of knowing if emergency or urgent HNRs are being responded to in a timely fashion, or indeed at

all. But even with this critical monitoring error, defendants are still unable to consistently comply with this Measure, particularly at Eyman and Florence, each of which has had nine consecutive months of noncompliance.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Douglas	100	100	100	100	100	100	100	100	100	100	100
Eyman	0	14	36	42	40	36	62	72	68	82	66
Florence	100	63	50	18	29	52	72	57	65	67	79
Lewis	2	21	4	71	81	70	79	28	49	89	78
Perryville	88	98	100	91	100	88	96	86	82	100	82
Phoenix	0	50	100	0	100	100	90	100	100	100	86
Safford	100	100	100	100	100	100	100	100	100	100	100
Tucson	55	89	62	79	69	88	92	99	70	65	77
Winslow	N/A	50	50	100	60	75	80	100	91	80	91
Yuma	93	67	91	94	95	100	100	100	100	100	98

Inadequate suicide prevention

35. A completed suicide is the ultimate failure of a prison mental health system. In my November 2013 report, I concluded that "there are serious deficiencies in ADC's suicide prevention policies and practices, and . . . these systemic policies and practices pose a substantial risk of serious harm to ADC prisoners" (p. 51).[11] See 11/8/13 report, pp. 51-58 (describing deficiencies in ADC suicide prevention and citing recent prisoner suicides that I concluded were preventable); 12/9/13 report, pp. 5-10 (describing additional prisoner suicides, including one found by the ADC reviewer to be preventable); 2/24/14 report, pp. 1-8 (describing additional suicides).

Performance Measure 94

36. An essential element of an adequate suicide prevention program is a functioning system for placing persons at risk of suicide on watch. While on watch, the patient's condition must be monitored by qualified mental health staff to assess the

[11] I also quoted the deposition testimony of Dr. Ben Shaw, ADC Mental Health Contract Monitor, that there was "a serious gap in our ability to provide suicide prevention." 11/8/13 report at p. 51.

patient's risk level and, of particular importance, to detect any decompensation or increased lethality.

37. For these reasons, PM 94 requires that "all prisoners on a suicide or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays, by a registered nurse." The obvious purpose of this requirement is to closely monitor the condition of the patient in order to detect changes that may indicate increased risk of self-harm. Incredibly, when monitoring this measure, defendants often do not examine the entire period when the patient was on watch, because they look only at a single calendar month. For example, imagine a patient who is on suicide watch from May 10 through June 2. When auditing for the month of June, the monitor would only look to see if the patient was seen on June 1 and June 2. Even if the patient was not seen at all while on suicide watch from May 10-31, his case would be counted as "compliant" for this measure.

38. Needless to say, the risk of suicide does not magically appear or vanish with a change in the calendar month. It is the intent of this Performance Measure – and it is critically important – that the patient on watch be seen every day. ADC's failure to verify that this is occurring creates a substantial risk of injury or death.

39. Even with this significant – and very dangerous – defect in monitoring, which artificially inflates compliance figures, ADC is not in compliance with this measure, with Eyman, Florence, Tucson, and Yuma all showing multiple consecutive months of noncompliance. It seems likely that this noncompliance results at least in part from the shortage of psychologists discussed above.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	29	35	17	60	78	60	100	70	75	65	90
Florence	56	64	100	80	80	90	30	0	40	100	60
Lewis	90	90	90	100	70	90	100	100	90	100	100
Perryville	100	90	100	100	80	100	90	100	90	80	90
Phoenix	100	100	100	70	100	91	100	100	100	100	100
Tucson	100	60	100	50	100	50	50	70	60	80	60
Yuma	38	45	0	60	100	90	73	90	70	90	100

40. I have reviewed the records of three ADC prisoners who died by suicide since the Stipulation went into effect on February 18, 2015.[12] My detailed analysis of these records is set forth at ¶¶ 50-71 below. All three of these prisoners received mental health treatment that fell far below the standard of care in the final months of their lives. In two of the three cases ([redacted] and [redacted]) there were failures to comply with the Stipulation's mental health Performance Measures in ways that significantly contributed to the patients' suicide. For example, [redacted] was not seen every 30 days by a mental health clinician (PM 87), and a mental health HNR he submitted, saying he was having "serious mental issues," was not triaged or responded to by staff (PM 98). Similarly, as her condition deteriorated in the final months of her life, [redacted] was not seen every 90 days by a mental health provider (PM 88). [13]

41. My record review discloses additional serious flaws in ADC's suicide prevention program. For example, the September 2015 CQI minutes from Florence reported three attempted suicides at that facility in a single month. In each case, the minutes read, "what we can improve upon: nothing." ADCM225798. This is a startling and very disturbing statement. Every suicide attempt is an opportunity for staff to learn about gaps in the suicide prevention program and to make improvements in that program that will save lives in the future. This cavalier attitude toward potentially lethal self-harm behavior by mental health patients suggests a culture that does not take suicide seriously.

42. The November 2015 CQI minutes from Perryville refer to a prisoner who "swallowed razor blades while on constant watch." ADCM 228143. As the term

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[12] My review did not include [redacted] and [redacted], who died by suicide on [redacted] and [redacted], respectively, as those records have not been provided to me. https://corrections.az.gov/article/inmate-death-notification-saba; https://corrections.az.gov/article/inmate-death-notification-aguilar-0.

[13] I also found significant deficiencies in care in the third case, [redacted]. But because [redacted] died less than 90 days after the Stipulation went into effect, the mental health Performance Measures requiring that various treatments be carried out every 90 days were not yet fully applicable in his case.

suggests, "constant watch" indicates that the patient is to be under continuous observation by staff. That a patient on constant watch was able to obtain and swallow razor blades indicates a serious and lethal defect in watch procedures.

43. Based on my review, I believe that ADC prisoners remain at a substantial and unnecessary risk of suicide.

Failure to monitor use of isolated confinement on the mentally ill

44. In my November 2013 report I discussed the damaging effects of isolated confinement – that is, confinement in a cell for 22 or more hours per day with limited social interaction and environmental stimulation. 11/8/13 report at 58-60. The evidence that isolated confinement can be profoundly damaging to mental health, even for prisoners with no known mental illness, continues to accumulate.[14] The American Psychiatric Association has declared that "prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates." "Prolonged segregation" is defined as "duration of greater than 3-4 weeks."[15] Isolated confinement is associated with a greatly increased risk of suicide; I note that all three of the suicides discussed at ¶¶ 50-71 below took place in isolated confinement.

Performance Measure 92

45. To mitigate this harm, PM 92 requires that "MH-3 and above prisoners who are housed in maximum custody shall be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days."[16] ADC has failed to achieve compliance with this Measure. For example, Lewis failed to achieve compliance in

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[14] See, e.g., Appelbaum KL, *American Psychiatry Should Join the Call to Abolish Solitary Confinement*, J. Am. Acad. Psychiatry Law 43:406 –15, 2015, *available at* http://www.jaapl.org/content/43/4/406.full.pdf+html.

[15] American Psychiatric Association Official Actions, *Position Statement on Segregation of Prisoners With Mental Illness,* Approved by the Board of Trustees December 2012, *available at* http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf.

[16] ADC prisoners housed in maximum custody are subject to isolated confinement as defined above.

any month from May through October 2015; Eyman was noncompliant in every month but one from February through August; and Florence, Tucson, and Perryville each had three consecutive months of noncompliance. This is likely related to the chronic shortage of psychologists discussed above.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	35	45	85	57	50	65	70	80	85	90	80
Florence	80	85	85	25	65	70	100	90	100	100	90
Lewis	80	50	100	40	70	70	70	50	30	90	80
Perryville	100	100	90	60	70	50	90	100	80	70	70
Phoenix	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100	100	100	100
Tucson	11	29	N/A	71	17	67	75	100	100	80	100

Performance Measure 93

46. Similarly, PM 93 requires that "mental health staff (not to include LPNs) shall make weekly rounds on all MH-3 and above prisoners who are housed in maximum custody." ADC continues to fall far below the compliance threshold at some prisons, with Lewis at 30% and Perryville at 50% in November; and Tucson at 0% in December.

	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Eyman	0	0	5	48	100	95	40	63	90	85	90
Florence	0	5	40	70	85	95	95	100	100	90	100
Lewis	0	0	0	100	10	100	90	100	100	30	100
Perryville	40	30	100	80	70	100	100	100	100	50	100
Phoenix	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100	100	100	100
Safford	N/A	N/A	N/A	N/A	N/A	100	N/A	N/A	N/A	N/A	N/A
Tucson	0	0	N/A	86	100	67	87	90	80	80	0

GLOBALLY INADEQUATE AND DANGEROUS MENTAL HEALTH CARE

47. In addition to the CGARs, I also reviewed other documents and information to assess the current state of mental health care provided to ADC prisoners. As already noted, I reviewed records pertaining to three prisoners who died

by suicide (see ¶¶ 50-71). I also spent two days (December 7-8, 2015) at ASPC-Eyman, evaluating prisoners and reviewing their records. The results of that review are set forth at ¶¶ 72-84, below. Finally, I reviewed records of (but did not personally interview) additional prisoners with serious mental health needs. See ¶¶85-112.[17]

48. My review revealed multiple instances in which ADC's failure to comply with the Performance Measures resulted in concrete harm to a prisoner. Even as [redacted] presented with floridly psychotic behavior, sitting naked in his cell and eating his feces, he was not seen by a provider every 90 days as required by PM 81; nor was his treatment plan updated every 90 days as required by PM 77. ¶¶85-92. Similarly, even though [redacted] was diagnosed with a psychotic disorder and was noted by staff to be "currently psychotic," he was not seen by a provider every 90 days as required by PM 81. ¶73. Additional examples are set forth in my review of individual cases below.

49. Based on all these sources of information, it is my conclusion that mental health treatment in ADC continues to fall far below the standard of care. Many of the deficiencies I identified in my earlier reports remain substantially unchanged. ADC is failing to comply with the Stipulation Performance Measures in ways that present a substantial risk of serious injury or death to ADC prisoners.

Suicide reviews

[redacted], [redacted] – died [redacted]

50. [redacted] hanged himself at the age of 26 on [redacted], at Eyman-Browning Unit, and died the following day. There were multiple significant lapses in his care that contributed to his death.

51. [redacted] was classified as MH-4 and carried a diagnosis of bipolar disorder. Upon intake into ADC, it was noted that he endorsed suicidal ideation and had a history of suicide attempts (4/23/08). For several years he was designated SMI,

[17] A complete list of the documents I reviewed is attached as **Exhibit 3**. I may use any of these documents to summarize, support, or illustrate my opinions.

but this designation was removed on 10/16/14 with no explanation.

52. [redacted]'s bipolar disorder was treated with Lithium, apparently with good effect. However, this medication was discontinued on 9/5/14 due to side effects of nausea and vomiting. At this point a medical/psychiatric workup should have been performed to determine why [redacted] became Lithium toxic. It is very likely that the Lithium could have been reinstituted at a lower dose. This was especially important in this case given [redacted]'s positive response to Lithium in the past. If, based on the results of the medical/psychiatric workup it was determined that [redacted] could no longer be safely treated with Lithium, then other medications should have been considered to treat his bipolar disorder. There is no indication that this occurred, and [redacted] received no further medication until his death.

53. When he was seen on 10/6/14, there was a lack of documentation that the provider evaluated for the presence of manic and/or depressive symptoms. This is a significant omission in light of [redacted]'s recent discontinuation of Lithium. At subsequent contacts, there was no adequate mental status exam or suicide risk assessment documented in the medical record. [redacted] had several risk factors that placed him at a chronically elevated risk of suicide, such as previous suicide attempts, panic attacks and anxiety, and a family history of suicide. While these factors are mentioned in the psychological autopsy, they are almost entirely absent from the mental health notes in the year preceding [redacted]'s suicide, suggesting that mental health staff either was not aware of them or did not take them into account in assessing his suicide risk. The absence of these risk factors being discussed in the medical records strongly suggests that the staff significantly underestimated [redacted]'s suicide risk.

54. On 4/28/15, [redacted] submitted an HNR saying "I want to get back on my lithium as soon as possible, I'm having serious mental issues." He was scheduled to be seen on 5/19/15, but a note on that date reads, "Pt was not brought by security to appt. for unknown reasons and will be rescheduled." In fact, the appointment was not

rescheduled and [redacted] still had not seen the psychiatrist when he hanged himself more than two months later.

55. On 7/23/15 he was seen upon intake to Browning Unit. The question "Do you have any current mental health complaints?" was checked "yes," but there is no indication that this answer generated any follow-up, or that his urgent request from 4/28/15 was communicated to the new facility. A 7/24/15 note from the medical record stated "inmate was scheduled for 5/19/15 but was not seen," but again, there is no indication that this resulted in any follow-up to ensure that [redacted] was seen. He was found hanging [redacted] days later.

56. The psychological autopsy notes several failures to provide [redacted] the mental health treatment required by policy and by the *Parsons* Stipulation:

> [I]t is noted that mental health contacts had not been made in a timely manner per policy which would have required [redacted] to be seen by a mental health clinician at a minimum of every 90 days.[18]
>
> * * *
>
> [H]is request for protective segregation was also (7/23/15) denied. However, he did not receive the required 72-hour mental health contact following denial of his request for protective custody.
>
> * * *
>
> [redacted] arrived at Browning Intake on Thursday morning, July 23 and was required to be assessed by a mental health clinician within 72 hours. By the time of his suicide on [redacted], he had not been seen by a mental health clinician.

Psychological autopsy, pp. 11-14. The psychology autopsy also notes (p. 5) that an HNR that [redacted] sent to mental health in April of 2015 was not triaged nor responded to by staff.[19]

57. Similarly, the Mortality Review Committee answered "yes" to the

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[18] In fact the Stipulation required that [redacted], a prisoner classified MH-4, be seen by the mental health clinician no less than every 30 days. Performance Measure 87.

[19] As discussed above, the Stipulation requires that mental health HNRs be responded to within specified timeframes. Performance Measure 98.

question "Could the patient's death have been prevented or delayed by more timely intervention?" and "no" to the question "Was sufficient care offered/provided regarding Mental Health Issues?" It answered "yes" to the question "How likely is it that the patient's death was caused by or affected in a negative manner by health care personnel?" It endorsed "delay in access to care" as a contributing cause of [redacted]'s death, and "preventative measures not taken" and "treatment not timely" under the heading "general critique."

58. It is my opinion that the multiple failures described above directly contributed to [redacted]'s suicide. I agree with the Mortality Review Committee that [redacted] did not receive adequate mental health care and that his death very likely was preventable.

[redacted], [redacted] - died [redacted]

59. [redacted] was a 28-year-old man with a history of primary psychotic and mood disorders with co-occurring substance use disorder who committed suicide on [redacted] by a sertraline (Zoloft) overdose while incarcerated at Eyman-SMU. (His post-mortem sertraline level was 6696, while the normal range is 30-200.) [redacted] carried multiple risk factors for suicide including history of psychotic disorder, mood disorder, history of prior suicide attempts, history of trauma (including childhood sexual abuse), chronic medical conditions including chronic pain, and substance abuse (heroin, alcohol, and methamphetamine). He was classified MH-3B.

60. Review of [redacted]'s medical record during the year leading up to his suicide indicates that he was in significant distress. He submitted 30 HNRs specifically for mental health providers, 14 of which were sertraline medication refill requests. Regarding psychiatric care, there is documentation that he was seen by a provider six times in the year leading up to his suicide. In review of the documentation, there is a standard template that is used for mental health visits. This template is an outline of what information should be obtained during an encounter;

however, providers often left items blank and omitted critical information, resulting in documentation well below the standard of care. For example, the provider would check "YES" for mood disturbance, but no additional information was gathered. The mental status exam consistently omitted descriptions of his affect. The assessment section was often left blank, and medication changes were made with little or no documented rationale. A risk assessment was never done, despite this patient carrying multiple risk factors for suicide.

61. Leading up to [redacted]'s suicide, he was seen on 11/10/14, at which time he endorsed command auditory hallucinations of "midgets" telling him to kill himself. Although command auditory hallucinations telling the patient to kill himself indicate a significantly elevated risk of suicide, no suicide risk assessment was done at that time. The provider also inexplicably indicated the patient's thought content was "normal. " He was next seen by a provider on 1/9/15 after a month long-lapse in care during which it was documented that he did not receive his prescribed psychotropic medications. During this appointment he reported that his mood was "unstable." Again, there was no suicide risk assessment.

62. [redacted] was scheduled to be seen on 3/23/15; there is a brief note that an AIMS (Abnormal Involuntary Movement Scale) exam was completed because he was receiving Haldol decanoate, but no other documentation was found in the chart. It does not appear that the patient was actually evaluated except for the AIMS exam. This is the last documented visit prior to his suicide on [redacted].

63. Regarding medications, it does not appear that any laboratory monitoring was done for carbamazepine, which was restarted on 1/9/15. A number of blood tests should be obtained prior to initiating the medication and a blood level should be obtained 5 days after initiation of the medication; it appears that none of this was performed. The psychological autopsy states that [redacted] died of a carbamazepine overdose, which appears to be an error, as it contradicts other documentation in the record consistently stating the cause of death to be sertraline

overdose.

64. Of note, in contrast to other psychotropic medications, the prisoner was allowed to "keep on person" (KOP) sertraline. Thirteen 30-day sertraline prescriptions that were filled were designated "keep on person" (KOP) in addition to four 30-day sertraline prescriptions that were not KOP in the year leading up to his suicide. He appears to fill one 30-day sertraline prescription on 3/20/15, which was not designated KOP and another 30-day sertraline prescription on 3/30/15, which was designated KOP.

65. The treatment received by [redacted] was consistently below the standard of care. Most critically, for prisoners with a history of suicide attempts and multiple suicide risk factors like [redacted], psychotropic medications should not be given KOP, to reduce the possibility of hoarding, overdose, or non-compliance. It is my experience that correctional health care systems that have insufficient staff often inappropriately rely on KOP medication, since doing so requires less staff resources than other, safer means of medication distribution. It is not clear why there were inconsistencies in the prescribing between sertraline and other psychotropic medications. Reviewing the record, it does not appear that his medications were properly monitored. This is a critical oversight that in this case facilitated the prisoner's suicide.

[redacted], [redacted] – died [redacted]

66. On [redacted], [redacted] hanged herself from the air vent in her cell at Perryville-Lumley Special Management Area. She was 25 years old, and was classified MH-4 and SMI. She carried multiple risk factors for self-harm/suicide including history of prior self-harm (including a March 2015 incident in which she cut her arm and required more than 70 stitches), history of command auditory hallucinations telling her to hurt herself, diagnosis of Schizoaffective Disorder and Serious Mental Illness, trauma, family history of substance use and suicide, personal substance use, poor coping skills and multiple stressors including incarceration and

the recent death of a cousin.

67. In review of her medical record from the year prior to her death and the psychological autopsy provided by the facility, she was found to have been placed on suicide watch four times. Documentation throughout this period was consistently incomplete and below the standard of care. For example:

1) Subjective: commonly repeated entries include "NAD [no apparent distress]. No new episodes." "IM states she is eating and drinking fluids. IM states she has no medical concerns during time of visit." "Inmate appears stable." There was a consistent failure to ask about suicidal ideation/plan/intent or about command auditory hallucinations telling her to harm herself.

2) Objective: this entry was commonly "none," which is completely inappropriate. A note on 12/13/14 appropriately documents that [redacted] is wearing a safety smock, but this was not documented in other encounters. Her last segregation visit was on [redacted], the day of her suicide; objective is again "none." This is clearly below the standard of care.

3) Assessment/Plan: this is often left blank. On 7/29/15 [redacted] reported medication non-compliance and was "encouraged to speak with psychiatrist;" however, in the plan there is no documentation that the psychiatrist was notified. [redacted] was taken off suicide watch on 8/6/15; "IM presents as stable. She denies SI [suicidal ideation] and HI [homicidal ideation]. IM future-oriented, IM does not appear to be a danger to herself or others." No suicide risk assessment was documented for this encounter, which is below the standard of care.

68. Regarding visits with mental health staff, the psychological autopsy

notes that [redacted] participated in groups by mental health, "but not twice weekly as required." It also noted that the level of individual counseling provided did exceed the frequency required by policy. But in reviewing the individual counseling notes, it is quickly apparent that standardized language was used over and over again for both the objective and the assessment, regardless of the content of the subjective material provided by [redacted] (see notes from 8/7/15, 8/14/15, 8/19/15, 8/21/15). For example, on 8/19/15, days prior to her suicide, when [redacted] reports that she is having a difficult time with the deaths of her brother and cousin, mental health staff documented "IM discussed her stability" but provided no further information. Staff did not explore suicidal ideation, thoughts of self-harm, or command auditory hallucinations. However, as in prior encounters, in the objective it states, "IM presented with logical and linear thought content and structure," which is incorrect – "logical and linear" refers to thought process; [redacted]'s thought content was not addressed. The assessment states "IM denied SI/HI/AVH [suicidal ideation/homicidal ideation/audio or visual hallucinations];" however, given that this was not covered in the subjective portion of the note, it is unclear if this was actually asked. There are many other examples throughout the record of plainly inadequate documentation, creating a significant possibility that mental health staff was not aware of the gravity of [redacted]'s condition.

69. Regarding medications, there are multiple references to issues with [redacted]'s medications in notes by non-psychiatric staff, but it does not appear that the psychiatrist was notified. On 12/12/14 she reported to the psychologist that since her medications were changed two weeks previously, she has been "struggling." One option on the template was "*consult psychiatrist for possible psychotropic initiation or adjustment;*" however, the psychiatrist was not consulted. On 7/31/15, suicide watch was discontinued, while [redacted] reported that she was not taking her medications; again, it does not appear that the psychiatrist was alerted.

70. In the year prior to her death, [redacted] was only seen by a psychiatrist

three times (11/10/14, 3/18/15, and 6/22/15). This was not consistent with the Stipulation, which required that she be seen at least every 90 days (PM 88), and the psychological autopsy notes, "[o]n several occasions, the psychiatry contacts were held beyond the timeframes set by policy." During the first visit on 11/10/14, the documented mental status exam was not consistent with the history provided by [redacted], and there was no plan or risk assessment documented (the risk assessment template was left blank). On 3/18/15 [redacted] complained of being sedated from olanzapine, which was then discontinued. This medication targets mood instability and psychotic symptoms including hallucinations; however, there is no documentation of screening for ongoing psychotic symptoms, which had been documented in prior notes, and no alternative medication was considered. Finally on 6/22/15 [redacted] was seen and found to have some irritability, mood instability, and perhaps paranoia. The mood stabilizer was increased, but the level was not checked after the medication increase. Of note, [redacted]'s carbamazepine level was consistently found to be below the therapeutic range, meaning that she was not receiving the benefit of the medication, and her illness was essentially going untreated. Reviewing [redacted]'s death, the Perryville CQI minutes correctly noted that "there is risk associated with failure to note lab results [and] adjust medications if appropriate to address mood symptoms." (ADCM 225818).

71. In summary, the mental health treatment provided [redacted] in the last year of her life falls below the standard of care in several respects, all of which increased her risk of suicide. The psychological autopsy notes "[i]n retrospect, a review of [redacted]'s self-harm events suggests there may have been a progression/acceleration in the severity of those incidents." The chronic absence of psychiatric input into her treatment, even as she deteriorated, is consistent with ADC's longstanding shortage of psychiatric providers noted above. Mental health staff's infrequent contacts with [redacted], the poor communication between psychiatry and other mental health staff, inadequate medication management, and the consistently

inadequate evaluations and documentation increased the risk that [redacted]'s deteriorating condition would be missed by mental health staff. This death could have been prevented by adequate mental health care.[20]

Patient evaluations and chart review –ASPC Eyman, December 7-8, 2015

72. On December 7 and 8, 2015, accompanied by counsel for both sides, I spent two full days at ASPC-Eyman viewing housing units, evaluating patients, and reviewing records.

[redacted], [redacted]

73. I evaluated [redacted] on 12/8/15. He is a 37 year old Native American designated SMI and MH-3A whom we found posturing in his cell. Posturing is a serious psychotic symptom. Upon exam I noted him to be responding to internal stimuli, displaying thought blocking and complaining of auditory hallucinations telling him that he and his family are going to be hurt. The last psychiatric note I found in his medical record was dated 7/13/15. It listed his diagnosis as Psychotic Disorder NOS. It went on to state "off meds for two months; currently psychotic. plan-restart Prozac 20mg am and Risperdal 3mg qhs." As a MH-3A he should be seen a minimum of every 90 days. This lack of appropriate follow up has caused [redacted] untold harm. He needs to be reevaluated immediately and have his medication regimen modified.

[redacted], [redacted]

74. [redacted] is an extremely impaired man who we found placed in a cell behind an additional portable barrier. On 9/7/15 the staff noted that he was very psychotic, malodorous and uncooperative. He was designated MH-3A and SMI with the diagnosis of "Dementia." He began treatment with Haldol Decanoate 100mg every four weeks. On 10/20/15 the staff documented that "patient was almost totally mute

[20] I am informed that more than six months after her suicide, there is still no mortality review of [redacted]'s death. This is an unconscionable delay in carrying out a critical function of a correctional mental health system.

and uncooperative for answering questions for completing this evaluation." His diagnosis on this visit was "Psychotic Disorder due to another medical condition with hallucinations." The "another medical condition" was not listed but based on the 9/7/15 note, I assumed it was Dementia. A 12/2/15 note stated that [redacted] was "tangential with delusions."

75. My exam on 12/7/15 revealed that [redacted] was very psychotic (responding to internal stimuli, stating that "my bible name is Peter") and he was extremely malodorous. His treatment has not changed in that he continues to receive Haldol Decanoate 100mg every four weeks. His condition has not improved and possibly deteriorated over the last several months. He requires transfer to an inpatient level of care. The most troublesome aspect of this case is that the use of antipsychotics is contraindicated in individuals with dementia, and can result in death. So if in fact he is demented, then his Haldol Decanoate should be immediately discontinued.

[redacted], [redacted]

76. Of note, one of his diagnoses listed in a 10/1/15 note was "diseases of the nervous system complicating pregnancy, unspecified trimester." I mention this only to demonstrate how unaware the staff is of [redacted]'s psychiatric condition. [redacted] is designated MH-3A and SMI. On 12/2/15, the staff noted that "patient was referred to mental health by security; patient is yelling at night, responding to internal stimuli and 'going down hill' the last few days." The patient complained of hearing the voices of his mother and his sister screaming at him. His dose of Haldol Decanoate was evidently increased to 150 mg every two weeks. This dose is exceedingly high in that the recommended dose of Haldol Decanoate for Schizophrenia is 50mg every four weeks.

77. My evaluation on 12/7/15 revealed a very psychotic and anxious young man who began to cry while speaking with me. Although he denied feeling suicidal he readily admitted to me that the voices he hears are "freaking me out." His medication regimen needs to be reassessed and I also believe he is at risk for self-harm. He should

be placed in an inpatient psychiatric unit.

[redacted], [redacted]

78. This is the case of a very ill young man that we evaluated on 12/8/15. He is classified MH-3A and SMI. At the time of my evaluation he was on a mental health watch for "decomposition (sic), urinating on himself and property." A 9/15/15 note listed his diagnosis as schizophrenia, undifferentiated. He was being treated with the antipsychotic Trilafon 24mg QHS, Cogentin 2mg QHS and Prozac 40mg QAM. He had previously been on a mental health watch on 11/6/15 for "being found unresponsive in his shower." The nurse's ICS response was to take his vital signs and return him to mental health watch. He was then placed on mental health watch again on 12/7/15 for displaying very disorganized behavior including urinary incontinence. I could find nothing in the chart documenting any medical intervention due to this episode of incontinence.

79. My evaluation revealed a very psychotic person who could not engage in a rational conversation. This case demands acute intervention in that he has had at least two serious medical episodes (unresponsive in the shower and urinary incontinence) for which nothing has been done. For example, urinary incontinence can be the result of overmedication, bladder or kidney infection or a seizure disorder just to name a few of the possibilities. These facts coupled with his being found unresponsive in the shower demand that [redacted] receive an immediate medical workup.

80. I note that I evaluated [redacted] in 2013 and discussed his situation in my November 2013 expert report:

> [redacted], [redacted]-Eyman. At the time of my evaluation he was extremely psychotic and suicidal. There was a HNR in his chart dated 5/9/13 and he had been seen by a mental health provider on 7/16/13. Also, no evidence in that chart that he had been seen by a psychiatrist during this period. This is especially bothersome given the severity of psychotic and suicidal symptoms. (p. 36)

> One example [of patients who remain highly symptomatic] is [redacted], 170180, whom I evaluated in Eyman-Browning Unit. When I evaluated him, he was very confused, standing at times naked in his cell, responding to internal stimuli, and was unable to communicate with us in any sort of rational manner. Upon reviewing his chart, I saw that it was only the day prior to my arrival that there were any mental health notes documenting the degree of psychosis that he was experiencing. This raises the question whether he was so acutely psychotic that he only began to display these symptoms in the last couple of days. In that case, he should be sent to the hospital for closer evaluation, as this may indicate a very serious neuropsychiatric problem. On the other hand, he had been on this unit for some time, and it is more likely that he had been displaying significant psychotic symptoms over an extended period of time, and no action had been taken. (p. 65-66)

81. It is extremely concerning that, more than two years later, [redacted] is still highly symptomatic, suggesting that he is not receiving effective treatment for his mental illness.

[redacted], [redacted]

82. [redacted] is classified as SMI and MH-3A. I evaluated him on 12/8/15 and found him to be experiencing very severe auditory hallucinations as well as other psychotic symptoms. These symptoms were causing him a tremendous amount of distress. A review of his chart revealed that he is currently receiving an insufficient amount of antipsychotic medication (Trilafon 16mg Qhs). In addition, during a previous incarceration [redacted] required treatment with two different antipsychotics (Haldol and Geodon) to control his symptoms. It is unclear from the medical record why he wasn't restarted on this previous regimen. An individual counseling note from 11/19/15 stated "IM appears to be functioning marginally as evidenced by responding to internal stimuli and presenting as confused." There is no indication in the medical record that the counselor alerted the psychiatrist to the severity of the patient's condition. Finally, a mental health note from 11/30/15 states "IM reported he was doing good (while lying on his bunk.)" Although [redacted] denied feeling suicidal during my exam it is my opinion that he is at risk of self-harm

due to the severity of his untreated psychotic symptoms. He should be moved to an area of higher observation and be reevaluated by the psychiatrist.

83. I evaluated [redacted] in 2013 and discussed him in my November 2013 expert report:

> [redacted], [redacted], Florence--Medication orders were written on 6/17/13 for Haldol l5 mg twice a day and Haldol decanoate 100 mg every three weeks. This is a tremendous amount of Haldol. When I evaluated the patient on 7/15/13 he was extremely sedated, so much so he was unable to get out of his bunk to speak with me. There was no indication in the chart that the prescribing psychiatrist was aware of the degree of the patient's sedation. (p. 67)

84. In both my 2013 and 2015 evaluations, there was no indication that the psychiatrist was aware of [redacted]'s condition.

Additional record reviews

[redacted], [redacted]

Records reviewed: 9/15/2014 – 9/18/2015

85. [redacted] is a 34 year old man with chronic psychosis and prior suicide attempts. He is classified MH-3A and SMI. My review of his file reveals repeated failure to treat psychotic decompensation, including (1) failure to perform reassessment by a psychiatrist despite multiple instances of messages to the on-call psychiatrist at various points of time, (2) failure to review medication regimen at any time when patient was on mental health watch, (3) failure to re-institute involuntary psychotropic medication administration despite florid disorganization, and (4) failure to increase his level of care to an inpatient psychiatric setting for appropriate treatment.

86. On 7/16/15, a mental health referral was made after [redacted] experienced "accidental drug poisoning." There is no indication that a psychiatrist or psychologist evaluated [redacted] after he returned from an emergency visit to the hospital, despite a discharge recommendation by the hospital physician that he have a

psychiatric evaluation. No suicide risk assessment was performed, despite his history of depression, psychosis, and prior suicide attempt. He was placed on suicide watch on 7/16/15. On 7/20/15, it was noted "CO reports that IM has defecated and urinated on the ground, and drank his urine while in a yoga position." On 7/21/15, "this writer observed urine and feces on the floor." On 7/22/15, [redacted] endorsed auditory hallucinations, but was inexplicably taken off watch.

87. He was placed back on watch later that day "due to psychotic behaviors on yard," when it was noted "IM was aggressive, no clothes on, in underwear only, uncooperative, thought process disorganized, reported active [auditory hallucinations]." On 7/24/15, "he had defecated by his bedside twice. COs reported he was seen presenting with bizarre behaviors like eating his feces and urine." On 7/25/15 it was noted "I/M sitting on the floor on a pad at cell door naked with private parts in his left hand. I/M does not respond to questions when asked but appears as if he is trying to process the questions." On 7/26/15 it was noted "I/M will not use his toilet, continues to urinate and defecate on the floor of the cell." He was taken off watch on 7/27/15.

88. [redacted] was placed back on watch on 8/1/15 "due to having an altered mental status. CO's state that IM is playing with his stool, drinking his urine, and other IM's are threatening to hurt him on the yard. IM slips in and out of knowing where he is but does not make sense when he is talking, and unable to assess IM at this time." The on-call psychiatrist was notified, but there is no indication that [redacted] was actually seen by a psychiatrist. On 8/2/15 it was noted, "I/m appears paranoid about surroundings and staff. … Many bizarre statements." On 8/3/15 it was noted "unstable, delusional thoughts expressed, poor emotion regulation, aggressive behaviors."

89. He was taken off watch on 8/6/15, and placed back on watch on 8/7/15. On 8/8/15 it was noted that "he was found lying next to his feces. … Bizarre, angry and flat affect." On 8/9/15 "officers report I/M continues to display bizarre behavior

as he urinates and defecates on the cell floor." On 8/10/15 "IM sat naked on concrete with puddles of urine around him and his wet pants on the ground next to him." He was taken off watch that day.

90. Throughout this period of nearly four weeks, when [redacted] was displaying floridly psychotic behavior, there is no indication that he was ever seen by a psychiatrist, evaluated for medication changes, or considered for an inpatient level of care. This is shockingly deficient and far below any acceptable standard of care.

91. On 8/31/15, the mental health RN wrote "not able to fully assess I/M at this time as he is actively psychotic." [redacted] was again placed on watch and referred to be seen by the psychiatrist "within the next 2 weeks." This did not occur; in fact, no subsequent psychiatric evaluation is included in the available records, which extend through 9/18/15.

92. Other significant deficiencies in the care received by [redacted] include:

- Globally substandard documentation. Mental status exams are either not included, lacking in standard categories, or inconsistent with reports often located in the subjective section of the notes. There is also a lack of appropriate assessments or plans.
- Lack of comprehensive treatment plan that addresses all diagnoses listed on patient's problem list. Failure to update treatment plan appropriately (i.e. treatment plan appears to have been copied and forwarded with outdated information).
- Lack of adequate suicide risk assessment despite (1) history of prior suicide attempt, (2) "accidental overdose" requiring hospitalization during the current period of incarceration, and (3) self-report of worsening depressive symptoms.
- Multiple medication doses missed for unexplained reasons.
- He was not seen by a provider every 90 days as required by PM 81, and

did not have his treatment plan updated every 90 days as required by PM 77.

[redacted], [redacted]

Records reviewed: 11/15/14 – 11/19/15

93. [redacted] is a 74-year-old man with a reported diagnosis of Schizoaffective Disorder, incarcerated since 1998. He is classified as MH-4 and SMI. He spent the entire time period covered by this file review in the mental health area of Florence-Kasson Unit, where his mental health treatment was grossly inadequate in numerous respects.

94. Despite being housed in a designated mental health unit and carrying a diagnosis of Schizoaffective Disorder, it appears that [redacted] was never evaluated by a psychiatrist or psychologist during the entire one-year period (while he was seen once by a psychologist for a segregation visit, this encounter did not include diagnostic formulation or treatment planning). Indeed, many of [redacted]'s mental health encounters were with staff who appear to have little or no mental health training or qualifications, such as "mental health clerks" (4/1/15, 4/8/15) and "administrative assistants" (3/19/15, 4/22/15). Moreover, despite being in segregation for the entire period beginning in November 2014, he did not receive any mental health segregation visits until March 2015. As a prisoner classified MH-4, [redacted] was required to be seen by a mental health clinician for a one-on-one session at least every 30 days (PM 87); this did not occur.

95. No diagnostic formulation is included in any of the available documentation; based on this absence, it is unclear how [redacted] carries a diagnosis of Schizoaffective Disorder. Treatment plans do not address his history of chronic psychosis; indeed, the three treatment plans included in the file are identical, with no attempt to make updates or adjustments. [redacted] refused to participate in more than 50 group therapy sessions during this time period, but there was no documented effort to explore the reason for these refusals, and no attempt to adapt his

treatment plan based on his obvious aversion to groups.

96. Mental health encounters are superficial and documentation is inadequate throughout the file. There is no complete mental status exam during the entire time period. The "subjective" section of the encounter notes is identical in many notes, and appears to have been simply cut and pasted. Many notes are internally contradictory; in others, there is no discernible relationship between the patient's presentation and mental health staff's assessment or plan; in others still, critical information is simply missing.

97. For example, in a 5/20/15 encounter, a psych associate notes "an odor and sishevld [sic] clothing" and "thoughts are blocking, content obsessive." The writer continues:

> IM discusses randomly the idea that he is 'Due out any day. The government will be paying me for keeping me in for a Civil case not a criminal case. They owe me SSI and disability. I'll be killing my number my number when I get out. I'm moving to New York.'

98. Under "assessment," the writer notes "delusional about releasing any day." Despite all of this, the plan is limited to "schedule 1:1 at 30 days" and "release planning process begin" [sic]. There is no attempt at written diagnostic formulation or risk assessment for danger to self or others.

99. In a "treatment plan review" on the same date, the only problem identified is "personal hygiene;" there is no attempt to address the patient's limited coping skills or chronic psychosis, despite the fact that those conditions are documented in the treatment plan itself. In the "patient participation" section of the form, staff checked boxes for both "contributed to plan" and "unable to participate." (Similarly, in a 9/3/15 note, staff checked the box for "medication compliant," despite the fact that [redacted] was not taking any psychotropic medication).

100. There is no adequate risk assessment of danger to self or others, despite

[redacted]'s history of assault. Moreover, there is no indication that [redacted] has received cognitive testing, which is indicated in light of his age (over 70) and history of chronic psychosis.

101. Finally, although [redacted]'s release was approaching, release planning was inadequate, with no attempt to assess whether this prisoner, currently housed in mental health segregation with a diagnosis of chronic psychosis, would be able to care for himself adequately in the community.

102. In sum, the treatment [redacted] received would be grossly inadequate for any patient with his profile. But the fact that he received such inadequate treatment while housed in what is allegedly a dedicated mental health unit is indicative of just how inadequate the overall mental health care is in the Arizona Department of Corrections.

[redacted], [redacted]

Records reviewed: 10/15/2014 – 10/27/2015

103. [redacted] is a 65-year-old man with a reported diagnosis of schizoaffective disorder and prostate cancer, incarcerated since 2001, who was housed in Florence-Kasson Mental Health Unit and who developed new irritability, impulsivity, and behavioral activation in late 2015. He is classified as MH-4 and SMI. Given the patient's age and his poor health, his behavioral changes should have triggered a thorough medical work-up, including for dementia and delirium, but there is no indication that this occurred. [redacted]'s mental health treatment was below the standard of care in multiple respects.

104. No diagnostic formulation in any of the available records. Accordingly, I am somewhat unclear about [redacted]'s underlying psychiatric diagnosis. The initial sentencing document indicates that he "suffers from a chronic mental illness." However, in his medical records, his psychiatric nurse practitioner writes that the patient has "no history of MH treatment in the community." No psychotic symptoms are described until October 2015, at which point the patient is described as "paranoid

about everybody in prison." (One of the mental health segregation visit notes also describes the patient as "very loud and psychotic" in July 2015, with no further description of symptoms). None of the medical notes attempt to reconcile past symptoms and current presentation in order to explain why the patient meets criteria for schizoaffective disorder. Needless to say, an accurate diagnosis is essential to effective treatment, and an inaccurate diagnosis places the patient at risk of deterioration and further harm.

105. Documentation is globally inadequate. Most notes have no mental status exam, or the MSE is limited to checkboxes that often contradict the subjective and assessment sections. Moreover, many notes appear to have been cut and pasted, without adequate description of the patient's mental status or wellbeing on that day. For instance, approximately half of the segregation visit notes have subjective sections that are identical, using the same text that I have seen used in another prisoner's file; many of the other notes use brief stock phrases and limited details (e.g. "The I/M was doing fine on welfare check"). Diagnostic assessments are virtually non-existent. At a minimum, such documentation falls far below the standard of care. More seriously, this minimal documentation suggests that the mental health contacts were *pro forma* and superficial, and failed to elicit information that is critical to diagnosis and treatment.

106. In addition, the level of training of mental health staff is unclear. For instance, many notes are written by "psychological examiners" and by "mental health clerks." It is unclear what, if any, mental health training these persons have; I note that they are not included in the definition of "mental health clinician" or "mental health provider" in the Stipulation.

107. Failure to work up the patient's change in mental status, including failure to coordinate care among different mental health and medical treatment team members. The patient's change in behavior raises the possibility of a neurodegenerative process. Starting in July 2015, mental health segregation visit

notes indicate new anger and hostility on the part of the patient (e.g. described as "loud and verbally abusive with profanities" on 8/26/15). Although the patient was seen by a psychiatric nurse practitioner on 6/18/2015 "due to the report of more agitation," the NP limited her assessment to saying that the patient "may be depressed with mood symptoms" (despite his explicit denial of depression) and that he refused antidepressant medication at the time. This NP observed that the patient seemed increasingly frail ("Looks like lost weight, very thin and with unsteady gait. Weight checked – 101 lbs. Physical health is deteriorating."), but no medical work-up was ordered.

108. [redacted] was on mental health watch from 10/7/15 to 10/21/15, but it does not appear that he was seen by a licensed clinician or nurse on 10/17 or 10/18/15, as required by PM 94.

109. This same NP saw the patient on 10/16/15, at which point she wrote, "Based on his current behaviors, onset and age inmate may be having some medical issues like dementia or related is considered." Rather than performing baseline cognitive screening or ordering a work-up for medical complications, however, the NP initiated a PMRB (involuntary medication process) "as long acting meds can be helpful for psychotic agitation/ mood stabilization." This represents a notable gap between the diagnostic assessment and the treatment plan. Significantly, the patient underwent no cognitive testing despite his age, his poor health with recent malignancy, and his reported chronic psychosis. It is very disturbing that [redacted]'s marked physical and psychiatric deterioration over a period of many weeks did not result in any further testing or work-up.

110. Mismatch between treatment plan and diagnosis. The patient underwent two treatment plan reviews during this period (11/20/2014 and 8/22/2015; these were not done at the 90-day intervals required by PM 77). In both, the patient's diagnosis is listed as schizoaffective disorder, but the target problem is listed as "mood disturbances." Moreover, the treatment goal is "Reduce/manage depressive

symptoms." This represents a complete disconnect between the stated diagnosis and the treatment plan, which no member of the mental health staff appears to have noticed.

111. Finally, there were episodes that should have resulted in further medical evaluation, but did not. On 6/14/15, [redacted] was found unresponsive in his cell; he was seen by a nurse, but there was no further medical work-up, or any further attempt to discover the cause of this episode. On 10/15/15, [redacted] was subject to a use of force by staff. Immediately afterwards, he was seen by a nurse for a "small Laceration on right forehead" and was noted to be "somnolent." (The following day he was again noted to have "a wound on his right forehead and discoloration over left lower eye area"). The nurse cleaned the wound and stabilized the bleeding, but no other intervention was offered. Standard of care for somnolence following a head injury would mandate an immediate head CT scan, but this was not done.

112. In summary, the mental health care received by this frail elderly man was globally inadequate by any standard, but particularly in light of the fact that he is housed in what is allegedly a specialized mental health unit.

CONCLUSION

113. ADC remains out of compliance with a number of critically important mental health Performance Measures, resulting in a substantial risk of serious harm or death to ADC prisoners with mental health needs. Many of the systemic deficiencies in ADC mental health care identified in my previous reports continue to exist and result in ongoing harm to patients.

114. The ongoing failure to comply with these Performance Measures, and to provide minimally adequate mental health care, is due in significant part to the lack of a sufficient number of qualified mental health staff. ADC should be required to immediately develop a plan to increase psychiatrist, psychologist, and other mental health staff to levels that allow each prison complex to reach a passing CGAR score

(80% compliance) on each of the Performance Measures I have discussed. In addition, to ascertain the number and type of mental health staff that will be sufficient to provide minimally adequate care, ADC should be required to undertake a workload staffing study without further delay, and to create and implement a staffing plan based on the results of that study.

COMPENSATION

115. I am being compensated for my work in this case at a rate of $300 per hour, with a daily cap of $2500.

Dated this 30TH day of MARCH, 2016, at San Francisco, California.

PABLO STEWART, M.D.

CURRICULUM VITAE

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(Updated February 2016)

EDUCATION:

University of California School of Medicine, San Francisco, California, M.D., 1982

United States Naval Academy, Annapolis, MD, B.S. 1973, Major: Chemistry

LICENSURE:

California Medical License #GO50899
Hawai'i Medical License #MD-11784
Federal Drug Enforcement Administration #BS0546981
Diplomate in Psychiatry, American Board of Psychiatry and Neurology, Certificate #32564

ACADEMIC APPOINTMENTS:

September 2006-Present	Academic Appointment: Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
July 1995 - August 2006	Academic Appointment: Associate Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1989 - June 1995	Academic Appointment: Assistant Clinical Professor, Department of Psychiatry, University of California, San Francisco, School of Medicine.
August 1986 - July 1989	Academic Appointment: Clinical Instructor, Department of Psychiatry, University of California, San Francisco, School of Medicine.

EMPLOYMENT:

December 1996-Present	Psychiatric Consultant Provide consultation to governmental and private agencies on a variety of psychiatric, forensic, substance abuse and organizational issues; extensive experience in all phases of capital litigation and correctional psychiatry.

EXHIBIT 1

January 1997- September 1998	Director of Clinical Services, San Francisco Target Cities Project. Overall responsibility for ensuring the quality of the clinical services provided by the various departments of the project including the Central Intake Unit, the ACCESS Project and the San Francisco Drug Court Also responsible for providing clinical in-service trainings for the staff of the Project and community agencies that requested technical assistance.
February 1996 - November 1996	Medical Director, Comprehensive Homeless Center, Department of Veterans Affairs Medical Center, San Francisco. Overall responsibility for the medical and psychiatric services at the Homeless Center.
March 1995 - January 1996	Chief, Intensive Psychiatric Community Care Program, (IPCC) Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for the IPCC, a community based case management program. Duties also include medical/psychiatric consultation to Veteran Comprehensive Homeless Center. This is a social work managed program that provides comprehensive social services to homeless veterans.
April 1991 - February 1995	Chief, Substance Abuse Inpatient Unit, (SAIU), Department of Veterans Affairs Medical Center, San Francisco. Overall clinical/administrative responsibility for SAIU.
September 1990 - March 1991	Psychiatrist, Substance Abuse Inpatient Unit, Veterans Affairs Medical Center, San Francisco. Clinical responsibility for patients admitted to SAIU. Provide consultation to the Medical/Surgical Units regarding patients with substance abuse issues.
August 1988 - December 1989	Director, Forensic Psychiatric Services, City and County of San Francisco. Administrative and clinical responsibility for psychiatric services provided to the inmate population of San Francisco. Duties included direct clinical and administrative responsibility for the Jail Psychiatric Services and the Forensic Unit at San Francisco General Hospital.
July 1986 - August 1990	Senior Attending Psychiatrist, Forensic Unit, University of California, San Francisco General Hospital. Administrative and clinical responsibility for a 12-bed, maximum-security psychiatric ward. Clinical supervision for psychiatric residents, postdoctoral psychology fellows and medical students assigned to the ward. Liaison with Jail Psychiatric Services, City and County of San Francisco. Advise San Francisco City Attorney on issues pertaining to forensic psychiatry.

July 1985 June 1986	Chief Resident, Department of Psychiatry, University of California San Francisco General Hospital. Team leader of the Latino-focus inpatient treatment team (involving 10-12 patients with bicultural/bilingual issues); direct clinical supervision of 7 psychiatric residents and 3-6 medical students; organized weekly departmental Grand Rounds; administered and supervised departmental residents' call schedule; psychiatric consultant to hospital general medical clinic; assistant coordinator of medical student education; group seminar leader for introduction to clinical psychiatry course for UCSF second-year medical students.
July 1984 - March 1987	Physician Specialist, Westside Crisis Center, San Francisco, CA. Responsibility for Crisis Center operations during assigned shifts; admitting privileges at Mount Zion Hospital. Provided psychiatric consultation for the patients admitted to Mount Zion Hospital when requested.
April 1984 - July 1985	Psychiatric Consultant, Marin Alternative Treatment, (ACT). Provided medical and psychiatric evaluation and treatment of residential drug and alcohol clients; consultant to staff concerning medical/psychiatric issues.
August 1983 - November 1984	Physician Specialist, Mission Mental Health Crisis Center, San Francisco, CA. Clinical responsibility for Crisis Center clients; consultant to staff concerning medical/psychiatric issues.
July 1982- July 1985	Psychiatric Resident, University of California, San Francisco. Primary Therapist and Medical Consultant for the adult inpatient units at San Francisco General Hospital and San Francisco Veterans Affairs Medical Center; Medical Coordinator/Primary Therapist - Alcohol Inpatient Unit and Substance Abuse Clinic at San Francisco Veterans Affairs Medical Center; Outpatient Adult/Child Psychotherapist; Psychiatric Consultant - Adult Day Treatment Center - San Francisco Veterans Affairs Medical Center; Primary Therapist and Medial Consultant - San Francisco General Hospital Psychiatric Emergency Services; Psychiatric Consultant, Inpatient Medical/Surgical Units - San Francisco General Hospital.
June 1973 - July 1978	Infantry Officer - United States Marine Corps. Rifle Platoon Commander; Anti-tank Platoon Commander; 81mm Mortar Platoon Commander; Rifle Company Executive Officer; Rifle Company Commander; Assistant Battalion Operations Officer; Embarkation Officer; Recruitment Officer; Drug, Alcohol and Human Relations Counselor; Parachutist and Scuba Diver; Commander of a Vietnamese Refugee Camp. Received an Honorable Discharge. Highest rank attained was Captain.

HONORS AND AWARDS:

June 2015	Recognized by the Psychiatry Residents Association of the University of California, San Francisco, School of Medicine, Department of Psychiatry for "Excellence in Teaching" for the academic year 2014-2015.
June 1995	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1994/1995.
June 1993	Selected by the class of 1996, University of California, San Francisco, School of Medicine as outstanding lecturer, academic year 1992/1993.
May 1993	Elected to Membership of Medical Honor Society, AOA, by the AOA Member of the 1993 Graduating Class of the University of California, San Francisco, School of Medicine.
May 1991	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1990-1991.
May 1990	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1989-1990.
May 1989	Selected by the graduating class of the University of California, San Francisco, School of Medicine as the outstanding psychiatric faculty member for the academic year 1988-1989.
May 1987	Selected by the faculty and students of the University of California, San Francisco, School of Medicine as the recipient of the Henry J. Kaiser Award For Excellence in Teaching.
May 1987	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident. The award covered the period of 1 July 1985 to 30 June 1986, during which time I served as Chief Psychiatric resident, San Francisco General Hospital.
May 1985	Selected by the graduating class of the University of California, San Francisco, School of Medicine as Outstanding Psychiatric Resident.
1985	Mead-Johnson American Psychiatric Association Fellowship. One of sixteen nationwide psychiatric residents selected because of a demonstrated commitment to public sector psychiatry. Made presentation at Annual Hospital and Community Psychiatry Meeting in Montreal, Canada, in October 1985, on the "Psychiatric Aspects of the Acquired Immunodeficiency Syndrome."

MEMBERSHIPS:

June 2000- May 2008	California Association of Drug Court Professionals.
July 1997- June 1998	President, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1996 - June 1997	President-Elect, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1995 - June 1996	Vice President, Northern California Area, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
April 1995 - April 2002	Associate Clinical Member, American Group Psychotherapy Association.
July 1992 - June 1995	Secretary-Treasurer, Alumni-Faculty Association, University of California, San Francisco, School of Medicine.
July 1990 - June 1992	Councilor-at-large, Alumni-Faculty Association, University of California, San Francisco, School of Medicine

PUBLIC SERVICE:

June 1992	Examiner, American Board of Psychiatry and Neurology, Inc.
November 1992 - January 1994	California Tuberculosis Elimination Task Force, Institutional Control Subcommittee.
September 2000- April 2005	Editorial Advisory Board, *Juvenile Correctional Mental Health Report.*
May 2001- 2010	Psychiatric and Substance Abuse Consultant, San Francisco Police Officers' Association.
January 2002- June 2003	Psychiatric Consultant, San Francisco Sheriff's Department Peer Support Program.
February 2003- April 2004	Proposition "N" (Care Not Cash) Service Providers' Advisory Committee, Department of Human Services, City and County of San Francisco.
December 2003- January 2004	Member of San Francisco Mayor-Elect Gavin Newsom's Transition Team.

February 2004- June 2004	Mayor's Homeless Coalition, San Francisco, CA.
April 2004- January 2006	Member of Human Services Commission, City and County of San Francisco.
February 2006- January 2007; April 2013- January 2015	Vice President, Human Services Commission, City and County of San Francisco.
February 2007- March 2013; February 2015- present	President, Human Services Commission, City and County of San Francisco.

UNIVERSITY SERVICE:

October 1999- October 2001	Lecturer, University of California, San Francisco, School of Medicine Post Baccalaureate Reapplicant Program.
July 1999- July 2001	Seminar Leader, National Youth Leadership Forum On Medicine.
November 1998- November 2001	Lecturer, University of California, San Francisco, School of Nursing, Department of Family Health Care Nursing. Lecture to the Advanced Practice Nurse Practitioner Students on Alcohol, Tobacco and Other Drug Dependencies.
January 1994 - January 2001	Preceptor/Lecturer, UCSF Homeless Clinic Project.
June 1990 - November 1996	Curriculum Advisor, University of California, San Francisco, School of Medicine.
June 1987 - June 1992	Facilitate weekly Support Groups for interns in the Department of Medicine. Also, provide crisis intervention and psychiatric referral for Department of Medicine housestaff.
January 1987 – June 1988	Student Impairment Committee, University of California San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to identify, treat and prevent student impairment.
January 1986 – June 1996	Recruitment/Retention Subcommittee of the Admissions Committee, University of California, San Francisco, School of Medicine. Advise the Dean of the School of Medicine on methods to attract and retain minority students and faculty.
October 1986 - September 1987	Member Steering Committee for the Hispanic Medical Education Resource Committee. Plan and present educational programs to increase awareness of the special health needs of Hispanics in the United States.

September 1983 - June 1989	Admissions Committee, University of California, School of Medicine. Duties included screening applications and interviewing candidates for medical school.
October 1978 - December 1980	Co-Founder and Director of the University of California, San Francisco Running Clinic. Provided free instruction to the public on proper methods of exercise and preventative health measures.

TEACHING RESPONSIBILITIES:

August 2014- Present	Small Group Facilitator, Foundations of Patient Care, University of California, San Francisco, School of Medicine.
July 2003- Present	Facilitate weekly psychotherapy training group for residents in the Department of Psychiatry.
January 2002- January 2004	Course Coordinator of Elective Course University of California, San Francisco, School of Medicine, "Prisoner Health." This is a 1-unit course, which covers the unique health needs of prisoners.
September 2001- June 2003	Supervisor, San Mateo County Psychiatric Residency Program.
April 1999- April 2001	Lecturer, UCSF School of Pharmacy, Committee for Drug Awareness Community Outreach Project.
February 1998- June 2000	Lecturer, UCSF Student Enrichment Program.
January 1996 - November 1996	Supervisor, Psychiatry 110 students, Veterans Comprehensive Homeless Center.
March 1995- December 20002	Supervisor, UCSF School of Medicine, Department of Psychiatry, Substance Abuse Fellowship Program.
September 1994 - June 1999	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Drug and Alcohol Abuse." This is a 1-unit course, which covers the major aspects of drug and alcohol abuse.
August 1994 - February 2006	Supervisor, Psychiatric Continuity Clinic, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Supervise 4th Year medical students in the care of dual diagnostic patients.
February 1994 - February 2006	Consultant, Napa State Hospital Chemical Dependency Program Monthly Conference.
July 1992 - June 1994	Facilitate weekly psychiatric intern seminar, "Psychiatric Aspects of Medicine," University of California, San Francisco, School of Medicine.

July 1991- Present	Group and individual psychotherapy supervisor, Outpatient Clinic, Department of Psychiatry, University of California, San Francisco, School of Medicine.
January 1991	Lecturer, University of California, San Francisco, School of Pharmacy course, "Addictionology and Substance Abuse Prevention."
September 1990 - February 1995	Clinical supervisor, substance abuse fellows, and psychiatric residents, Substance Abuse Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - November 1996	Off ward supervisor, PGY II psychiatric residents, Psychiatric Inpatient Unit, San Francisco Veterans Affairs Medical Center.
September 1990 - June 1991	Group therapy supervisor, Psychiatric Inpatient Unit, (PIU), San Francisco Veterans Affairs Medical Center.
September 1990 - June 1994	Course coordinator, Psychiatry 110, San Francisco Veterans Affairs Medical Center.
September 1989 - November 1996	Seminar leader/lecturer, Psychiatry 100 A/B.
July 1988 - June 1992	Clinical supervisor, PGY III psychiatric residents, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project.
September 1987 - Present	Tavistock Organizational Consultant. Extensive experience as a consultant in numerous Tavistock conferences.
September 1987 - December 1993	Course Coordinator of Elective Course, University of California, San Francisco, School of Medicine. Designed, planned and taught course, Psychiatry 170.02, "Alcoholism". This is a 1-unit course offered to medical students, which covers alcoholism with special emphasis on the health professional. This course is offered fall quarter each academic year.
July 1987- June 1994	Clinical supervisor/lecturer FCM 110, San Francisco General Hospital and Veterans Affairs Medical Center.
July 1986 - June 1996	Seminar leader/lecturer Psychiatry 131 A/B.
July 1986 - August 1990	Clinical supervisor, Psychology interns/fellows, San Francisco General Hospital.
July 1986 - August 1990	Clinical supervisor PGY I psychiatric residents, San Francisco General Hospital
July 1986 -	Coordinator of Medical Student Education, University of

August 1990	California, San Francisco General Hospital, Department of Psychiatry. Teach seminars and supervise clerkships to medical students including: Psychological Core of Medicine 100 A/B; Introduction to Clinical Psychiatry 131 A/B; Core Psychiatric Clerkship 110 and Advanced Clinical Clerkship in Psychiatry 141.01.
July 1985 – August 1990	Psychiatric Consultant to the General Medical Clinic, University of California, San Francisco General Hospital. Teach and supervise medical residents in interviewing and communication skills. Provide instruction to the clinic on the psychiatric aspects of ambulatory medical care.

COMMUNITY SERVICE AND PRISON CONDITIONS EXPERT WORK:

June 2015-Present	Senior Fellow, University of California Criminal Justice & Health Consortium.
April 2014-Present	Plaintiffs' expert in *Hernandez, et al. v. County of Monterey, et al.*, No.: CV 13 2354 PSG. This case involves the provision of unconstitutional mental health and medical services to the inmate population of Monterey County Jail.
January-December 2014	Federal Bureau of Prisons: Special Housing Unit Review and Assessment. This was a year-long review of the quality of mental health services in the segregated housing units of the BOP.
August 2012-Present	Plaintiffs' expert in *Parsons et al. v. Ryan* et al., (District Court, Phoenix, Arizona.) This case involves the provision of unconstitutional mental health and medical services to the inmate population of the Arizona Department of Corrections.
October 2007 -Present	Plaintiffs' expert in 2007-2010 overcrowding litigation and in opposing current efforts by defendants to terminate the injunctive relief in *Coleman v. Brown,* United States District Court, Eastern District of California, Case No. 2:90-cv-00520-LKK-JFM. The litigation involves plaintiffs' claim that overcrowding is causing unconstitutional medical and mental health care in the California state prison system. Plaintiffs won an order requiring the state to reduce its population by approximately 45,000 state prisoners. My expert opinion was cited several times in the landmark United States Supreme Court decision upholding the prison population reduction order. *See Brown v. Plata,* __ U.S. ___, 131 S. Ct. 1910, 1933 n.6, 1935, 179 L.Ed.2d 969, 992 n.6, 994 (2011).
July/August 2008-Present	Plaintiff psychiatric expert in the case of Fred Graves, et al., plaintiffs v. Joseph Arpaio, et al., defendants (District Court, Phoenix, Arizona.) This case involved Federal oversight of the mental health treatment provided to pre-trial detainees in the Maricopa County Jails.

February 2006- December 2009	Board of Directors, Physician Foundation at California Pacific Medical Center.
June 2004- September 2012	Psychiatric Consultant, Hawaii Drug Court.
November 2003- June 2008	Organizational/Psychiatric Consultant, State of Hawaii, Department of Human Services.
June 2003- December 2004	Monitor of the psychiatric sections of the "Ayers Agreement," New Mexico Corrections Department (NMCD). This is a settlement arrived at between plaintiffs and the NMCD regarding the provision of constitutionally mandated psychiatric services for inmates placed within the Department's "Supermax" unit.
October 2002- August 2006	Juvenile Mental Health and Medical Consultant, United States Department of Justice, Civil Rights Division, Special Litigation Section.
July 1998- June 2000	Psychiatric Consultant to the Pacific Research and Training Alliance's Alcohol and Drug Disability Technical Assistance Project. This Project provides assistance to programs and communities that will have long lasting impact and permanently improve the quality of alcohol and other drug services available to individuals with disabilities.
July 1998- February 2004	Psychiatric Consultant to the National Council on Crime and Delinquency (NCCD) in its monitoring of the State of Georgia's secure juvenile detention and treatment facilities. NCCD is acting as the monitor of the agreement between the United States and Georgia to improve the quality of the juvenile justice facilities, critical mental health, medical and educational services, and treatment programs. NCCD ceased to be the monitoring agency for this project in June 1999. At that time, the Institute of Crime, Justice and Corrections at the George Washington University became the monitoring agency. The work remained unchanged.
July 1998- July 2001	Psychiatric Consultant to the San Francisco Campaign Against Drug Abuse (SF CADA).
March 1997- Present	Technical Assistance Consultant, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
January 1996- June 2003	Psychiatric Consultant to the San Francisco Drug Court.
November 1993- June 2001	Executive Committee, Addiction Technology Transfer Center (ATTC), University of California, San Diego.
December 1992 - December 1994	Institutional Review Board, Haight Ashbury Free Clinics, Inc. Review all research protocols for the clinic per Department of Health and Human Services guidelines.

June 1991- February 2006	Chief of Psychiatric Services, Haight Ashbury Free Clinic. Overall responsibility for psychiatric services at the clinic.
December 1990 - June 1991	Medical Director, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Responsible for directing all medical and psychiatric care at the clinic.
October 1996-July 1997	Psychiatric Expert for the U.S. District Court, Northern District of California, in the case of Madrid v. Gomez, No. C90-3094-TEH. Report directly to the Special Master regarding the implementation of constitutionally mandated psychiatric care to the inmates at Pelican Bay State Prison.
April 1990 –January 2000	Psychiatric Expert for the U.S. District Court, Eastern District of California, in the case of Gates v. Deukmejian, No. C1V S-87-1636 LKK-JFM. Report directly to the court regarding implementation and monitoring of the consent decree in this case. (This case involves the provision of adequate psychiatric care to the inmates at the California Medical Facility, Vacaville).
January 1984 - December 1990	Chief of Psychiatric Services, Haight Ashbury Free Clinic, Drug Detoxification and Aftercare Project. Direct medical/psychiatric management of project clients; consultant to staff on substance abuse issues. Special emphasis on dual diagnostic patients.
July 1981- December 1981	Medical/Psychiatric Consultant, Youth Services, Hospitality House, San Francisco, CA. Advised youth services staff on client management. Provided training on various topics related to adolescents. Facilitated weekly client support groups.

SERVICE TO ELEMENTARY AND SECONDARY EDUCATION:

January 1996 - June 2002	Baseball, Basketball and Volleyball Coach, Convent of the Sacred Heart Elementary School, San Francisco, CA.
September 1994 - Present	Soccer Coach, Convent of the Sacred Heart Elementary School, San Francisco, CA.
June 1991- June 1994	Board of Directors, Pacific Primary School, San Francisco, CA.
April 1989 - July 1996	Umpire, Rincon Valley Little League, Santa Rosa, CA.
September 1988 - May 1995	Numerous presentations on Mental Health/Substance Abuse issues to the student body, Hidden Valley Elementary School and Santa Rosa Jr. High School, Santa Rosa, CA.

PRESENTATIONS:

1. San Francisco Treatment Research Unit, University of California, San Francisco, Colloquium #1. (10/12/1990). "The Use of Anti-Depressant Medications with Substance-Abusing Clients."

2. Grand Rounds. Department of Psychiatry, University of California, San Francisco, School of Medicine. (12/5/1990). "Advances in the Field of Dual Diagnosis."

3. Associates Council, American College of Physicians, Northern California Region, Program for Leadership Conference, Napa, California. (3/3/1991). "Planning a Satisfying Life in Medicine."

4. 24th Annual Medical Symposium on Renal Disease, sponsored by the Medical Advisory Board of the National Kidney Foundation of Northern California, San Mateo, California. (9/11/1991). "The Chronically Ill Substance Abuser."

5. Mentoring Skills Conference, University of California, San Francisco, School of Medicine, Department of Pediatrics. (11/26/91). "Mentoring as an Art."

6. Continuing Medical Education Conference, Sponsored by the Department of Psychiatry, University of California, San Francisco, School of Medicine. (4/25/1992). "Clinical & Research Advances in the Treatment of Alcoholism and Drug Abuse."

7. First International Conference of Mental Health and Leisure. University of Utah. (7/9/1992). "The Use of Commonly Abused Street Drugs in the Treatment of Mental Illness."

8. American Group Psychotherapy Association Annual Meeting, San Francisco, California. (2/20/1993). "Inpatient Groups in Initial-Stage Addiction Treatment."

9. Grand Rounds. Department of Child Psychiatry, Stanford University School of Medicine. (3/17/93, 9/11/96). "Issues in Adolescent Substance Abuse."

10. University of California, Extension. Alcohol and Drug Abuse Studies Program. (5/14/93), (6/24/94), (9/22/95), (2/28/97). "Dual Diagnosis."

11. American Psychiatric Association Annual Meeting. (5/26/1993). "Issues in the Treatment of the Dual Diagnosis Patient."

12. Long Beach Regional Medical Education Center and Social Work Service, San Francisco Veterans Affairs Medical Center Conference on Dual Diagnosis. (6/23/1993). "Dual Diagnosis Treatment Issues."

13. Utah Medical Association Annual Meeting, Salt Lake City, Utah. (10/7/93). "Prescription Drug Abuse Helping your Patient, Protecting Yourself."

14. Saint Francis Memorial Hospital, San Francisco, Medical Staff Conference. (11/30/1993). "Management of Patients with Dual Diagnosis and Alcohol Withdrawal."

15. Haight Ashbury Free Clinic's 27th Anniversary Conference. (6/10/94). "Attention Deficit Disorder, Substance Abuse, Psychiatric Disorders and Related Issues."

16. University of California, San Diego. Addiction Technology Transfer Center Annual Summer Clinical Institute: (8/30/94), (8/29/95), (8/5/96), (8/4/97), (8/3/98). "Treating Multiple Disorders."

17. National Resource Center on Homelessness and Mental Illness, A Training Institute for Psychiatrists. (9/10/94). "Psychiatry, Homelessness, and Serious Mental Illness."

18. Value Behavioral Health/American Psychiatry Management Seminar. (12/1/1994). "Substance Abuse/Dual Diagnosis in the Work Setting."

19. Grand Rounds. Department of Oral and Maxillofacial Surgery, University of California, San Francisco, School of Dentistry. (1/24/1995). "Models of Addiction."

20. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project. (1/25/95, 1/24/96, 1/13/97, 1/21/98, 1/13/99, 1/24/00, 1/12/01). "Demystifying Dual Diagnosis."

21. First Annual Conference on the Dually Disordered. (3/10/1995). "Assessment of Substance Abuse." Sponsored by the Division of Mental Health and Substance Abuse Services and Target Cities Project, Department of Public Health, City and County of San Francisco.

22. Delta Memorial Hospital, Antioch, California, Medical Staff Conference. (3/28/1995). "Dealing with the Alcohol and Drug Dependent Patient." Sponsored by University of California, San Francisco, School of Medicine, Office of Continuing Medical Education.

23. Centre Hospitalier Robert-Giffaard, Beoupont (Quebec), Canada. (11/23/95). "Reconfiguration of Psychiatric Services in Quebec Based on the San Francisco Experience."

24. The Labor and Employment Section of the State Bar of California. (1/19/96). "Understanding Alcoholism and its Impact on the Legal Profession." MCCE Conference, San Francisco, CA.

25. American Group Psychotherapy Association, Annual Training Institute. (2/13-2/14/96), National Instructor - Designate training group.

26. American Group Psychotherapy Association, Annual Meeting. (2/10/96). "The Process Group at Work."

27. Medical Staff Conference, Kaiser Foundation Hospital, Pleasanton, California, "The Management of Prescription Drug Addiction". (4/24/96)

28. International European Drug Abuse Treatment Training Project, Ankaran, Slovenia, "The Management of the Dually Diagnosed Patient in Former Soviet Block Europe". (10/5-10/11/96)

29. Contra Costa County Dual Diagnosis Conference, Pleasant Hill, California, "Two Philosophies, Two Approaches: One Client". (11/14/96)

30. Faith Initiative Conference, San Francisco, California, "Spirituality: The Forgotten Dimension of Recovery". (11/22/96)

31. Alameda County Dual Diagnosis Conference, Alameda, California, "Medical Management of the Dually Diagnosed Patient". (2/4/97, 3/4/97)

32. Haight Ashbury Free Clinic's 30th Anniversary Conference, San Francisco, California, "Indicators for the Use of the New Antipsychotics". (6/4/97)

33. DPH/Community Substance Abuse Services/San Francisco Target Cities Project sponsored conference, "Intake, Assessment and Service Linkages in the Substance Abuse System of Care", San Francisco, California. (7/31/97)

34. The Institute of Addictions Studies and Lewis and Clark College sponsored conference, 1997 Northwest Regional Summer Institute, "Addictions Treatment: What We Know Today, How We'll Practice Tomorrow; Assessment and Treatment of the High-Risk Offender". Wilsonville, Oregon. (8/1/97)

35. The California Council of Community Mental Health Agencies Winter Conference, Key Note Presentation, "Combining funding sources and integrating treatment for addiction problems for children, adolescents and adults, as well as coordination of addiction treatment for parents with mental health services to severely emotionally disturbed children." Newport Beach, California. (2/12/98)

36. American Group Psychotherapy Association, Annual Training Institute, Chicago, Illinois. (2/16-2/28/1998), Intermediate Level Process Group Leader.

37. "Multimodal Psychoanalytic Treatment of Psychotic Disorders: Learning from the Quebec Experience." The Haight Ashbury Free Clinics Inc., sponsored this seminar in conjunction with the San Francisco Society for Lacanian Studies and the Lacanian School of Psychoanalysis. San Francisco, California. (3/6-3/8/1998)

38. "AIDS Update for Primary Care: Substance Use & HIV: Problem Solving at the Intersection." The East Bay AIDS Education & Training Center and the East Bay AIDS Center, Alta Bates Medical Center, Berkeley, California sponsored this conference. (6/4/1998)

39. Haight Ashbury Free Clinic's 31st Anniversary Conference, San Francisco, California, "Commonly Encountered Psychiatric Problems in Women." (6/11/1998)

40. Community Networking Breakfast sponsored by San Mateo County Alcohol & Drug Services and Youth Empowering Systems, Belmont, California, "Dual Diagnosis, Two Approaches, Two Philosophies, One Patient." (6/17/1998)

41. Grand Rounds, Department of Medicine, Alameda County Medical Center-Highland Campus, Oakland, California, "Medical/Psychiatric Presentation of the Patient with both Psychiatric and Substance Abuse Problems." (6/19/1998)

42. "Rehabilitation, Recovery, and Reality: Community Treatment of the Dually Diagnosed Consumer." The Occupational Therapy Association of California, Dominican College of San Rafael and the Psychiatric Occupational Therapy Action Coalition sponsored this conference. San Rafael, California. (6/20/1998)

43. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", Los Angeles County Department of Mental Health sponsored conference, Los Angeles, CA. (6/29/98)

44. Grand Rounds, Wai'anae Coast Comprehensive Health Center, Wai'anae, Hawaii, "Assessment and Treatment of the Patient who presents with concurrent Depression and Substance Abuse." (7/15/1998)

45. "Dual Diagnostic Aspects of Methamphetamine Abuse", Hawaii Department of Health, Alcohol and Drug Abuse Division sponsored conference, Honolulu, Hawaii. (9/2/98)

46. 9th Annual Advanced Pain and Symptom Management, the Art of Pain Management Conference, sponsored by Visiting Nurses and Hospice of San Francisco. "Care Issues and Pain Management for Chemically Dependent Patients." San Francisco, CA. (9/10/98)

47. Latino Behavioral Health Institute Annual Conference, "Margin to Mainstream III: Latino Health Care 2000." "Mental Illness and Substance Abuse Assessment: Diagnosis and Treatment Planning for the Dually Diagnosed", Los Angeles, CA. (9/18/98)

48. Chemical Dependency Conference, Department of Mental Health, Napa State Hospital, "Substance Abuse and Major Depressive Disorder." Napa, CA. (9/23/98)

49. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", San Mateo County Drug and Alcohol Services, Belmont, CA. (9/30/98)

50. "Assessment, Diagnosis and Treatment of the Patient with a Dual Diagnosis", Sacramento County Department of Mental Health, Sacramento, CA. (10/13/98)

51. California Department of Health, Office of AIDS, 1998 Annual AIDS Case Management Program/Medi-Cal Waiver Program (CMP/MCWP) Conference, "Triple Diagnosis: What's Really Happening with your Patient." Concord, CA. (10/15/98)

52. California Mental Health Director's Association Meeting: Dual Diagnosis, Effective Models of Collaboration; "Multiple Problem Patients: Designing a System to Meet Their Unique Needs", San Francisco Park Plaza Hotel. (10/15/98)

53. Northwest GTA Health Corporation, Peel Memorial Hospital, Annual Mental Health Conference, "Recognition and Assessment of Substance Abuse in Mental Illness." Brampton, Ontario, Canada. (10/23/98)

54. 1998 California Drug Court Symposium, "Mental Health Issues and Drug Involved Offenders." Sacramento, CA. (12/11/98)

55. "Assessment, Diagnosis and Treatment Planning for the Dually Diagnosed", Mono County Alcohol and Drug Programs, Mammoth Lakes, CA. (1/7/99)

56. Medical Staff Conference, Kaiser Foundation Hospital, Walnut Creek, CA, "Substance Abuse and Major Depressive Disorder." (1/19/99)

57. "Issues and Strategies in the Treatment of Substance Abusers", Alameda County Consolidated Drug Courts, Oakland, CA. (1/22/99 & 2/5/99)

58. Compass Health Care's 12th Annual Winter Conference on Addiction, Tucson, AZ: "Dual Systems, Dual Philosophies, One Patient", "Substance Abuse and Developmental Disabilities" & "Assessment and Treatment of the High Risk Offender." (2/17/99)

59. American Group Psychotherapy Association, Annual Training Institute, Houston, Texas. (2/22-2/24/1999). Entry Level Process Group Leader.

60. "Exploring A New Framework: New Technologies For Addiction And Recovery", Maui County Department of Housing and Human Concerns, Malama Family Recovery Center, Maui, Hawaii. (3/5 & 3/6/99)

61. "Assessment, Diagnosis and Treatment of the Dual Diagnostic Patient", San Bernardino County Office of Alcohol & Drug Treatment Services, San Bernardino, CA. (3/10/99)

62. "Smoking Cessation in the Chronically Mentally Ill, Part 1", California Department of Mental Health, Napa State Hospital, Napa, CA. (3/11/99)

63. "Dual Diagnosis and Effective Methods of Collaboration", County of Tulare Health & Human Services Agency, Visalia, CA. (3/17/99)

64. Pfizer Pharmaceuticals sponsored lecture tour of Hawai'i. Lectures included: Major Depressive Disorder and Substance Abuse, Treatment Strategies for Depression and Anxiety with the Substance Abusing Patient, Advances in the Field of Dual Diagnosis & Addressing the Needs of the Patient with Multiple Substance Dependencies. Lecture sites included: Straub Hospital, Honolulu; Maui County Community Mental Health; Veterans Administration Hospital, Honolulu; Hawai'i (Big Island) County Community Mental Health; Mililani (Oahu) Physicians Center; Kahi Mohala (Oahu) Psychiatric Hospital; Hale ola Ka'u (Big Island) Residential Treatment Facility. (4/2-4/9/99)

65. "Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders", Mendocino County Department of Public Health, Division of Alcohol & Other Drug Programs, Ukiah, CA. (4/14/99)

66. "Assessment of the Substance Abusing & Mentally Ill Female Patient in Early Recovery", Ujima Family Services Agency, Richmond, CA. (4/21/99)

67. California Institute for Mental Health, Adult System of Care Conference, "Partners in Excellence", Riverside, California. (4/29/99)

68. "Advances in the Field of Dual Diagnosis", University of Hawai'i School of Medicine, Department of Psychiatry Grand Rounds, Queens Hospital, Honolulu, Hawai'i. (4/30/99)

69. State of Hawai'i Department of Health, Mental Health Division, "Strategic Planning to Address the Concerns of the United States Department of Justice for the Alleged Civil Rights Abuses in the Kaneohe State Hospital." Honolulu, Hawai'i. (4/30/99)

70. "Assessment, Diagnosis and Treatment Planning for the Patient with Dual/Triple Diagnosis", State of Hawai'i, Department of Health, Drug and Alcohol Abuse Division, Dole Cannery, Honolulu, Hawai'i. (4/30/99)

71. 11th Annual Early Intervention Program Conference, State of California Department of Health Services, Office of Aids, "Addressing the Substance Abuse and Mental Health Needs of the HIV (+) Patient." Concord, California. (5/6/99)

72. The HIV Challenge Medical Conference, Sponsored by the North County (San Diego) AIDS Coalition, "Addressing the Substance Abuse and Mental Health Needs of the HIV (+) Patient." Escondido, California. (5/7/99)

73. "Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders", Sonoma County Community Mental Health's Monthly Grand Rounds, Community Hospital, Santa Rosa, California. (5/13/99)

74. "Developing & Providing Effective Services for Dually Diagnosed or High Service Utilizing Consumers", third annual conference presented by the Southern California Mental Health Directors Association. Anaheim, California. (5/21/99)

75. 15th Annual Idaho Conference on Alcohol and Drug Dependency, lectures included "Dual Diagnostic Issues", "Impulse Control Disorders" and "Major Depressive Disorder." Boise State University, Boise, Idaho. (5/25/99)

76. "Smoking Cessation in the Chronically Mentally Ill, Part 2", California Department of Mental Health, Napa State Hospital, Napa, California. (6/3/99)

77. "Alcohol and Drug Abuse: Systems of Care and Treatment in the United States", Ando Hospital, Kyoto, Japan. (6/14/99)

78. "Alcoholism: Practical Approaches to Diagnosis and Treatment", National Institute On Alcoholism, Kurihama National Hospital, Yokosuka, Japan. (6/17/99)

79. "Adolescent Drug and Alcohol Abuse", Kusatsu Kinrofukushi Center, Kusatsu, Japan. (6/22/99)

80. "Assessment, Diagnosis and Treatment of the Patient with Multiple Diagnoses", Osaka Drug Addiction Rehabilitation Center Support Network, Kobe, Japan. (6/26/99)

81. "Assessment, Diagnosis and Treatment of the Patient with Multiple Diagnoses", Santa Barbara County Department of Alcohol, Drug, & Mental Health Services, Buellton, California. (7/13/99)

82. "Drug and Alcohol Issues in the Primary Care Setting", County of Tulare Health & Human Services Agency, Edison Ag Tac Center, Tulare, California. (7/15/99)

83. "Working with the Substance Abuser in the Criminal Justice System", San Mateo County Alcohol and Drug Services and Adult Probation Department, Redwood City, California. (7/22/99)

84. 1999 Summer Clinical Institute In Addiction Studies, University of California, San Diego School of Medicine, Department of Psychiatry. Lectures included: "Triple Diagnosis: HIV, Substance Abuse and Mental Illness. What's Really Happening to your Patient?" "Psychiatric Assessment in the Criminal Justice Setting, Learning to Detect Malingering." La Jolla, California. (8/3/99)

85. "Assessment, Diagnosis and Treatment Planning for the Patient with Dual and Triple Diagnoses", Maui County Department of Housing and Human Concerns, Maui Memorial Medical Center. Kahului, Maui. (8/23/99)

86. "Proper Assessment of the Asian/Pacific Islander Dual Diagnostic Patient", Asian American Recovery Services, Inc., San Francisco, California. (9/13/99)

87. "Assessment and Treatment of the Dual Diagnostic Patient in a Health Maintenance Organization", Alcohol and Drug Abuse Program, the Permanente Medical Group, Inc., Santa Rosa, California. (9/14/99)

88. "Dual Diagnosis", Residential Care Providers of Adult Residential Facilities and Facilities for the Elderly, City and County of San Francisco, Department of Public Health, Public Health Division, San Francisco, California. (9/16/99)

89. "Medical and Psychiatric Aspects of Methamphetamine Abuse", Fifth Annual Latino Behavioral Health Institute Conference, Universal City, California. (9/23/99)

90. "Criminal Justice & Substance Abuse", University of California, San Diego & Arizona Department of Corrections, Phoenix, Arizona. (9/28/99)

91. "Creating Balance in the Ohana: Assessment and Treatment Planning", Hale O Ka'u Center, Pahala, Hawai'i. (10/8-10/10/99)

92. "Substance Abuse Issues of Runaway and Homeless Youth", Homeless Youth 101, Oakland Asian Cultural Center, Oakland, California. (10/12/99)

93. "Mental Illness & Drug Abuse - Part II", Sonoma County Department of Mental Health Grand Rounds, Santa Rosa, California. (10/14/99)

94. "Dual Diagnosis/Co-Existing Disorders Training", Yolo County Department of Alcohol, Drug and Mental Health Services, Davis, California. (10/21/99)

95. "Mental Health/Substance Abuse Assessment Skills for the Frontline Staff", Los Angeles County Department of Mental Health, Los Angeles, California. (1/27/00)

96. "Spirituality in Substance Abuse Treatment", Asian American Recovery Services, Inc., San Francisco, California. (3/6/00)

97. "What Every Probation Officer Needs to Know about Alcohol Abuse", San Mateo County Probation Department, San Mateo, California. (3/16/00)

98. "Empathy at its Finest", Plenary Presentation to the California Forensic Mental Health Association's Annual Conference, Asilomar, California. (3/17/00)

99. "Model for Health Appraisal for Minors Entering Detention", Juvenile Justice Health Care Committee's Annual Conference, Asilomar, California. (4/3/00)

100. "The Impact of Alcohol/Drug Abuse and Mental Disorders on Adolescent Development", Humboldt County Department of Mental Health and Substance Abuse Services, Eureka, California. (4/4-4/5/00)

101. "The Dual Diagnosed Client", Imperial County Children's System of Care Spring Training, Holtville, California. (5/15/00)

102. National Association of Drug Court Professionals 6th Annual Training Conference, San Francisco, California. "Managing People of Different Pathologies in Mental Health Courts", (5/31 & 6/1/00); "Assessment and Management of Co-Occurring Disorders" (6/2/00).

103. "Culture, Age and Gender Specific Perspectives on Dual Diagnosis", University of California Berkeley Extension Course, San Francisco, California. (6/9/00)

104. "The Impact of Alcohol/Drug Abuse and Mental Disorders on Adolescent Development", Thunder Road Adolescent Treatment Centers, Inc., Oakland, California. (6/29 & 7/27/00)

105. "Assessing the Needs of the Entire Patient: Empathy at its Finest", NAMI California Annual Conference, Burlingame, California. (9/8/00)

106. "The Effects of Drugs and Alcohol on the Brain and Behavior", The Second National Seminar on Mental Health and the Criminal Law, San Francisco, California. (9/9/00)

107. Annual Conference of the Associated Treatment Providers of New Jersey, Atlantic City, New Jersey. "Advances in Psychopharmacological Treatment with the Chemically Dependent Person" & "Treatment of the Adolescent Substance Abuser" (10/25/00).

108. "Psychiatric Crises In The Primary Care Setting", Doctor Marina Bermudez Issues In College Health, San Francisco State University Student Health Service. (11/1/00, 3/13/01)

109. "Co-Occurring Disorders: Substance Abuse and Mental Health", California Continuing Judicial Studies Program, Center For Judicial Education and Research, Long Beach, California. (11/12-11/17/00)

110. "Adolescent Substance Abuse Treatment", Alameda County Behavioral Health Care Services, Oakland, California. (12/5/00)

111. "Wasn't One Problem Enough?" Mental Health and Substance Abuse Issues. 2001 California Drug Court Symposium, "Taking Drug Courts into the New Millennium." Costa Mesa, California. (3/2/01)

112. "The Impact of Alcohol/Drug Abuse and Mental Health Disorders on the Developmental Process." County of Sonoma Department of Health Services, Alcohol and Other Drug Services Division. Santa Rosa, California. (3/8 & 4/5/01)

113. "Assessment of the Patient with Substance Abuse and Mental Health Issues." San Mateo County General Hospital Grand Rounds. San Mateo, California. (3/13/01)

114. "Dual Diagnosis-Assessment and Treatment Issues." Ventura County Behavioral Health Department Alcohol and Drug Programs Training Institute, Ventura, California. (5/8/01)

115. Alameda County District Attorney's Office 4th Annual 3R Conference, "Strategies for Dealing with Teen Substance Abuse." Berkeley, California. (5/10/01)

116. National Association of Drug Court Professionals 7th Annual Training Conference, "Changing the Face of Criminal Justice." I presented three separate lectures on the following topics: Marijuana, Opiates and Alcohol. New Orleans, LA. (6/1-6/2/01)

117. Santa Clara County Drug Court Training Institute, "The Assessment, Diagnosis and Treatment of the Patient with Multiple Disorders." San Jose, California. (6/15/01)

118. Washington Association of Prosecuting Attorneys Annual Conference, "Psychiatric Complications of the Methamphetamine Abuser." Olympia, Washington. (11/15/01)

119. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project, "Adolescent Development and Dual Diagnosis." (1/14/02)

120. First Annual Bi-National Conference sponsored by the Imperial County Behavioral Health Services, "Models of Family Interventions in Border Areas." El Centro, California. (1/28/02)

121. The California Association for Alcohol and Drug Educators 16th Annual Conference, "Assessment, Diagnosis and Treatment of Patients with Multiple Diagnoses." Burlingame, California. (4/25/02)

122. Marin County Department of Health and Human Services, Dual Diagnosis and Cultural Competence Conference, "Cultural Considerations in Working with the Latino Patient." (5/21/02)

123. 3rd Annual Los Angeles County Law Enforcement and Mental Health Conference, "The Impact of Mental Illness and Substance Abuse on the Criminal Justice System." (6/5/02)

124. New Mexico Department of Corrections, "Group Psychotherapy Training." Santa Fe, New Mexico. (8/5/02)

125. Judicial Council of California, Administrative Office of the Courts, "Juvenile Delinquency and the Courts: 2002." Berkeley, California. (8/15/02)

126. California Department of Alcohol and Drug Programs, "Adolescent Development and Dual Diagnosis." Sacramento, California. (8/22/02)

127. Haight Ashbury Free Clinic's 36th Anniversary Conference, San Francisco, California, "Psychiatric Approaches to Treating the Multiple Diagnostic Patient." (6/6/03)

128. Motivational Speaker for Regional Co-Occurring Disorders Training sponsored by the California State Department of Alcohol and Drug Programs and Mental Health and the Substance Abuse Mental Health Services Administration-Center for Substance Abuse Treatment, Samuel Merritt College, Health Education Center, Oakland, California. (9/4/03)

129. "Recreational Drugs, Parts I and II", Doctor Marina Bermudez Issues In College Health, San Francisco State University Student Health Service. (10/1/03), (12/3/03)

130. "Detecting Substance Abuse in our Clients", California Attorneys for Criminal Justice Annual Conference, Berkeley, California. (10/18/03)

131. "Alcohol, Alcoholism and the Labor Relations Professional", 10th Annual Labor and Employment Public Sector Program, sponsored by the State Bar of California. Labor and Employment Section. Pasadena, California. (4/2/04)

132. Lecture tour of Japan (4/8-4/18/04). "Best Practices for Drug and Alcohol Treatment." Lectures were presented in Osaka, Tokyo and Kyoto for the Drug Abuse Rehabilitation Center of Japan.

133. San Francisco State University, School of Social Work, Title IV-E Child Welfare Training Project, "Adolescent Development and Dual Diagnosis." (9/9/04)

134. "Substance Abuse and the Labor Relations Professional", 11th Annual Labor and Employment Public Sector Program, sponsored by the State Bar of California. Labor and Employment Section. Sacramento, California. (4/8/05)

135. "Substance Abuse Treatment in the United States", Clinical Masters Japan Program, Alliant International University. San Francisco, California. (8/13/05)

136. Habeas Corpus Resource Center, Mental Health Update, "Understanding Substance Abuse." San Francisco, California. (10/24/05)

137. Yolo County Department of Behavioral Health, "Psychiatric Aspects of Drug and Alcohol Abuse." Woodland, California. (1/25/06), (6/23/06)

138. "Methamphetamine-Induced Dual Diagnostic Issues", Medical Grand Rounds, Wilcox Memorial Hospital, Lihue, Kauai. (2/13/06)

139. Lecture tour of Japan (4/13-4/23/06). "Assessment and Treatment of the Patient with Substance Abuse and Mental Illness." Lectures were presented in Hiroshima and Kyoto for the Drug Abuse Rehabilitation Center of Japan.

140. "Co-Occurring Disorders: Isn't It Time We Finally Got It Right?" California Association of Drug Court Professionals, 2006 Annual Conference. Sacramento, California. (4/25/06)

141. "Proper Assessment of Drug Court Clients", Hawaii Drug Court, Honolulu. (6/29/06)

142. "Understanding Normal Adolescent Development," California Association of Drug Court Professionals, 2007 Annual Conference. Sacramento, California. (4/27/07)

143. "Dual Diagnosis in the United States," Conference sponsored by the Genesis Substance Abuse Treatment Network. Medford, Oregon. (5/10/07)

144. "Substance Abuse and Mental Illness: One Plus One Equals Trouble," National Association of Criminal Defense Lawyers 2007 Annual Meeting & Seminar. San Francisco, California. (8/2/07)

145. "Capital Punishment," Human Writes 2007 Conference. London, England. (10/6/07)

146. "Co-Occurring Disorders for the New Millennium," California Hispanic Commission on Alcohol and Drug Abuse, Montebello, California. (10/30/07)

147. "Methamphetamine-Induced Dual Diagnostic Issues for the Child Welfare Professional," Beyond the Bench Conference. San Diego, California. (12/13/07)

148. "Working with Mentally Ill Clients and Effectively Using Your Expert(s)," 2008 National Defender Investigator Association (NDIA), National Conference, Las Vegas, Nevada. (4/10/08)

149. "Mental Health Aspects of Diminished Capacity and Competency," Washington Courts District/Municipal Court Judges' Spring Program. Chelan, Washington. (6/3/08)

150. "Reflection on a Career in Substance Abuse Treatment, Progress not Perfection," California Department of Alcohol and Drug Programs 2008 Conference. Burlingame, California. (6/19/08)

151. Mental Health and Substance Abuse Training, Wyoming Department of Health, "Diagnosis and Treatment of Co-occurring Mental Health and Substance Abuse." Buffalo, Wyoming. (10/6/09)

152. 2010 B.E. Witkin Judicial College of California, "Alcohol and Other Drugs and the Courts." San Jose, California. (August 4th & 5th, 2010)

153. Facilitating Offender Re-entry to Reduce Recidivism: A Workshop for Teams, Menlo Park, CA. This conference was designed to assist Federal Courts to reduce recidivism. "The Mentally-Ill Offender in Reentry Courts," (9/15/2010)

154. Juvenile Delinquency Orientation, "Adolescent Substance Abuse." This was part of the "Primary Assignment Orientations" for newly appointed Juvenile Court Judges presented by The Center for Judicial Education and Research of the Administrative Office of the Court. San Francisco, California. (1/12/2011, 1/25/12, 2/27/13 & 1/8/14)

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157. Mexican Capital Legal Assistance Program Meeting, "Issues Related to Mental Illness in Mexican Nationals." Santa Fe, New Mexico (10/12/12); Houston, Texas (4/23/13)

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159. "Perspectives on Race and Ethnicity for Capital and Non-Capital Defense Lawyers," conference sponsored by the Administrative Office of the US Courts, New York, NY., September 18-20, 2015.

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Third Supplemental Expert Report of Pablo Stewart, M.D.

Parsons v. Ryan, No. 2:12-cv-00601-DJH (D. Ariz.)

August 29, 2014

EXHIBIT 2

Introduction

I have been asked to review medical records and other documents covering the period from September 27, 2013 through April 1, 2014. The documents provided to me are listed in Appendix A, attached hereto.

More specifically, I have been asked to consider whether these documents demonstrate any significant change in the delivery of mental health services in the Arizona Department of Corrections (ADC), or in conditions of confinement for prisoners with mental illness, such that I would change one or more of the opinions expressed in my previous reports. See Expert Report of Pablo Stewart, M.D., November 8, 2013; Supplemental Expert Report of Pablo Stewart, M.D., December 9, 2013; Rebuttal Expert Report of Pablo Stewart, M.D., January 31, 2014; Second Supplemental Report of Pablo Stewart, M.D., February 24, 2014.[1] I reserve the right to supplement or modify these opinions as additional information becomes available.

As explained more fully below, it is my opinion that the problems I identified in my previous reports persisted during the period between September 27, 2013 and April 1, 2014. Accordingly, I stand by the opinions I have previously expressed in this case.

[1] These reports were attached to and incorporated by reference in my declaration submitted to the Court on June 18, 2014 as Doc. 947, Exhibits 1-4.

Inadequate Staffing

In my initial report I expressed the opinion that "pervasive and longstanding staffing shortages in ADC's health care system undermine the ability of clinicians to provide minimally adequate mental health care services." 11/8/13 Report at 11. Defendants' own monitoring reports (known as MGAR reports) continue to show shortages, both of mental health staff and of other health care staff that are essential to the delivery of mental health services, such as nurses and medical records staff:

> "There are vacancies with [] ongoing recruiting efforts in the areas of medical director, psychiatry, dental, and nursing." ADC 211268 (Lewis).
>
> "There are vacancies that impair the adequacy of staff," including nursing and medical records staff. ADC 211318 (Perryville).
>
> "San Pedro does not have a full time medical records librarian. It is very difficult to keep up with the filing, movement, and other activities when that position is filled only part-time." ADC 268943 (Perryville).
>
> "Positions of Director of Nursing, psych techs, medical records, Facility Health Administrator are vacant resulting in non compliance." ADC 211371 (Phoenix). See also AGA_Review 108408 (indicating that psychiatric director position is vacant at Phoenix and may have been vacant for more than 60 days).
>
> "Key positions yet to be filled include: (1) Medical Director; (1) Psychiatric RN; (1) Psychologist; (3) Nursing Supervisors. … Although, nursing and Mental Health staff levels are improving, levels do not appear adequate to meet the need at the current time." ADC 211175 (Eyman).
>
> "There are vacancies that must be filled in order to meet the needs of the inmate population." ADC 211566 (Yuma).

> "Per site staff, no psychiatry provider was scheduled to be on the unit for the foreseeable future." ADC 210980 (Tucson).
>
> "The Psyche Associate was also terminated which has added to the already heavy burden on nursing." ADC 211508 (Winslow).
>
> "The fact that there is not a [mental health] Clinician on site every day is a staffing issue that must be addressed to be in compliance with this performance measure." ADC 422598 (Winslow).
>
> "There are multiple compliance issues with Mental Health at the Douglas Complex. The Psych Associate was terminated on 1/22/14. Deborah Kinder will try to do her best, but clearly this Complex cannot be compliant without a Mental Health Provider." ADC 268367 (Douglas).[2]

Arthur Gross, Assistant Director of ADC's Health Services Contract Monitoring Bureau, had this to say about mental health staffing at Eyman:

> Eyman's SCD for [mental health] is 12 FTEs; and 8.5 positions are listed as being filled, with only 7.26 actually working … . This level of coverage is unacceptable. No wonder there are problems with [mental health] issues at Eyman. 2 more Psych Associates, 1 more [mental health] RN and 2 [mental health] Techs are projected to be in the future SCD at Eyman. So 17 are projected for [mental health] coverage down the road, which doesn't truly address the underlining [sic] REAL problem. Corizon can't fill the 12 FTEs they currently are recruiting to fill. Yikes?!?!?!!!!"

AGA_Review 107026.

[2] Although I was told that prisoners with mental health needs are not housed at the Douglas, Winslow, and Safford complexes, this is apparently not true. ADC 268367 (Douglas) ("We should not have MH 3 Inmates at our complex. However we frequently are getting them in from other yards").

These staffing shortages result in needed services not being provided. ADC 211416 ("On 12/27 this auditor was there all day and Nurseline was not conducted. Nurse stated she had no time") (Tucson); 268381 ("Nurse's Lines (NL) were not run daily Monday-Friday during January, 2014 on any of the five ASPC-Eyman yards"); 268931 ("Nurse line is required to be staffed by a Registered Nurse. That has consistently not been the case at San Pedro for several months and from time to time on other yards") (Perryville). In addition, it is my opinion that many of the failures of mental health treatment described below are attributable, in whole or in part, to inadequate staffing.

In addition to these staffing shortages, ADC does not reliably verify that the health care staff it does have are licensed. At Lewis, the "Databease [sic] of all licensure staff indicates that there are 9 nursing staff, 4 [mental health] staff, 1 dental staff and 2 providers with noted licenses that are expired." ADC 210412. At Yuma, "some of the licenses of the medical staff were not current and up to date." ADC 211567.

Inadequate medical records

In my initial report, I noted that "[a]t every prison I visited, the records were disorganized to the point of being chaotic, and frequently incomplete, making it very difficult or impossible to follow the patient's history and course of treatment." 11/8/13 Report at 19. As I describe below, I found that this continues

to be true of the records I reviewed covering the period from September 27, 2013 to April 1, 2014.

In addition, the MGAR reports show continuing defects in ADC's medical records. At Lewis, "There is a significant backlog of loose filing with dates ranging from February 2013 – October 2013." ADC 210387. At Tucson, "there appears to be missing watch notes from inmate's chart as it is unclear when the inmate was placed on watch." ADC 269372. See also ADC 211291 ("significant loose filing") (Perryville); 211243 (loose filing "equal to approximately 10 inches" and "contained records exceeding 5 months") (Lewis); 268943 ("Many charts had misfiled documents") (Perryville); 269356 ("The loose/mis-filed paperwork appearing in the charts reflects a new trend that is beginning at our Complex") (Tucson). There are also deficiencies in the quality and completeness of information being recorded in the files. See ADC 268459 ("notes completed by an unlicensed Psychology Associate were not countersigned [and] many times were a photocopy. CB2, CB3, CB4, CB5 & CB7: The vast majority of notes done by the Psychology Associate were only ½ way completed notes") (Florence).

Particularly troubling are the significant deficiencies in medical records at ASPC-Phoenix, which is ADC's dedicated mental health facility. At Phoenix, "medical records in all areas require thinning and organizational evaluation." ADC 211371. See also ADC 268974 (noting "approximately 4 inches of loose filing" in medical records); ADC 269294 (noting that "Continuity of Care summary was loose and not filed; two unauthorized memos in medical record");

ADC 268583 ("medical record is highly disorganized to the point of preventing … accurate information gathering"); 269280 (medical record "highly disorganized").

In addition, ADC Mental Health Monitor Nicole Taylor documented the inadequate notes being written by the psychiatrists at the Phoenix complex:

> Please be advised that there are notes being written by the Psychiatrist at MTU that in my clinical opinion are inadequate. Also, the notes by the other Psychiatrist that is providing services at Flamenco are severely lacking in information as there are typically only 4 lines written, and would be hard to defend if an issue arose.

AGA_Review 113242. ADC's inability to maintain accurate, reliable medical records poses a significant risk of harm to prisoners with mental illness.

Inadequate medication system

In my initial report, I described a number of significant and dangerous deficiencies in ADC's medication system. 11/8/13 Report at 21-29. These deficiencies persisted throughout the period from September 27, 2013 to April 1, 2014.

In many cases, prisoners are not receiving their prescribed medication in a timely fashion, or at all. See ADC 211261 (71% of charts reviewed showed "unreasonable delays in inmate receiving prescribed medications") (Lewis); 210886 (11 out of 54 MARs reviewed showed unreasonable delays in receiving prescribed medication) (Perryville); 210804 (three prisoners did not receive Haldol injection in a timely fashion) (Florence); 211365 (listing examples)

(Phoenix); 268776 ("Yuma has experienced a back log in renewing psyche medications"). At Perryville, ADC Monitor Barlund expressed concern that "with the [history] of weather delays and 'we're shortstaffed and can't fill your meds today' that there will be further delays in inmates receiving their meds." AGA_Review 105005. See also AGA_Review 116456 (at Eyman, "the AM meds did not go out on time, and the afternoon meds may not have been delivered at all").

Due to the shortage of nurses to hand out medications to prisoners, not only are prisoners not receiving medication, but staff have apparently resorted to smuggling medication out of the prison and taking it home with them, or hiding medication:

> AGA_Review_110553 (Tucson: "I was at Main Point of Entry checking in four staff when I came upon CRN Ashly Paradis. I went through her bag and found a gallon size ziplock bag full of Rincon watch swallow meds in small manilla [sic] envelopes addressed to each inmate[.] … Ashly advised that she was unable to pass out some of the watch swallows on Thursday night so instead of checking them back in she brought them home. … Medical staff confirmed meds were not passed out on 11/28/13").
>
> AGA_Review_113556 (Eyman: "As a result of the issue of the [Director of Nursing] finding a large number of HNRs and medication in envelopes hidden in Meadows; yesterday I conducted an audit for such [.] … On SMU1 I found a stash of medication in drawers in the medication room that had no [inmate] identification on them. Five had the medication name and dosage removed. […] My audit of the Browning Unit produced a box with envelop[e]s containing medication that had not been passed and had not been disposed of properly. They were in a box which I sealed and isolated after taking the attached photos." [AGA_Review_113562-63]:

In many other cases, records are so deficient that it is simply impossible to tell if prisoners are receiving their medication. Medication Administration Records (MARs) are not completed correctly and are often missing critically important information. See ADC 268398-99 ("In a review of 50 handwritten MARs … 1 (2%) was found to have met all the criteria") (Eyman); 268945 ("At Perryville, very few MARs contain start dates"); 269307 ("A review of MARS show incomplete documentation") (Phoenix); 210466 (3 of 54 MARs reviewed completed in accordance with standard nursing practices) (Perryville); 210990 (3 out of 92 MARs reviewed completed in accordance with standard nursing practices) (Tucson); 210706 (48 out of 50 MARs reviewed NOT completed in accordance with standard nursing practices) (Yuma); 268618 (4 of 72 MARs reviewed completed in accordance with standard nursing practices) (Phoenix); 268520 (0 of 70 MARs reviewed completed in accordance with standard nursing practices) (Lewis).

There appear to be breakdowns at every stage of the medication process:

> Medications are simply allowed to expire without renewal. ADC 268857 (Eyman); 210791 (Florence); 210909 (Phoenix); 211430 (Tucson); 268775-76 (Yuma); 268918 (Lewis). See also ADC 211248 (noting that SMI prisoner's "psych medications expired without follow-up in 2009") (Lewis).
>
> Prisoner refusals of medication are not properly documented. 269140 (Eyman); 269172 (Florence).
>
> Medication errors are not reliably reported. ADC 210325, 210748 (Eyman); 210347 (Florence); 210993 (Tucson).
>
> The process for obtaining non-formulary drugs does not appear to be functional. ADC 210851, 211244, 268504 (Lewis); 211153 ("the Non formulary process still seems to escape employees when asked at some locations") (Eyman); 211430 ("The Non Formulary process continues to be a challenge") (Tucson); AGA-Review 106421 ("a centralized location for the Non Formularies in some units seems to be nonexistent or not accurately maintained").

ADC's pharmacy monitor documented significant deficiencies in medication practices at multiple complexes:

> "Eyman continues to struggle with policy/procedures. On my visit (10-21-2013) it was evident that the facility is in need of intensive retraining in multiple areas concerning pharmacy." ADC 210299.
>
> "I continue to alert the facility on medication issues/concerns/questions." ADC 210791 (Florence).
>
> "Florence as with many of the facilities continues to struggle with policy and procedure. Documentation of clinic stock is inaccurate, Refrigerator/Room temperature logs continue to be incomplete, expired medication exists in refrigerators, vials opened and not dated." ADC 211200.

> "As with previous months, I am concerned with the transfer of medication with the inmate." ADC 210910 (Phoenix).
>
> "Overall, of the 6 sites visited at Tucson, I witnessed the same procedural problems." ADC 210977.
>
> "I am still concerned with refills for active medication being filled in a timely manner." ADC 268680-81 (Tucson).
>
> "I am concerned with the significant drop in the timely renewal of medications." ADC 211537 (Yuma).
>
> "I am still concerned with refills for active medi[c]ation being refilled in a timely manner." ADC 211245 (Lewis).

I agree with ADC Pharmacy Monitor Martin Winland when he writes that "it is my sincere hope that the new Corizon leadership will not tolerate such a haphazard approach to proper documentation of medication as I have witnessed previously." AGA_Review 110551.

Inadequate monitoring of prisoners taking psychotropic medication

As was the case at the time of my initial report (11/8/13 Report at 29-32), prisoners on psychotropic medications are still not being seen by a psychiatrist, or even by a psychiatric mid-level provider, at least every three months. ADC 422637, 211544-46, 211077-79, 210670-71 (Yuma); 422422-24, 211251-52, 210836-37, 210396-98 (Lewis); 422333, 211159-61, 210754, 210305 (Eyman); 422465, 210877-78 (Perryville); 422576-77, 211439-40 (Tucson). Many

prisoners have gone far longer than three months without being seen. See ADC 422423 ("This inmate is currently on a watch and has been on approximately 5 watches in the last year – inmate was not referred to psychiatry once in the last several watches/months") (Lewis). As a result, some prisoners (including those with SMI) have had their psychotropic medications simply expire with no psychiatric follow-up; others have had their medications renewed without being seen by a psychiatrist. Both are improper and dangerous practices.

Inadequate monitoring and management of medication therapeutic levels and side effects

In my initial report, I wrote that "ADC does not have an adequate system in place to monitor and manage medication side effects," and identified named plaintiff [redacted] as one patient who was suffering side effects. 11/8/13 Report at 32. As noted below, Mr. [redacted] continues to suffer side effects that are not being adequately managed, as does named plaintiff [redacted].

Inadequate access to care

In my initial report I wrote that "ADC does not have a reliable means for prisoners to make their mental health needs known, and to have those needs met, in a timely manner by qualified staff." 11/8/13 Report at 33. This continues to be true. ADC's documents show breakdowns at every step of the access-to-care process.

Significant backlogs of HNRs continue to exist, and it appears that HNRs are sometimes simply forgotten. See AGA_Review 113522 (pile of over 200 HNRs at Eyman); AGA-Review 113556 (Director of Nursing finds "a large number of HNRs and medication in envelopes hidden at Meadows") (Eyman); AGA-Review 116455 (noting HNRs at Eyman-SMU that have not been addressed by nursing; "of those 34 are marked as emergency or otherwise require rapid attention (I.e. requesting med refills, pain issues, etc)"; ADC 210481 ("I found over 50 HNRs in various areas of the medical room") (Phoenix); 211243 ("a loose stack of HNR's was located with dates ranging from 9/10/2013 – 12/14/2013") (Lewis).

Tucson alone had the following backlog in a single month: HNRs 463; charts requiring provider review 364; nurse line backlog 360; provider line backlog 453. ADC 211415. In March 2014, the auditor for the Tucson complex wrote that "provider line backlogs, and Provider chart reviews are higher than they have been at Tucson Complex, since Corizon took over the Contract," and added that "it is HIGHLY recommended that a Regional request be made – to bring in reinforcements immediately, to address the entire Sick call issue, and to bring backlogs down for the providers at this Complex!" ADC 269333.

HNRs requesting mental health services are not triaged within 24 hours of receipt. ADC 269095 (Yuma); 268893, 268457, 210794 (Florence); ADC 268862, 268407, 211156 (Eyman); ADC 268986 (Phoenix); ADC 268509 (Lewis); ADC 211435 (Tucson); 210875 (Perryville). Even multiple HNRs

sometimes do not result in the prisoner receiving timely care. ADC 268962 (Phoenix) ("this is the 3rd HNR for medication issues and has not been seen by provider"); 210834 (Lewis) ("Inmate referred 10/3 (5 HNRs submitted), not seen until 10/28").

Sick call is often canceled or does not occur as scheduled. ADC210546 (Tucson); 211337 (Phoenix); 211241 (Lewis); 268931 (Perryville); 269380 (Winslow); 211146 (Eyman).

Once patients are referred to a mental health provider, they are very rarely seen within seven days. This finding is remarkably consistent both across institutions and over time:

Yuma: ADC 269096 (3 of 34 charts in compliance), 268787-88 (1 of 29 charts in compliance), 211542 (0 of 21 charts in compliance), 211074 (2 of 23 charts in compliance).

Tucson: ADC 269037-38 (2 of 26 charts in compliance), 268688-89 (5 of 30 charts in compliance), 211435-36 (3 of 22 charts in compliance), 210980 (3 of 27 charts compliant).

Lewis: ADC 268924-25 (3 of 25 charts in compliance), 268509-10 (1 of 22 charts in compliance), 211248 (3 of 11 charts in compliance), 210834 (0 of 15 charts in compliance).

Florence: ADC 268893-94 (1 of 12 charts in compliance), 268458 (2 of 8 charts in compliance), 211203 (0 of 10 charts in compliance), 210794-95 (2 of 12 charts in compliance).

Eyman: ADC 268863 (2 of 11 charts in compliance), 268408 (2 of 12 charts in compliance), 211156-57 (2 of 17 charts in compliance), 210752 (1 of 7 charts in compliance).

Phoenix: ADC 268611-12 (2 of 7 charts in compliance).

Perryville: ADC 268953-54 (10 of 22 charts in compliance), 268555 (3 of 14 charts in compliance), 210875 (2 of 6 charts in compliance).

Winslow: 211493 (0 of 1 charts in compliance), 210626 (0 of 4 charts in compliance).

Many patients, including those with serious mental illness (SMI), have experienced extraordinarily long delays in seeing a psychiatrist, during which they were in extreme distress and/or at serious risk of suicide. For example, a January 2014 note from Perryville describes a woman with SMI who "has been on Suicide/[mental health watch] approximately 7 times since 09/2013. Inmate has not seen psychiatrist since 9/30/13. Inmate should have been referred to psychiatry during the 09/2013-01/2014 time period but was not." ADC 268555. At Yuma, a SMI prisoner "was referred to psychiatry on 10/29/14[sic], 1/14/14 & 1/15/14; however, inmate was not seen until 1/29/14." ADC 269096. Another Yuma prisoner "was referred to psychiatry on 8/5/13; however inmate was not seen until 12/20/13." ADC 268787-88. At Lewis, an SMI prisoner "was referred to psychiatry his HNRs [sic] on 12/25/13 and 1/10/14; inmate still has not been seen [as of February 2014]." ADC 268924-25. At Eyman, "Inmate was referred on 11/6/13 via HNR. In HNR, inmate reported his psych medications were ineffective and that he was 'going crazy.' … Inmate has still not been seen [as of December 2013]." ADC 211156-57. At Florence, a 2/28/14 note identifies a

prisoner who "was referred to psychiatry on 12/4/13, 12/30/13, 1/2/14 and 1/22/14 … ; however, inmate has never been seen." ADC 268893-94.

Such delays occur even at ADC's dedicated mental health facility; an SMI patient "was referred to psychiatry on 2/12/14 & 2/11/14 in a Mental Health Clinician's note and on 2/3/14 via inmate's HNR. However, inmate has never been seen by psychiatry." ADC 268986-87 (Phoenix).

It is my understanding that, rather than taking steps to ensure that patients referred to a mental health provider are seen within seven days, ADC instead changed the standard to require only that such patients be seen within fourteen days. As noted above, many patients are not seen even within this longer time period.

Lack of mental health programming

In my initial report, I expressed the opinion that "the ADC mental health care system relies almost exclusively on medication (which it fails to provide reliably or appropriately), and does not provide an appropriate level of non-medication mental health programming." 11/8/13 Report at 37.

After reviewing documents from September 27, 2013 through April 1, 2014, I stand by this opinion. It remains the case that prisoners classified as MH-3 and above, including those classified as SMI, are not being seen by non-psychiatrist mental health staff as required by policy. ADC 269427, 269097, 268788-89, 210669 (Yuma); 269268-69, 268954-55, 268556, 211299, 210876

(Perryville); 269230, 268511 (Lewis); 269146-47, 268863-64, 211158, 210753, 210303(Eyman); 268690-91, 211437 (Tucson); 268458-59 (Florence).

There are many examples of long and dangerous delays. At Perryville, one prisoner "has not been seen by psychology staff since 1/27/2010;" another "has never been seen by a licensed mental health staff member." ADC 269268-69. Other examples include ADC 268690-91 ("this SMI inmate (who is asking for help) was not seen in a timely manner") (Tucson); ADC 268511 ("the length of time this SMI inmate had to wait to be seen by psychology is clinically inappropriate") (Lewis); ADC 269427 (March 2014 note that SMI prisoner "has not been seen since 9/20/13") (Yuma). See also AGA_Review 106272-74 (12/6/13 email exchange between Dr. Taylor and Mr. Musson, indicating that prisoner had not been seen by mental health since November 2012). Many prisoners with mental illness, including those with SMI, have *never* been seen by psychology staff.

While I understand that ADC alleges that prisoners with mental illness are receiving individual therapy, this was not supported by the MGAR reports. "There was little to no documentation found in charts indicating that inmates are being seen for monthly individual therapy sessions." ADC 268458-59 (Florence). Similarly in the Behavioral Health Unit at Tucson, "several charts audited indicated that inmates are not being seen for monthly individual therapy sessions." ADC 268690-91. At Perryville, a 2/28/14 note indicated that one prisoner "has

not been seen for individual therapy per policy," and another "has not received an individual therapy session since 10/22/13." ADC 268954.

Similarly, I understand that ADC claims that prisoners with mental illness are now participating in mental health treatment groups. I did see some evidence of groups in some of the charts I reviewed (see below), but it does not appear that such groups are provided either consistently or to more than a small minority of prisoners with mental illness. This is confirmed by the July 1, 2014 deposition of Carson McWilliams, ADC's Division Director of Prison Operations. See McWilliams dep. at 28:20-25 (as of April 1, 2014, there is no programming for Seriously Mentally Ill prisoners in Florence-Central-CB4); 93:1-9 (25% of prisoners in Florence-Central-Kasson receive one hour a week of programming), 95:16-20 (prisoner could receive "zero hours a week [of programming] if you were on a waiting list"), 111:10-12 (no out of cell programs for Step I prisoners at Perryville-Lumley-SMA). Mr. McWilliams also testified that what ADC calls "group" programming may actually occur with prisoners locked in their cells; "they're still doing the group, they're just not doing it together." McWilliams dep. 148:25-150:12.

Lack of inpatient care

In my initial report, I wrote that "it appears that ADC lacks a reliable system to ensure that prisoners needing a higher level of mental health care are transferred in a timely fashion to appropriate facilities." 11/8/13 Report at 40.

Cited below are additional examples of patients who needed inpatient care but did not receive it ([redacted], [redacted], [redacted]).

Inadequate treatment plans

In my initial report, I wrote that "[t]he treatment plans I reviewed in ADC do not meet minimum standards," 11/8/13 Report at 44, and that "the treatment plans were often incomplete, with key information missing; out of date; or simply missing from the chart altogether." 11/8/13 Report at 45.

It appears that little has changed. According to the MGAR reports, mental health treatment plans are still not being timely reviewed and updated. ADC 269427, 268786, 211543, 210669 (Yuma); 269370 (Tucson); 269267, 268952 (Perryville); 269146, 268407, 211157 (Eyman); 269228 (Lewis). Many prisoners, including those with SMI, were found to have treatment plans that were out of date, "incomplete and unacceptable," or simply had no treatment plan at all in the chart.

Inadequate suicide prevention

I wrote in my initial report that "there are serious deficiencies in ADC's suicide prevention policies and practices." 11/8/13 Report at 51. This continues to be true. The MGARs from October 2013 through March 2014 show widespread noncompliance with the requirement that prisoners on watch be seen daily by medical or mental health staff. See ADC 269372 (3 of 23 charts

compliant), 210986 (1 of 7 charts compliant) (Tucson); ADC 269270-71 (5 of 16 charts compliant), 210880 (1 of 9 charts compliant) (Perryville); ADC 269230 (2 of 18 charts compliant), 210839 (0 of 10 charts compliant) (Lewis); ADC 269181 (3 of 10 charts compliant) (Florence); ADC 269148 (1 of 16 charts compliant), 210757 (1 of 9 charts compliant) (Eyman); ADC 211082 (0 of 5 charts compliant) (Yuma). See also ADC 269270-71 ("it was impossible to tell whether or not the inmate was seen per policy while on watch because the watch disposition form from when the inmate was placed on watch had no date or time written on the watch order. Also, there appeared to be no note documenting when/why/how the inmate was placed on a watch") (Perryville).

Similarly, there is widespread noncompliance with the requirement that prisoners being discontinued from mental health watch are seen by a mental health clinician within specified time frames. See ADC 422572 (2 of 23 charts compliant) (Tucson); 422330-31 (0 of 14 charts compliant) (Eyman); 422367 (1 of 9 charts compliant) (Florence); 422419 (3 of 16 charts compliant) (Lewis); 422461 (5 of 15 charts compliant) (Perryville); 422635 (4 of 8 charts compliant) (Yuma). This was true even at ADC's dedicated mental health facility. ADC 422511 (3 of 14 charts compliant) (Phoenix).

Indeed, medical records are apparently so deficient that in some cases it was impossible to determine when the prisoner was removed from watch. ADC 422573 (Tucson); 422512 (Phoenix).

Prisoners are placed on watch because they are believed to be at risk of self-harm or suicide or otherwise in a state of crisis. Many of these prisoners are seriously mentally ill. ADC's failure to ensure that such prisoners are seen by medical or mental health staff while on watch, and followed by mental health clinicians after they are removed from watch, creates a substantial risk of serious harm or death.

A November 26, 2013 email from Caroline Haack to Jeff Hood attaches a chart of "FY 13 Self Harm Inmates – OD/ingest category." AGA Review 114506-07. This chart describes numerous prisoners with Mental Health scores of 3, 4, or even 5 swallowing razor blades, glass, pieces of metal, and other foreign objects, as well as overdosing on pills. Many prisoners had multiple such incidents; one prisoner had 10. It is extremely concerning that ADC is unable to prevent these seriously mentally ill prisoners from engaging in such potentially lethal self-harm.

I reviewed records from three suicides that occurred between September 27, 2013 and April 1, 2014:

1. [redacted], [redacted]-Mr. [redacted] was a 22-year-old male prisoner who hanged himself on [redacted]. He was housed at ASPC-Eyman/SMU1 at the time of his death. Mr. [redacted] medical record is very sparse and does not contain a lot of mental health-related information. His intake mental health evaluation noted that he had a depressed affect and a history of depression that was responsive to medications. These medications were listed as Prozac and Zoloft. Despite his presentation and very significant psychiatric history, Mr. [redacted] was designated a "MH2" with no follow up with a psychiatrist scheduled. The next mental health note is for an anger management class. The medical record is difficult to follow but it appears that Mr. [redacted] experienced some difficulties in the anger

management classes. The psych autopsy indicated that during this same time frame he had escalating violations within the prison system. The combination of his difficulties in group and his increased prison violations should have triggered a psychiatric referral. The medical records indicated that he did not receive any psychiatric follow up at this time or at any time prior to his death.

The medical record then indicates that on 8/3/13, Mr. [redacted] had a very serious suicide attempt. This suicide attempt consisted of his overdosing on 405mg of Remeron and 36mg of Risperdal. Once again, Mr. [redacted] was denied access to a psychiatrist. What Mr. [redacted] received was an extremely cursory examination by a psychologist. The mental status examination performed by the psychologist omitted observations on suicidality, affect and thought process. There was not a risk assessment completed and no differential diagnosis was made. As mentioned above, there was no referral to a psychiatrist for possible medication management. Mr. [redacted] was placed on suicide watch but was removed after one day. His last contact with mental health occurred on 9/27/13. Although the mental status examination documented in this note is an improvement over the one completed after his suicide attempt of 8/3/13, there is still no diagnosis made or plans to refer Mr. [redacted] to a psychiatrist. He killed himself in his cell on [redacted].

There are many serious problems with the care that Mr. [redacted] received but none so glaring as the fact that I found no evidence that he was ever evaluated by a psychiatrist. Mr. [redacted] past history of medication-responsive depression and his recent, serious suicide attempt should have alerted staff that he was at a very high risk to kill himself. It is my firm opinion that his death was preventable.

In addition, review of the Administrative Investigation Report (AIR) reveals that security checks on Mr. [redacted] pod were not timely performed on the day of his death, but records were falsified to show that they had been performed on time. The officer who falsified the logs had previously received a write-up for fabricating records.

I have now reviewed several records in which staff falsified records in connection with a prisoner suicide. See 11/8/13 report at 52 (suicide of [redacted]); 12/9/13 report at 8 (suicide of [redacted]). I have never before encountered a system in which such fraudulent and possibly criminal behavior by staff is so widespread and is apparently tolerated by department leadership.

2. [redacted]-Mr. [redacted] was a 48-year-old male prisoner who hanged himself on [redacted]. He was housed at ASPC-Eyman/Browning at the time of his death. A review of his medical record reveals that Mr. [redacted] had

very little contact with mental health. Most of his contacts during his 20-year commitment were medical. He suffered from a variety of serious medical conditions, including skin cancer, eczema, hypertension, history of head injury with a subsequent seizure disorder and right-sided partial hemiplegia. Over the years of his commitment, he presented with a variety of psychiatric symptoms to his medical MD's. These symptoms included being "moody and anxious," "paranoia-? Psychosis," and being "angry, loud, demanding." The medical MD's that were seeing Mr. [redacted] should have referred him for a psychiatric evaluation when he presented with these symptoms. I disagree with the ADC psych autopsy that Mr. [redacted] suicide was unpredictable and unavoidable from a mental health perspective. As previously mentioned, his medical MD's should have initiated a referral for a psychiatric evaluation given his symptom presentation. Also, it is a well-established medical fact that older men with multiple medical problems are at a much greater risk for self-harm than the general population. Although Mr. [redacted] was not elderly per se -- he was almost 49-years-old at the time of his death -- in my opinion, 49 is elderly for a prisoner and he had been on death row for approximately twenty years and had several serious medical problems that were clearly causing him significant distress and anxiety. All of these risk factors should have been taken into consideration to help protect him from self-harm.

3. [redacted], [redacted]-Mr. [redacted] was a 38-year-old male prisoner who hanged himself on [redacted]. He was housed at ASPC-Eyman/SMU1 at the time of his death. Mr. [redacted] has a long and complicated mental health and medical history. He was found to be hypothyroid and was started on low dose (0.05mg daily) thyroid replacement therapy. This dose was not changed over time. I could not locate any medical follow up or repeat laboratory tests in the medical record for this condition, which can have profound effects on an individual's mental functioning.

He carried the psychiatric diagnosis of Mood Disorder, NOS. He was begun on a combination of Haldol and Amantadine. This medication regimen is problematic given Mr. [redacted] history of having a seizure disorder. What is even more problematic is that his medications were abruptly discontinued in January 2013 without any follow up by a psychiatrist.

The next notable event for Mr. [redacted] is his submitting an HNR on 3/29/13 asking for help with psychosis. Mental health staff waited until 4/4/13 to follow up with him. A progress note from 4/5/13 documents that the patient stated "people are saying things" and staff find a noose. He is placed on suicide watch but his

medications are not restarted until 4/10/13. A progress note from 4/13/13 notes that the patient cut himself and he is placed on continuous watch. Mr. [redacted] submitted HNR's on 5/7/13 and 5/19/13 requesting an increase of his Haldol for persistent psychotic symptoms. He was finally evaluated for these concerns on 6/17/13. At that time the psychiatrist continued Mr. [redacted] medications of Haldol, Amantadine and Tegretol. Mr. [redacted] submitted three additional HNR's (7/10/13, 7/16/13 and 7/26/13) requesting to see the psychiatrist.

He is placed on suicide watch on 8/14/13 after lighting his cell on fire, which resulted in him being evacuated to the hospital with smoke inhalation and second-degree burns. A progress note from 8/20/13 documents that the patient was experiencing trauma-related flashbacks and was noted to be psychotic. His mental health score was increased to MH-4, but incredibly, a psychiatrist did not see Mr. [redacted] until 9/24/13. Mr. [redacted] was noted to be experiencing flashbacks, poor mood and worsening medication-induced involuntary movements. He was started on Paxil 20mg QD and Cogentin 2mg BID is substituted for the amantadine.

The final psychiatric visit Mr. [redacted] received prior to his death occurred on 10/23/13. It appears that he was experiencing worsening psychotic symptoms as well as increased flashbacks. The psychiatrist increased the Paxil but did not address the worsening psychotic symptoms. Also, the Amantadine was reintroduced and the Cogentin was discontinued. A psychiatric follow up appointment didn't occur as scheduled. Mr. [redacted] was scheduled for a 30-day follow up but this did not happen. He hanged himself on [redacted].

Several troubling issues arise out of this review. Mr. [redacted] hypothyroidism was not properly addressed. He was started on low dose thyroid replacement therapy but I could not locate if this was ever followed up. His diagnosis was Mood Disorder, NOS yet he was begun on an antipsychotic medication. This means that either the diagnosis and/or the treatment was incorrect. Mr. [redacted] repeatedly complained of flashbacks yet PTSD was never considered as a diagnosis. Though he displayed steadily escalating symptoms over the last several months of his life, at no time was he considered for transfer to a higher level of care such as an inpatient facility. This is especially egregious given that a noose was found in his cell, he cut himself, and he set his cell on fire. He also had a history of additional suicide attempts, including at least one by hanging. Any one of these events should have alerted staff to Mr. [redacted] need for a higher level of psychiatric care than was available on the SMU1. It is my opinion that this suicide was completely preventable.

I have previously discussed the importance of psychological autopsies in cases of suicide, and ADC's failure to perform them in a timely manner, or in some cases at all. This problem appears to persist unchanged. A document dated March 6, 2014 shows that as of that date, psychological autopsies had not been performed on suicides that occurred in 2013, 2012, 2011, 2010, and even 2009. AGA_Review 108573-75.

Inappropriate use of isolated confinement

In my initial report I noted that ADC has no policy that bars the housing of prisoners with serious mental illness in isolated confinement. 11/8/13 Report at 59. I saw nothing in the materials I reviewed from the September 27, 2013 – April 1, 2014 time period suggesting that this has changed.

The danger created by ADC's failure to exclude the SMI from isolation is aggravated by ADC's additional failure to monitor the mental health of prisoners placed in isolation. For example, the medical records of prisoners being placed in segregation are sometimes not reviewed by mental health staff for contraindications. ADC 210364 (Florence); 210318-19 ("Out of the 40 charts reviewed (37) were not in compliance") (Eyman). At Eyman, "segregation rounds are not consistently done/documented three times weekly." ADC 210320. See also ADC 210593 (0 of 43 charts of segregated prisoners compliant with requirement for monitoring by medical or mental health staff) (Tucson); ADC

269427 (March 2014 note that SMI prisoner is "in lockdown and not seen since 1/6/14") (Yuma).

Finally, I note that of the ten suicides that occurred in ADC between the Corizon takeover in March 2013 and April 1, 2014, eight occurred in SMU I, Browning Unit, and Florence Central Unit, although these units collectively hold only a small percentage of ADC prisoners. This is further evidence of the extremely damaging and sometimes lethal effects of isolated confinement.

Inappropriate use of chemical agents on the mentally ill

In my initial report, I wrote that "[t]he use of chemical agents on prisoners with mental illness can be extremely harmful and is contraindicated with these patients." 11/8/13 Report at 60. More specifically, I noted that chemical agents were used against [redacted] on at least three occasions, adding that [redacted] "is an extremely mentally ill individual, and the repeated use of chemical agents poses a grave risk of harm." 11/8/13 Report at 62. As noted below, ADC staff continue to use chemical agents against [redacted].

Inappropriate use of psychiatry via videolink

In addition to the problems with telepsychiatry noted in my earlier reports, it appears that ADC is unable to ensure timely care for patients who refuse treatment by telepsychiatry. AGA_Review 104913-14 (email exchange describing

staffing and other "barriers" to seeing "the roughly 100 refusals at Rynning and Cook") (Eyman).

Chart reviews

I have been provided a list of charts I reviewed for my initial and supplemental reports. I selected every fifth chart from this list for a total of eight charts. Because this random selection turned out not to include any female prisoners, I then selected one chart of a female prisoner at random, for a total of nine charts reviewed.

1. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/22/13. At that time he was on watch status for "erratic behavior" and was noted to be experiencing worsening psychotic symptoms. There were numerous chart entries about his not receiving his medications for over a week. A review of his recent set of medical records reveals that in the months following my evaluation, Mr. [redacted] remained on watch status and was referred to ASPC Phoenix due to the severity of his mental illness. He was waiting for transfer to Phoenix for several weeks and was eventually taken off the referral list for reasons that are not apparent from the medical record. At no time was a psychiatrist involved in the decision to refer Mr. [redacted] to ASPC Phoenix and/or to remove him from the referral list. The October 2013 MAR lists his medications as Haldol 15mg QHS, Depakote 1500mg QHS, Buspar 20mg QHS and Cogentin 2mg QHS. Mr. [redacted] had his medications properly renewed on 12/16/13 but went seven days without his medications. They were restarted on 12/23/13 and there is no explanation in the medical record why this occurred. For the six-month period of 10/1/13 through 3/31/14 Mr. [redacted] was only seen by a psychology associate six times and a psychologist twice. Of note, he only saw a psychiatrist once during this six-month period even though he was noted to be symptomatic and was having problems with medication compliance.

2. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/22/13. He was diagnosed with PTSD/Depression for which he was supposed to take Risperdal and Celexa. He reported that he had not received his medications for several months. His medical record was very disorganized and I could not determine which medications he is prescribed or if he was receiving them. A review of his recent set of medical records reveals that Dr. Jaffe renewed Mr. [redacted] Risperdal 1mg QHS and Celexa 20mg QHS on 5/16/13. I mention this only to point out that Dr. Jaffe documented that he prescribed these medications even though he had not assessed the patient in person. I could not find any evidence that mental health staff followed up with Mr. [redacted] during the six-month period 10/1/13 through 3/31/14. This is especially bothersome given the fact that there are multiple medication refusal forms in the medical record during this time frame. Finally, on 11/25/13, almost two weeks after Mr. [redacted] medications expired, he was seen by a psychiatrist who discontinued his medications. There are no subsequent mental health contacts in the medical record. This represents very poor psychiatric care. Mr. [redacted] medications were renewed in the absence of an in-person evaluation and then he was completely ignored by the mental health staff. There are no documented medical record entries that staff attempted to determine why Mr. [redacted] was refusing his medications or that they attempted to do anything about it.

3. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/16/13. He was diagnosed with Psychotic Disorder, NOS and was described as being "loud and argumentative." He was prescribed high dose Haldol decanoate, 150mg q4weeks. I found him to be extremely psychotic, shouting and cursing at me. He actually ran full speed into the Plexiglas door of his cell while I was standing there. At that time I felt he represented a danger to himself and required immediate transfer to an inpatient psychiatric facility. A review of the recent set of medical records reveals that since my evaluation Mr. [redacted] has continued to be in an extremely psychotic and manic state despite treatment with Haldol decanoate. During the period from 10/1/13 through 3/31/14 I noted at least two incidents where chemical agents were used against Mr. [redacted] and at least one incident where he assaulted staff. Due to his inability to cooperate with his treatment, staff appropriately applied for an involuntary medication order. In this application, staff noted that Mr. [redacted] presents with "tangential thought processes, verbally demanding and threatening to staff, no insight into his mental illness and need for treatment and poor judgment." This is

in addition to a documented assault on staff. Of particular note is that during this six-month period, I found only three incidences where Mr. [redacted] was seen by mental health staff. All three of these clinical encounters occurred at the cell front. Psychology associates performed two of these encounters and a psychiatrist performed the third. Several points are demonstrated by this case: 1) Mr. [redacted] is an extremely mentally ill individual who should be treated in a psychiatric hospital setting; 2) Staff did not make a sufficient attempt to engage him in the treatment process; 3) The psychiatrist continued with the same medication approach notwithstanding the lack of any clinical improvement. Mr. [redacted] has suffered needlessly and staff has been put at risk due to this exceptionally poor psychiatric care.

4. [redacted], [redacted]-I reviewed his medical record on 7/15/13. I determined that he was a mental health patient who was being evaluated via a telemed psychiatrist. I also noted that the mental health diagnosis listed in the medical record was different from that listed by the telemed psychiatrist. It was apparent from my review that the telemed psychiatrist did not have access to Mr. [redacted] medical record when he evaluated him. Also, I did not find a medication order from the telemed psychiatrist in the medical record. A review of the recent set of medical records reveals that Mr. [redacted] is a patient on the Kasson Unit at the Florence complex. He was seen by a psychiatrist two days after my evaluation and was prescribed Lamictal 100mg daily and Remeron 15mg QHS. I could not determine from the medical record if this visit was via telemed or was an in-person visit. A psychiatrist did not see him again until 12/18/13. At that time Dr. French saw Mr. [redacted] did not list a diagnosis but renewed his medications. He was next seen by a nurse practitioner on 3/12/14 when he was diagnosed with "Mood Disorder, NOS with Personality Disorder," and his medications were adjusted. Of note, during the period from 10/1/13 through 3/31/14 Mr. [redacted] had 15 documented visits with psychology associates and attended 16 groups.

5. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/16/13. The medical record indicated that his diagnosis is Psychosis, NOS and that his most recent treatment plan was over a year old; it was dated 5/20/12. It appeared from the medical record that his last dose of antipsychotic medication was administered 3/4/13. Upon my examination, he presented as extremely psychotic. That is, he was mute and posturing in an almost catatonic

state. The medical records that I reviewed covered the period of 11/4/13 through 4/1/14. On 11/4/13 Mr. [redacted] submitted an HNR that stated, "I need my medication. I need to see the Dr. It's an emergency. I take Risperdal, Remeron, Tegretol, Celexa. I hear voices that tell me to kill myself. I need help. I don't want to hurt myself. I sing all night and bang to stop the voices and everyone yells at me. I don't want this. Help me." A psych tech acknowledged receiving the HNR and documented that Mr. [redacted] was "no DTS/O." This is an amazing statement by an unqualified individual given the nature of the HNR. The next thing that occurred is that on 11/14/13 a nurse practitioner prescribed Tegretol 400mg BID. This medication order occurred in the absence of a comprehensive mental health progress note. A mental health staff attempted to complete a mental health evaluation on 11/21/13 that Mr. [redacted] refused. Starting on 12/26/13 and ending on 2/11/14, Mr. [redacted] received 33 cell front visits by members of the psychology staff that documented his extremely altered mental status. A psychiatrist did not evaluate him until 2/11/14. At that time, Mr. [redacted] was diagnosed with Psychosis, NOS. A PMRB meeting was held on 2/12/14 and recommended Mr. [redacted] for involuntary medication. The psychiatrist then prescribed Haldol decanoate 100mg Q4weeks. Starting on 2/12/14 and ending on 3/14/14, Mr. [redacted] received an additional 22 cell front visits by the psychology staff. The therapeutic efficacy of these multiple cell-front visits was not apparent from my review of the medical record. The psychiatrist saw him again on 3/26/14. At no time during this period did any member of the mental health staff consider referring Mr. [redacted] to an inpatient psychiatric facility. He suffered needlessly during this period. He should have been transferred to an appropriate psychiatric treatment facility instead of languishing in the SMU. Of note, Mr. [redacted] was left in a state of extremely debilitating psychosis from the time of my examination, 7/16/13, at least through 3/26/14. This represents exceedingly injurious psychiatric care.

6. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/22/13. I noted that he carried the diagnosis of Mood Disorder, NOS. A 7/18/13 chart note indicated "IM reports he is out of psych meds and has been for four months." There was no apparent follow up to this note. I could not locate a MAR for July 2013 or any medication orders. Mr. [redacted] claimed that he has not seen a psychiatrist since his arrival at Lewis. This fact is confirmed in the medical record. A review of the recent set of medical records documents the chaotic nature of Mr. [redacted] psychiatric care. As noted above, I evaluated him

at Lewis on 7/22/13. Prior to his arrival at Lewis, he was housed at Tucson. While at Tucson, Mr. [redacted] was prescribed Risperdal 1mg QHS and Celexa 40mg QD. These medications were not continued when he was transferred to Lewis. Of note, these medications were not ordered to be discontinued; rather, their dispensing just fell through the cracks. Mr. [redacted] was sent back to Tucson where on 9/11/13 Dr. Harrison started him on Lithium 600mg QHS. There is no psychiatric progress note associated with this order. On 11/20/13 Mr. [redacted] submitted an HNR requesting to stop his Lithium. He was not seen for this request for over two weeks. On 12/5/13, Dr. Harrison evaluated Mr. [redacted] and discontinued his Lithium. There was no follow up to this 12/5/13 Tucson-based evaluation as Mr. [redacted] was transferred to Yuma. On 3/28/14, he submitted an HNR requesting "to see psych." A mental health associate saw him on 3/31/14 noting that Mr. [redacted] wanted to restart his medications. This case points out the difficulties patients experience when they are transferred between and among institutions. His medications did not follow him from Tucson to Lewis. Also, his psychiatric follow up did not occur when he was transferred from Tucson to Yuma.

7. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/16/13. He is diagnosed with "Undifferentiated Schizophrenia" and was prescribed Haldol decanoate 50mg Q4weeks. Upon examination he was very sedated and unable to speak with me. Of note, he was housed in a lockdown unit at the Eyman complex. It was my opinion that the harsh and isolated conditions of the lockdown unit were exacerbating Mr. [redacted] Schizophrenic condition. A review of the recent set of medical records reveals that Mr. [redacted] remains seriously mentally ill and that he is languishing in this lockdown setting. On 11/28/13 Mr. [redacted] was placed on 30-minute watch status due to his "giving away $40.00 worth of store, not eating, presents depressed. IM reported to be making statements that he wants to hang himself." He remained on this 30-minute watch until 12/10/13. At no time during this 13-day period did a psychiatrist evaluate him. There is no evidence from the medical record that the mental health staff even bothered to consult with a psychiatrist. Two separate medication orders for Haldol decanoate 50mg Q30days were written without an accompanying psychiatric progress note. One order was written on 12/4/13 and the other on 1/2/14. I cannot determine from the medical record if Mr. [redacted] was administered any Haldol secondary to these orders. A psychiatrist finally evaluated him on 1/28/14. This was a cell-front visit. The psychiatrist did not

make a diagnosis but only ordered Haldol decanoate 50mg Q4weeks. The next mental health contact was 3/9/14 when Mr. [redacted] refused his Haldol decanoate injection. The final psychiatric contact of the period occurred on 3/31/14 when Mr. [redacted] refused to speak with the psychiatrist at cell-front. Basically, Mr. [redacted] remained untreated from the time of my examination on 7/16/13 through 3/31/14. During this period he was noted to be suicidal, psychotic and suffering needlessly due to his conditions of confinement and the lack of proper psychiatric treatment.

8. [redacted], [redacted]-I evaluated Mr. [redacted] and reviewed his medical record on 7/8/13. At that time, he was experiencing problems with the timely delivery of his psychotropic medications. The MAR for May 2013 indicated that Mr. [redacted] was prescribed the antidepressants Prozac and Remeron. He was not aware that he was prescribed Remeron, as he had not been receiving this medication. Mr. [redacted] readily admitted to taking Prozac for over a year but he had not received this medication for over a week. Staff informed him "they ran out of it." A review of the recent set of medical records reveals that a significant portion of his medical records is dedicated to his multiple medical problems. Of note, from October 2013 through February 2014, Mr. [redacted] submitted eight HNR's outlining problems with his medications for his medical problems. A psychiatrist saw him on 11/19/13 and diagnosed him with "Depression/Anxiety." I must point out that there is no such diagnosis as "Depression/Anxiety" in the DSM. At that time the psychiatrist prescribed Prozac 40mg QAM and Remeron 15mg QHS. During the time period of October 2013 through February 2014, Mr. [redacted] was only seen four times by psychology associates and he attended two groups. A psychiatrist saw him again on 2/11/14 when Risperdal 1mg QHS was added to his medication regimen.

9. [redacted], [redacted]-I previously evaluated Ms. [redacted] on 7/18/13 at ASPC-Perryville. At that time I found her to be extremely psychotic. I noted her shouting incoherently at the walls of her cell. At the time of my evaluation, she was on a "constant watch" because she had been banging her head in her cell. A review of her medical record at that time revealed that her most current treatment plan was dated 9/19/11. I found a very brief psychiatric note written on 6/26/13, which corresponded to a medication order for Haldol decanoate 100mg Q4weeks. Ms. [redacted] had also been prescribed Celexa 20mg QHS, Cogentin 2mg BID and Tegretol 400mg QHS. She was very impaired and I felt strongly that she required

an inpatient level of care. The medical records provided for my review were from 10/19/13 through 4/1/14 so I am unable to evaluate her care in the period of time immediately following my evaluation. Of note is that Ms. [redacted] had a positive PPD and was placed in medical isolation for the months of September through December 2013. Throughout this period of isolation she was seen at cell-side and administered her monthly Haldol decanoate. The first mental health note is from 10/22/13 when she was seen by a LMSW. At that time her mental status exam was noted to be within normal limits. The same LMSW next saw her on 12/4/13 and recorded that Ms. [redacted] was anxious but otherwise stable. There is a reference to a 12/12/13 treatment plan but I could not locate it in the medical record. A psychiatrist saw her on 12/17/13 and renewed her previous medications. Her overall care consisted of a monthly check-in with the LMSW and her monthly Haldol decanoate injection. There is a "Mental Health Group Progress Note" dated 11/5/13. There were two separate group refusal forms dated 2/25/14 and 3/25/14. These three notes are the only references to Ms. [redacted] being assigned to a therapeutic group. Finally, I located a "Mental Health Treatment Plan-Outpatient" form in the medical record dated 2/28/14. This form stated her strengths/limitations were "unable to participate." It also listed her treatment goals as "attain/maintain stable mood" and "decrease/eliminate psychotic symptoms." Of note, a psychology associate prepared this treatment plan with no apparent input from psychiatry or nursing. I am unable to fully appreciate what Ms. [redacted] psychiatric condition actually is from my review of the medical records. What I was able to determine is that a psychiatrist only saw her every six months. She may have been assigned to a mental health group. Her only documented mental health contacts were with a LMSW on a monthly basis as well as seeing the psychiatric nurse on a monthly basis for her Haldol injection. A review of the MAR's demonstrated that she did have good medication compliance during this period. My overall opinion of this case is that the quality and appropriateness of her mental health care is seriously in doubt.

The mental health care received by these prisoners during this six-month period continues to fall below the standard of care.

I have also been provided a list of charts for patients who carry the SMI designation. For the first 60 charts, I selected every tenth one for a total of six charts. I then selected the last chart listed for an overall total of 7 charts.

1. [redacted], [redacted]-Mr. [redacted] is a 73-year-old male SMI patient who is housed at ASPC-Tucson, Rincon Unit. There are no mental health-related progress notes located in the medical record for the period of 9/27/13 through 3/31/14. What I did encounter in the medical record were a series of forms titled "Skin Integrity Assessment." This form is a weekly checklist of the following health-related parameters: General Physical Condition, Mental Status, Activity, Mobility, Incontinence, Nutrition and Existing (skin) Breakdown. These checklists were completed weekly on Mr. [redacted] for the period of 9/27/13 through 3/31/14. Overall, Mr. [redacted] general physical condition was listed as "fair-poor" and his mental status was listed as "confused." Of note, the "Admitting Diagnosis" listed on these forms was "Schizophrenia-Dementia." The only psychotropic medication that he received during this period was Buspar 30mg BID. He received this medication during the month of September 2013 and then it was not continued for the remainder of the period in question. There was no psychiatric progress note explaining anything about this medication. Mr. [redacted] did not receive any documented mental health contacts during the period of 9/27/13 through 3/31/14. This is tremendously poor care of an apparently very ill elderly patient.

2. [redacted], [redacted]-Mr. [redacted] is a 29-year-old male SMI patient who is housed at ASPC-Tucson, Santa Rita Unit. A "Transfer Summary/Continuity of Care" form dated 9/24/13 listed his diagnoses as "Depression Disorder NOS, Anxiety Disorder NOS, hx Schiz, suicide attempt age 14 plus 2 other attempts." This transfer summary also listed Mr. [redacted] medications as Zoloft 100mg QHS and Hydroxyzine 25mg QHS. The next document I encountered in the medical record was an Initial Mental Health Assessment. This initial mental health assessment was conducted at ASPC-Phoenix by a psychiatric technician and signed off by a psychologist. It listed the disposition as "No Mental Health services needed at this time." However, a medication order signed by Dr. Ramirez for Zoloft 100mg QHS and Hydroxyzine 25mg QHS was dated the same day, 9/25/13. Written below this order in bold

letters was the phrase "Bridge Orders." It is abundantly clear from the medical record that there was no coordination among the members of the mental health treatment team. Mr. [redacted] is then transferred to ASPC-Tucson where he is seen by a psychologist on 10/2/13. A psychiatrist finally evaluates him on 10/15/13. The psychiatrist wishes to change Mr. [redacted] antidepressant medication from Zoloft to Paxil and notes "I/M seeks better relief of his anxiety with change to Paxil." The medication order reads, "Cont. Zoloft 100mg PO QHS until Paxil arrives, then stop Zoloft 100mg; start Paxil 40mg PO QHS." The MAR from October 2013 indicates that Paxil was eventually started on 10/18/13. Of note, the next psychiatric contact doesn't occur until 4/8/14, which is far too long for a patient starting a new medication.

3. [redacted], [redacted]-Mr. [redacted] is a 42-year-old male SMI patient who is housed at ASPC-Yuma. His medical records are very disorganized and difficult to follow. A psychiatrist saw him on 9/18/13 and noted that he had a dysphoric mood and pressured speech and thought process. Mr. [redacted] was prescribed Lithium 1200mg QHS for 90 days at that time. On 10/18/13, Mr. [redacted] submitted an HNR stating "I need to see the physc Docter (sic) ASAP… I'm starting to lose it. Thank you. And I need to know how to get to the mental hospital." He was not seen for five days. On 10/23/13 Dr. Martinez noted "no new issues other than his insistence on being sent to a MH facility." Mr. [redacted] submitted another HNR on 11/21/13 basically stating the same thing -- that he needed to see a psychiatrist ASAP because he was trying to stay out of trouble and that he was losing it. He was seen by a mental health associate on 11/26/13 who attempted to address some medication issues. Of note, a mental health associate doesn't have the clinical expertise to deal with medication issues. Mr. [redacted] submitted yet another HNR on 12/2/13 reiterating his problems with his medication and stating "my nortriptilin (sic) does not work…It make me violent." He was seen on 12/3/13 by a psychiatrist who diagnosed him with Bipolar Disorder and continued his Lithium at 1200mg QHS. A Lithium level obtained at that time was within normal limits. Mr. [redacted] submitted two more HNR's, both on 1/6/14, again complaining about his medications. A psychiatrist saw him on 1/10/14 noting that Mr. [redacted] ran out of Lithium 6 days ago. A review of the January MAR documents that he went without Lithium from 12/31/13 through 1/13/14. Finally, the last mental health progress note was dated 1/29/14. I did not find any other mental health contacts through 3/31/14. This case is a good illustration of the difficulties that patients in the ADC experience with their

medications, leading to needless suffering and risking aggravation of their mental illness.

4. [redacted], [redacted]-Mr. [redacted] is a 33-year-old male SMI patient who in May 2013 was noted to have the diagnoses of Bipolar/Depression/Anxiety and was being treated with Lithium 300mg QHS. His medical records are extremely disorganized so it was difficult to determine exactly where he has been housed. It appears that as of 9/6/13 he was housed at ASPC-Tucson. On that date, Mr. [redacted] was evaluated by Dr. Winsky who discontinued the Lithium and started Mr. [redacted] on Risperdal 1mg QHS for 180 days. Of note, a six-month follow up is too long when starting a patient on a new medication. On 9/12/13 he was referred to the MTU at ASPC-Phoenix. The reason for the referral was stated as "Inmate expressed a desire to break his patterns and know more about his mental health condition." As laudable as these goals are, I do not understand why this relatively stable patient was referred to the MTU knowing that there are hundreds of more seriously mentally ill individuals who drastically require treatment in a specialized mental health unit. Between 9/25/13 and 11/8/13 Mr. [redacted] refused his Risperdal 1mg QHS ten times without there being any documented intervention by the staff. In fact he was seen by a psychologist on 10/7/13 and was described as being "pretty stable." Also, there was no mention of Mr. [redacted] poor medication compliance. Equally mysterious is a psychiatrist note dated 10/25/13 in which no mention is made of Mr. [redacted] poor medication compliance. The next psychiatrist note is from 12/16/13 which lists Mr. [redacted] diagnosis as Mood Disorder, NOS. At that time the psychiatrist, Dr. Akhtar, discontinued the Risperdal 1mg QHS. From the medical records, it appears that Dr. Akhtar is a psychiatrist at ASPC-Phoenix. I could not locate a comprehensive psychiatric intake assessment on Mr. [redacted] I did locate a very cursory note written by a psychology associate dated 12/17/13. I was able to locate three additional psychology associate notes dated 1/15/14, 2/18/14 and 3/18/14. Mr. [redacted] attended nine groups from 2/19/14 through 4/1/14. There were no psychiatric contacts documented in the medical record during this same period. This case points out three issues: 1) It is not clear why Mr. [redacted] was referred to ASPC-Phoenix given his relatively stable condition, 2) his poor medication compliance was not noted by any mental health staff, and 3) Between 12/16/13 through 4/1/14 he was only seen by a psychiatrist once and psychology associates three times; he never received a comprehensive psychiatric assessment.

5. [redacted], [redacted]-Mr. [redacted] is a 57-year-old male SMI patient who also suffers from multiple medical problems. He was housed at ASPC-Tucson. His Initial Mental Health Assessment from June 2013 listed his diagnoses as Substance-Induced Psychotic Disorder versus Psychosis NOS. On July 23, 2013 Mr. [redacted] was evaluated by Dr. Winsky who prescribed Paxil 10mg QAM, Risperdal 3mg BID and Cogentin 0.5 mg BID. All of these medications were ordered for 180 days. During the period of 9/27/13 through 3/31/14, Mr. [redacted] was only seen by a psychologist on 10/4/13 and 12/19/13. He was only seen by Dr. Winsky once during this period. There is no evidence in the medical record that Mr. [redacted] attended any groups. So for this six-month period, Mr. [redacted] who is designated as an SMI patient, only had three contacts with anyone from the mental health staff.

6. [redacted], [redacted]-Mr. [redacted] is a 43-year-old male SMI patient who during the period of 9/27/13 through 3/31/14 was housed at ASPC-Phoenix. He was officially designated SMI on 9/19/13. His first documented visit with a psychiatrist occurred on 11/13/13. At that time, Mr. [redacted] Lithium was discontinued and he began treatment with the antidepressants Remeron, Celexa and Trazodone, the antipsychotic Trilafon and the antianxiety medication Buspar. Mr. [redacted] submitted an HNR on 12/14/13 complaining of worsening nightmares. He was promptly seen by Dr. Akhtar on 12/16/14 who modified his medication regimen. He was seen by a nurse practitioner on 1/10/14 who discontinued his Remeron and Celexa and began Paxil. During the time frame of 9/27/13 through 3/31/14, Mr. [redacted] had seven contacts with Psychology Associates and attended four groups. Finally, he was seen by a different nurse practitioner on 2/7/14. This case further illustrates just how little treatment patient receive at ASPC-Phoenix, which ADC describes as its specialized mental health facility. For this six-month period, Mr. [redacted] had a total of 14 contacts with mental health staff. This works out to be approximately one mental health contact every two weeks. This represents a woefully inadequate level of treatment for a mental health facility.

7. [redacted], [redacted]-Mr. [redacted] is a 57-year-old male SMI patient with a long history of psychosis and dementia. He had previously been treated with large doses (1500mg QHS) of the antipsychotic medication, Thorazine. Mr. [redacted] SMI status was renewed on 8/27/13. During the period of 9/27/13

through 3/31/14 he has been housed at ASPC-Tucson. Mr. [redacted] received very cursory monthly visits from a psychologist for the months of October, November and December 2013. These brief monthly visits continued into 2014. These visits in 2014 were conducted by a psychology associate and documented that Mr. [redacted] was not fully oriented and was disheveled and confused. He was placed on 10-minute watch status on 3/25/14 for making threatening statements. This was changed to 30-minute watch status on 3/26/14. On 3/27/14, a psychologist visited Mr. [redacted] and noted that he was "rambling at times, disjointed presentation with flight of ideas." The note also included the statement "need chart." This clearly demonstrates that the psychologist saw Mr. [redacted] without the benefit of the chart. Needless to say this is extremely poor practice especially given the patient's recent threatening statements. Mr. [redacted] received a cell-front contact on 3/28/14 which documented his mental status as "confused, distractible, poor concentration, apathetic mood, detached affect and tangential thought structure." Remarkably, his watch status was discontinued on 3/31/14. At no time during this six-month period did a psychiatrist evaluate him. Of special concern is during this six-month period, no effort was made to treat his underlying psychiatric conditions. This is highly inadequate care.

The mental health care received by these prisoners during this six-month period falls below the standard of care.

Inadequate mental health care of named plaintiffs

I have been provided updated charts for the named plaintiffs in this case:

1. [redacted], [redacted]-As previously reported, I evaluated him on 7/16/13 and 7/19/13. I first saw him on the SMU where he was very agitated and questionably psychotic. I next saw him on the Flamenco Unit where his clinical condition remained unchanged and I encountered serious problems with his medical record. At that time, it was unclear whether he was assigned a psychiatric diagnosis and whether he was receiving any psychotropic medication. A review of his recent set of medical records reveals that mental health staff did not see him during the period 9/27/13 through his release on 12/11/13. Per his medical records, his most recent psychiatric visit occurred on 7/25/13. At that time, Dr. Cleary

diagnosed him as suffering from Mood Disorder, NOS and Antisocial Personality Disorder. Mr. [redacted] prescribed medications were Neurontin 600mg BID, Inderal 10mg BID and Wellbutrin 100mg BID. I am unable to determine from the medical record if he in fact received these medications. His last contact with a psychologist occurred on 7/31/13. Of note, a nursing entry in the medical record on the evening of 7/31/13 reported that the "inmate began screaming, yelling and threatening at 1800 re: follow through of wasting syndrome diet." The nurse went on to state that Dr. Cleary would be contacted to obtain an order for a tranquilizer. There is no indication from the medical records if Dr. Cleary was contacted or if a tranquilizer was prescribed. There is also no apparent follow up to Mr. [redacted] "screaming, yelling and threatening" outburst.

2. [redacted], [redacted]-As previously reported, Mr. [redacted] suffers from both mental and medical illnesses. He was diagnosed with Psychotic Disorder, NOS and was prescribed Risperdal, Cogentin and Sertraline. He experienced heat-induced medication-related problems and requested that medications be discontinued. In fact his Risperdal and Cogentin were stopped on 6/27/13. No mental health follow up occurred to evaluate how he was doing without these medications. A review of the recent set of medical records reveals that Mr. [redacted] submitted an HNR on 1/2/14 stating "I am experiencing severe anxiety attacks, irritation and depression." In response to this HNR he was seen by a psychology associate on 1/6/14 and 1/13/14. Mr. [redacted] then submitted a very elaborate HNR on 1/29/14 explaining in great detail his mental health problems and his need for treatment. Staff apparently ignored this HNR and Mr. [redacted] submitted a new HNR on 2/9/14 simply stating "Severe Depression-would like to enroll in a treatment plan." He was seen by a psychology associate on 2/10/14 who stated "I/M will be seen 1:1 approximately every two weeks with focus on anger management and depression." Mr. [redacted] was next seen by a psychologist on 2/18/14 who diagnosed him with Psychotic Disorder, NOS and referred him to a psychiatrist. He was seen the next day, diagnosed with Depressive Disorder, NOS and started on Effexor 37.5mg QHS. Of note, it took over six weeks for Mr. [redacted] to be seen by a psychiatrist after he submitted his initial HNR. In addition, a review of his medical records reveals that Mr. [redacted] was prescribed Remeron 15mg QHS from 10/19/13 through 3/7/14 and Zoloft 200mg QAM from 6/27/13 through 12/24/13. I did not find any mention of these medications in any of the mental health progress notes during this period. This represents extremely poor care and lack of coordination among the members of his treatment team.

3. [redacted], [redacted]-As previously reported, Mr. [redacted] is an SMI prisoner who is diagnosed with "bipolar and PTSD." At the time of my last evaluation, I noted that Mr. [redacted] experienced extended periods where he was not administered his prescribed psychotropic medications. A review of the recent set of medical records reveals that his lithium expired on 11/6/13. He was next seen by a psychology associate on 2/4/14 at which time Mr. [redacted] was asking to be started on Wellbutrin. He was seen by a psychiatrist on 2/11/14 when he was diagnosed with Depressive Disorder and started on Remeron 15mg QHS. This dose was increased to 30mg on 2/20/14. A chart entry on 2/21/14 indicates that Mr. [redacted] is refusing his Remeron because "he doesn't like the way it makes him feel." A psychologist saw him on 2/26/14 and described Mr. [redacted] as being "depressed, anxious and mildly histrionic." Of concern is that the psychologist is apparently unaware that Mr. [redacted] has been refusing his medication for the previous five days. He submitted an HNR on 3/1/14 once again requesting to be started on Wellbutrin. The response to this HNR is that the patient will be seen "on psych line on 3/19/14." Mr. [redacted] is seen by a psychologist on 3/5/14. The psychologist is once again oblivious to the problems that Mr. [redacted] is having with his medication. She also noted that "IM reports increased irritability, sleeping and vegetative symptoms." She then inexplicably states, "IM appears stable." Mr. [redacted] then submits two HNR's on 3/13/14 and two HNR's on 3/17/14, all of which involve requests to be started on Wellbutrin. Of note, the response to all of these HNR's is to repeat that Mr. [redacted] will be seen on 3/19/14. He is finally seen on 3/19/14 and prescribed Wellbutrin-SR 100mg BID. For reasons that are not readily apparent from the chart, the medication is not begun until 3/25/14. This case demonstrates a complete lack of coordination among the mental health treatment team. Also, it took over six weeks for Mr. [redacted] to be finally prescribed the antidepressant Wellbutrin.

4. [redacted], [redacted]-As previously reported Ms. [redacted] has a long history of psychotic and mood symptoms for which she has been prescribed a variety of psychotropic medications. At the time of my previous evaluation, 7/18/13, she was diagnosed with Schizophrenia, paranoid type and was being prescribed five different psychotropic medications including two antipsychotics. At that time, I found her lying on her cell floor, extremely sedated and displaying prominent medication-induced side effects. A review of the recent set of medical

records reveals that she remains on a tremendous amount of antipsychotic medication. A 2/26/14 psychiatrist note documented her medications as Haldol decanoate 200mg q4weeks, Prozac 40mg BID, Prolixin 5mg BID, Geodon 80mg BID, Cogentin 3mg BID and Buspar 15mg BID. I cannot adequately express what an absurd amount of medication this represents. For example, the recommended dose of Haldol decanoate for the treatment of schizophrenia is 50mg q 4weeks. Ms. [redacted] is prescribed four times that amount. Prolixin and Geodon are both antipsychotics. This is even more medication than when I evaluated her last year. At that time she was displaying prominent medication-induced side effects. An Abnormal Involuntary Movement Scale (AIMS) was administered on 2/26/14. It purportedly documented that the patient was not displaying any involuntary movements. I seriously challenge the results of this finding. In addition, it is my firm opinion that this patient remains at serious risk for medication and heat-related problems.

5. [redacted], [redacted]-As previously reported Mr. [redacted] has a long history of treatment for Bipolar Disorder with Lithium, Tegretol and Celexa. At the time of my evaluation, 7/16/13, he was not receiving any medication and was extremely agitated, having recently destroyed the sprinkler heads in two cells. He was housed in a lockdown cell, reinforced with Plexiglas at the Eyman Unit. Of note, he had not been evaluated by a psychiatrist by the time of my inspection of the unit. A review of the recent set of medical records reveals that the first psychiatric evaluation documented in the medical record occurred on 1/24/14. At that time he was prescribed Lithium 900mg QHS and Paxil 40mg QHS. Mr. [redacted] had a follow up psychiatric evaluation on 2/15/14 at which time he was diagnosed with Bipolar Disorder, NOS and his Paxil and Lithium were continued at their previous doses. His clinical condition was described as "less symptomatic." This is the extent of the medical records that were made available for my review. I find it amazing and very disturbing that a patient as ill as Mr. [redacted] was not seen by a psychiatrist for over six months after my evaluation of 7/16/13.

6. [redacted], [redacted]-As previously reported, Ms. [redacted] is a chronically mentally ill woman who I evaluated on 7/18/13. I noted her to be extremely psychotic despite being prescribed Haldol decanoate, Depakote, Prozac and Cogentin. She had also suffered at least two serious bouts of dehydration requiring IV therapy and she was pepper sprayed twice for allegedly not following

the orders of the guards. A review of the recent set of medical records reveals that she continues to have problems at Perryville and was placed on suicide watch on several occasions. It is apparent from the medical record that her psychotic behavior was misinterpreted as being volitional. Although she continued to receive the above-listed psychotropic medications, her diagnosis was felt to be that of a personality disorder. Due to the persistent difficulties she was experiencing at Perryville, she was eventually transferred to Arizona State Prison Complex Phoenix. She was admitted to the mental health program at ASPC Phoenix on 1/15/14. She was diagnosed with a Mood Disorder, Psychotic Disorder, NOS and Borderline Personality Disorder. The medical records from ASPC Phoenix are extremely disorganized so I could only find two brief notes that indicated she was seen by a psychiatrist. One note was titled "Psychiatric Admission Note." This note was incomplete and unsigned. The other note indicated she was seen for approximately 15 minutes. This "psychiatric follow up note" was not signed and did not list diagnoses but only her medications, which were Haldol decanoate 100mg Q2weeks, Prozac 40mg QAM, Depakote 750mg QHS and Cogentin 2mg BID. It is not clear from the medical records if Ms. [redacted] was ever evaluated by a psychiatrist while she was at ASPC Phoenix. In fact, even the admitting medical orders were received via FAX. All the rest of her clinical contacts were with psychologists or psychological associates. It appears from the medical records that she was discharged from ASPC Phoenix around 2/11/14. In summary, this is a very ill woman who required inpatient psychiatric care when I evaluated her on 7/18/13. She suffered needlessly at the Perryville prison until she was transferred to the "George Unit" at ASPC Phoenix on 1/15/14. It is unclear from the medical records if she was ever seen by a psychiatrist while there. Finally, it is unclear from the medical record when she actually returned to Perryville. Her medications were renewed by a nurse practitioner at ASPC Phoenix on 1/16/14 and the Depakote dose was modified on 2/6/14. These are the most recent medication orders that I was able to find in her medical record. The overall handling of her case represents very poor care of a seriously mentally ill woman.

7. [redacted], [redacted]-As previously reported I evaluated Mr. [redacted] on 7/16/13. At that time I found him to be experiencing auditory hallucinations despite his being treated with Haldol decanoate. He also was suffering the medication-induced side effects of sedation and involuntary movements. A review of the recent set of medical records reveals that Mr. [redacted] continued to suffer medication-induced side effects until he began to refuse his Haldol decanoate in

late September 2013. His medications were subsequently changed on 10/1/13. Even after this medication adjustment he continued to experience side effects. On 11/8/13 he was described as "anxious/hyperactive-constant movement." He continued to refuse medications and was not seen by a psychiatrist until 1/14/14 for an adjustment of his medications. Once again this medication adjustment did not resolve his difficulties and he again began to refuse medications. Mr. [redacted] was seen by a psychiatrist on 3/14/14 when his medications were adjusted again. This case demonstrates inappropriately long waits to be seen by a psychiatrist as well as overall very poor medication management. This is especially problematic given that Mr. [redacted] was suffering from medication-induced side effects.

8. [redacted], [redacted]-As previously reported I evaluated Mr. [redacted] on 7/22/13. At that time I noted that his last visit with a psychiatrist occurred on 1/21/13. During this six-month period, he spent a considerable amount of time on watch status for danger to self. At no time during this period was he seen by a psychiatrist. He also experienced problems with medication administration as he was told, "they were out of Risperdal." A review of the recent set of medical records reveals that the most recent Medication Administration Record (MAR) is for January 2014. This MAR documented that Mr. [redacted] was prescribed Tegretol 600mg QHS, Risperdal 1mg QHS, Cogentin 0.5mg QHS, Prozac 60mg QAM. There were actually two separate MAR's that listed Risperdal 1mg QHS. One listed the Risperdal as KOP and the other documented that he was administered Risperdal 1mg QHS every day of the month. During the period of 9/27/13-3/31/14 I located a psychology associate note dated 12/10/13. I also located two psychology notes dated 1/13/14 & 1/23/14. I also located a note, which documented that Mr. [redacted] refused to attend a Telepsychiatry visit in 2014 but the exact date is unreadable. This lack of documented psychiatric involvement is especially worrisome given the confusion over his Risperdal dosing and the fact that two of the medication orders were not accompanied by a progress note by a psychiatrist (i.e. Risperdal 1mg QHS dated 12/12/13 & Tegretol 600mg QHS dated 12/24/13.) Finally, I located an order discontinuing his Tegretol on 4/1/14.

9. [redacted], [redacted]-As previously reported I evaluated Ms. [redacted] on 7/18/13. She suffers from a variety of medical and psychiatric conditions. I especially noted that she experienced many problems in receiving her medications on a consistent basis. A review of the recent set of medical records

reveals that her problems with medications continued. She submitted an HNR on 10/1/13 stating she was experiencing side effects from Lamictal 200mg QD. She refused her Lamictal on 10/4/13. She was seen by a nurse practitioner on 10/8/13 who decreased her dose of Lamictal to 25mg QD. The next chart entry is 1/2/14 when Ms. [redacted] again began refusing her Lamictal. This refusal continued through 1/6/14. She was seen by a nurse practitioner on 1/9/14 who finally discontinued her Lamictal. It is unclear from the medical record why it took over three months to address her very straightforward issues with her medications. At no time during this period was she evaluated by a psychiatrist.

The mental health care received by the named plaintiffs over this six-month period continues to fall below the standard of care.

Inadequate monitoring and oversight

In my initial report I wrote that "ADC's monitoring is deficient in significant respects." 11/8/13 Report at 72. Continuing deficiencies in monitoring and oversight are exemplified by the revised MGAR reports for March 2014. In many cases, the comments by the monitor have nothing at all to do with the item ostensibly being monitored. For example, for the Safford MGAR under "Mental Health," one performance measure reads "Are inmates currently on watch being seen daily by QMHP (including RNs on weekends and holidays)?" The monitor has written "N/A There are no SMI inmates on this complex" – a complete non-sequitur. ADC 422530. For the performance measure "Are reentry/discharge plans established no later than 30 days prior release [sic] for all inmates with a MH score of MH-3 and above?" the monitor writes "If an inmate is placed on a

Mental Health Watch they are transferred to a corridor facility ASAP." ADC 422530. Similarly nonsensical entries appear in the revised March 2014 MGAR reports for Douglas (ADC 422303). The fact that such obvious errors occurred, and still had not been corrected by the time I received these documents nearly five months later, casts serious doubt on the integrity and reliability of the MGAR reports.

Similarly, the "Corrective Action Plans" appended to the MGARs are sometimes meaningless. In the revised Tucson MGAR for March 2014, the "Corrective Action Plans" for two mental health performance measures consist of a verbatim restatement of the monitor's findings of noncompliance. Compare ADC 422578 with ADC 422571-72 and 422573-75. Needless to say, simply restating the fact of noncompliance is not a "corrective action plan."

Nicole Taylor, ADC Mental Health Monitor, testified in her August 1, 2014 deposition that several of the requirements set forth in the ADC Mental Health Technical Manual (MHTM) are simply not monitored. 8/1/14 Taylor deposition, pp. 71-72 (requirement that mental health staff visit SMI prisoner placed in maximum custody with 24 hours of notification); pp. 72-73 (requirement that mental health staff or medical staff with mental health training visit prisoners in maximum custody three times a week); p. 106 (requirement that mental health clinician meet with minor prisoner within two business days of the minor's arrival); pp. 128-32 (requirement that patients discharged from Men's Treatment Unit (MTU) or Women's Treatment Unit (WTU) are seen by a mental health

clinician within seven days). With respect to other requirements, she testified she is unsure whether or how they are monitored. 8/1/14 Taylor deposition, pp. 32-33 (requirement that prisoner's medical record be reviewed within 12 hours of arrival at a new prison complex); pp. 135-36 (requirement that patients in MTU and WTU receive weekly structured activities); pp. 138-141 (requirement that arriving prisoner receive mental health assessment within two days).

Conclusion

For all of these reasons, I stand by the opinions stated in my earlier reports. Based on my review of documents covering the period from September 27, 2013 through April 1, 2014, it remains my opinion that ADC's delivery of mental health services and its conditions of confinement for prisoners with mental illness fall below the standard of care and create a substantial risk of serious harm or death.

Dated this 29th day of August, 2014 at Coeur d'Alene, Idaho.

PABLO STEWART, M.D.

Documents Sent from Plaintiffs' Counsel to Dr. Pablo Stewart

In Preparation for 3/30/16 Report

Sent 1/29/16 via UPS:

- Medical Records for the following inmates:
  - [redacted]
- Institutional Files (MRFs) for the following inmates:
  - [redacted]
- Medical Records and Psych Autopsy for the following inmate:
  - [redacted]
- Medical Records, Psych Autopsy, and Mortality Review for the following inmates:
  - [redacted]
- CGARs for February – November, 2015
  - CGAR CAPs submitted in May 2015 for Douglas, Lewis, Perryville, Phoenix, Safford, and Eyman
- Notice of Substantial Noncompliance with Appendices, 10/15/2015
- Defendants' Response to Notice of Substantial Noncompliance, with Appendix, 11/24/2015
- Defendants' Monitoring Spreadsheet (CGAR Methodology), 12/18/2015
- ADC Count Sheet for 1/13/2016
- 12/18/2015 Memo from Shane Evans to Lucy Rand

Sent 3/14/2016 via UPS:

- *Parsons v. Ryan* Stipulation and Exhibits
- Compliance Data Analysis Chart
- Monthly Staffing Reports for Aug. – Dec. 2015

EXHIBIT 3

- Colorado Staffing – 1/14/16 email from Adrienne Jacobson to Rebecca Wallace
- CQI Meeting Minutes:
  - Sept. – Nov. 2015 for all facilities
  - Feb. – May 2015 for Eyman and Perryville
  - June – Aug. 2015 for Florence
  - May – July 2015 for Lewis
- CGAR Reports:
  - Dec. 2015 for all facilities
  - Jul. and Sept. 2015 for Phoenix
  - Nov. 2015 for Florence
- CGAR CAPs:
  - May – Aug. 2015 for all facilities
  - CAP re Smith – Eyman

Sent 3/24/16 via email:

- Monthly staffing reports for March – July 2015 for all facilities
- April 2014 Mental Health Technical Manual
- Article: "American Psychiatry Should Join the Call to Abolish Solitary Confinement," by Kenneth Appelbaum

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF TODD R. WILCOX

I, Todd Wilcox, declare:

1. I have personal knowledge of the matters set forth herein and if called as a witness I could competently so testify.

I. Introduction and background

2. This report assesses Arizona's prison medical care one year after the Court approved the parties' Stipulation settling this action. Under the Stipulation, defendants agreed to comply with 103 health care-related performance measures, to request that the Arizona Legislature approve a budget to allow ADC and its contracted health services vendor to modify the health services contract to increase health care staffing, and to implement additional policies and training programs.

3. Through my three-day visit to Arizona State Prison Complex-Tucson on December 2-4, 2015, and my review of patient records, including death records, I have found that ADC prisoners continue to suffer serious harm, and in some cases preventable death, because defendants fail to provide necessary and timely health care on a system-wide basis. Tragically, this situation should come as a surprise to no one. The audits that Defendants have compiled every month since the Stipulation was entered document a system where patients lack reliable access to nurse triage, physicians, specialists, and/or necessary medication. The system is obviously broken, and human suffering is the unavoidable result.

A. Qualifications

4. My qualifications are fully set forth in my November 8, 2013 Report. My updated curriculum vitae is attached as Appendix A. The cases in which I have been deposed and/or given trial testimony in the last two years are listed in Appendix B.

B. Information sources

5. I undertook an extensive investigation of current conditions to develop my opinions expressed in this report. I reviewed the CGAR monitoring reports for the

months of February through December 2015, as well as summary charts reflecting CGAR results, well over 100 partial and full healthcare records of Arizona prisoners, and miscellaneous logs and minutes while at ASPC-Tucson. I reviewed staffing reports, lists of prisoners awaiting specialty referrals and meetings minutes of health care staff. I also interviewed staff and approximately two dozen prisoners at the Tucson prison complex. The documents I reviewed are listed in Appendix C.

C. Methodology

6. To prepare this report, I reviewed documents regarding the statewide health care system, prison-specific audits and patient records, as set forth more fully below. I also conducted a prison site visit for three days in December, 2015, at ASPC-Tucson. I chose this prison because it is one of the largest in the state and is one of only two men's prisons with an inpatient/infirmary unit, and because it was one of the five prisons I had visited in 2013, when preparing my initial report.[1]

7. I reviewed all records for people who died in ADC custody during 2015 that were produced to me by 1/19/16. I reviewed patient healthcare records while visiting ASPC- Tucson and also reviewed records provided to me by plaintiffs' counsel. As was true for my previous reports, I did not review a random sample of records during my ASPC-Tucson site visit; instead, I chose to look at files of the same types of prisoners I reviewed for previous reports, including files for patients with diabetes, hypertension, HIV, kidney failure, hepatitis, infections and cancer. I also looked through lab reports, diagnostic test logs, and Health Needs Requests on site to identify patients who had objective findings that were concerning and then I asked for their charts to be pulled for my review. If I found areas of concern in the health care record, I frequently would

[1] Given that the ADC monitoring reports were highly consistent for the large prisons, and based upon my familiarity with the system, having visited half of the state's prisons previously and the fact that the medical record system is comprehensive and inclusive of care rendered at all state prison facilities, I concluded that I could opine about the prison system as a whole based on the documents provided to me and a multi-day visit to a representative institution.

request that the patient be pulled for me to interview to confirm my findings. I also interviewed patients I identified while on tours of the various housing units and then would review their charts afterward to gain additional information about their condition and the care plan. As I explained in previous reports, I focus my review on those patients with conditions requiring them to use the health care system.

8. Although my role when touring ASPC-Tucson was to gather information, I felt obligated to report cases to prison officials and their attorneys when I discovered patients who were in imminent risk of harm. I reported such problems for twelve prisoners, many of whom are discussed in some detail in this report.

II. Opinions

9. When I reviewed Arizona's prison medical care system in 2013 and 2014, I found that it was significantly below community standards and placed patients at serious risk of harm. Wilcox Reports, Doc. 1104-1 and 1138-1. Based upon my recent return visit at Tucson prison complex and my review of documents, my opinion has not changed. Prisoners in ADC custody continue to suffer an unreasonable risk of harm because the health care delivery system of their contractor, Corizon Health, Inc., is woefully deficient, and ADC officials do not acknowledge the gravity and impact of these deficiencies. Many of the deficiencies are rooted in staffing shortages, particularly for primary care providers,[2] and are exacerbated by the adoption of a poorly organized and highly inefficient electronic medical record-keeping system that impedes rather than facilitates health care delivery. What is particularly apparent is that, lacking a sufficient number of providers and medical managers, the system is incapable of self-correction, even when gross systemic problems are identified. Consequently, the auditing reports document the same failure to comply with critical performance measures, month after month; class counsel continue to raise serious systemic issues when advocating for individuals with

[2] I use the term "provider" throughout this report to mean a Physician, Nurse Practitioner or Physician's Assistant who provided primary care to class members.

serious unmet medical needs; and patients suffer preventable deaths that are poorly reviewed.

10. In the short term, the system requires an immediate infusion of physicians and mid-level providers, and nurses. Defendants should be ordered to immediately add a sufficient number of medical professionals to enable all ten prisons to achieve passing scores of 80% on Performance Measures # 37 and # 39 (measuring timely access to nurse triage and to primary care appointments), Measure # 46 (measuring whether provider timely reviews diagnostic reports and acts upon abnormal values) Measure # 54 (measuring timeliness of chronic care appointments) and Measure # 66 (measuring timeliness of provider care in inpatient facility). In a system of this complexity, the only way to achieve a sustainable long-term solution is to undertake a systematic evaluation of the staffing using an established methodology. In my experience, estimates and ratios alone and in a vacuum simply do not work in a correctional healthcare staffing analysis. What is required is to evaluate the setting in which the care is delivered (segregation vs. open yard), the actual demand load for the system (number of sick call requests, number of pills administered, number of intakes done per day), and then apply reasonable healthcare metrics to the equation of meeting the demand in each individual setting with adequate clinical resources. For example, we know that the actual face-to-face time for a patient to be with a provider in a routine appointment should take about 15 minutes. It doesn't matter whether they are a segregated patient or a minimum security patient, it takes 15 minutes. What changes, however, is the impact of the security component on the entire patient care experience. It may take an hour in a high security setting to secure and transport a patient each way and other prisoner movement is restricted during that time. So the 15 minute appointment becomes 1:15 for that setting.

11. We have done extensive staffing modeling, both for Maricopa County and the California Department of Corrections, and these variables really have to be taken into consideration in order to figure out what minimum staffing must be to accomplish the required healthcare tasks dictated by the system demand. Based upon my review of the

system, it is clear to me that the Arizona Department of Corrections healthcare staffing is below what is required to meet minimum performance standards. What is not clear is how far below, and in what job descriptions, the deficiencies exist. Even with all of my experience, without doing the actual math, you cannot discern the answer. As such, completing a formal workload staffing study is a pre-requisite to develop a long-term sustainable staffing plan. The failure to complete a formal workload staffing study will result in ongoing argument about adequacy of staffing and a prolonged and unnecessary continuation of inadequate care as staffing is slowly ratcheted up with each successive legal action and mediation.

12. Until ADC addresses its staffing deficiencies head-on, prisoners will continue to suffer from neglect and inadequate care, and in some cases, they will die unnecessarily. Without sufficient staff, the system will not be able to carry out basic quality review to identify and remedy systemic deficiencies.

13. Review of three similar cancer cases at one prison, ASPC-Tucson, vividly illustrates a system in disrepair. I discussed the case of [redacted] in my Second Supplemental Report, served on defendants in September, 2014. Doc. 1138-1 at 165. He experienced unconscionable delays in screening and treatment for testicular cancer, a condition which, if treated timely is almost always curable. The 5-year survival rate of testicular cancer is approximately 95%. Siegel RL, Miller KD, Jemal A., Cancer statistics, 2015. CA Cancer J. Clin. 2015; 65:5. Declaration of Corene Kendrick, filed herewith, Ex. 4,[3] PLTF-PARSONS-036248-36272.

14. Mr. [redacted]'s complaints of testicular pain in mid-June, 2013 were essentially ignored, and despite a urology recommendation for a radical orchiectomy (removal of the testicle) in September, 2013, the surgery was not provided until 3/24/14. Ex. 60 at ADC418740, ADC418712, 418718, 418740. I noted previously that this delay has exposed Mr. [redacted] to an unreasonable risk of harm. Doc. 1138-1 at 165. I

[3] All subsequent references to exhibits are to the exhibits to the Kendrick Declaration.

interviewed Mr. [redacted] recently while at Tucson complex on 12/4/15, and reviewed his current medical record. Tragically, but predictably, the cancer has spread to his lungs and has been deemed inoperable and untreatable. Sadly, Mr. [redacted] who is 30 years old, has now been diagnosed as terminal, and has less than a year to live. He will die of a treatable and curable disease. In a healthy medical care system, I would expect that the identification of a case with the inexcusable and dangerous health care delays identified in Mr. [redacted]'s case would trigger a review of the case history and remedial measures to ensure that the deficiencies in Mr. [redacted]'s case do not recur for future patients.

15. Sadly, Mr. [redacted]'s case was not an isolated aberration. In addition to his case, I found two other cases of testicular cancer in young men who suffered unconscionable delays in care. [redacted], died of testicular cancer on [redacted] less than a month shy of his 43rd birthday. Mr. [redacted] sought care for an enlarged testicle in June, 2014. He underwent an orchiectomy (removal of his testicle) in September, 2014, just days after my report was submitted. He should have seen an oncologist immediately after this procedure, but he did not. Indeed, I found no documentation from the hospital following the orchiectomy, and it appears he received virtually no medical attention for the three months following the surgery. He was not seen by an oncologist until five months after the surgery, on 2/12/15. On 10/20/15 he underwent surgery to remove lymph nodes and the surgeons found that he had widespread cancer in major blood vessels. He ultimately died of shock resulting from a severe post-operative bleed. The ADC's Mortality Review Committee concluded, correctly, that Mr. [redacted]'s death was preventable. Ex. 69 at ADCM228197-199.

16. Twenty-seven year old [redacted] may be the next victim. Counsel for plaintiffs found Mr. [redacted] by speaking to random prisoners at cell front while walking through a housing unit, and brought his complaints to my attention. I interviewed him and reviewed his health records, which confirmed his allegations of inadequate care. He started complaining of testicular pain in July 2015. He was initially scheduled to have an orchiectomy on 9/30/15. However, because nobody within the Arizona Department of

Corrections or Corizon communicated appropriately, he was fed breakfast that morning and thus his surgery had to be cancelled. It took the system an additional month to get him scheduled for his necessary care, and he had an orchiectomy on 10/30/15.

17. Because of the urgency of his condition, the surgeon ordered a post-operative appointment two weeks later to review pathology, post-operative imaging and to refer him to an oncologist. As of 12/4/15 when I interviewed him, he had not seen an oncologist to consider chemotherapy and radiation. During my prison visit, I notified ADC officials and their attorneys of Mr. [redacted]'s critical needs. Since visiting Tucson, I reviewed more recent documents from his medical file dated through 2/10/16. Despite the alarm that I raised to ADC staff during the tour of Mr. [redacted]'s critical need for immediate health care, he still has not received chemotherapy or seen an oncologist, as discussed in more detail in Part II.D.3 below. If provided proper care, Mr. [redacted]'s condition is curable and he would be able to survive this occurrence of cancer. Given the unconscionable delays and incompetence that appear to be standard in these three cases, I fear he will not.

A. Death Reviews

18. I reviewed medical records and corresponding mortality reviews, when available, for 72 ADC prisoners who died and for whom defendants produced medical records through January, 2016. In most cases, the records I received covered roughly the year leading up to the patient's death. From the 72, I identified 57 files that contained sufficient records to evaluate the quality of care, for patients who died of natural causes. Of these cases, I conclude that 21 prisoners (37%) received grossly deficient care. Tragically, in 11 cases, it is likely that the patient would have lived had he or she received timely adequate care. Ten other cases had significant deficits in care, including delays in diagnosis and delays in obtaining definitive care. Even where the deaths were not preventable, the deficient care resulted in patients enduring unnecessary pain and suffering and resulted in a significant shortening of lifespan.

19. As detailed below, a substantial proportion of the problematic deaths involved health care delivery system failures, including limited access to care based on an insufficient number of qualified providers and nurses; unreliable chronic care programs; failure to provide timely access to specialty care and, when patients do see a specialist, failure to timely follow-up to implement the specialist's recommendations; and failure to effectively track and monitor lab and diagnostic test results. While one or two of these types of deaths in a large system could be considered aberrant, the number and quality of the problematic cases in ADC in 2015 reveal a system that is fundamentally dysfunctional and dangerous. As discussed below, this finding is entirely consistent with the state's own CGAR monitoring scores.

B. Essential building blocks to a correctional healthcare delivery system

20. As I explained in my initial report, it is well established that functional healthcare delivery systems are comprised of certain building blocks necessary to provide effective care. Doc. 1104-1 at 223. Two years ago, I found ample evidence that most of these elements are either missing or profoundly flawed in the Arizona system. Little has changed in the intervening period, and the system remains grossly deficient.

1. Centralized organization/management structure

21. A functional system must be well structured, with clear lines of authority, oversight, and accountability. The healthcare delivery system in Arizona prisons had none of these characteristics two years ago, and it remains chaotic and ineffective.

(a) The CGAR system

22. The oversight structure ADC currently uses to monitor Corizon and ensure that care is delivered in its prisons is the Compliance Green-Amber-Red (CGAR) reporting process, an offshoot of the MGAR reporting process described in my first report. In this system, the performance measures listed in Exhibit B to the Stipulation are monitored monthly at each prison complex. Doc. 1185-1 at 7-15. As before, the ADC monitor measures compliance with the performance measures, and enters a numeric score

and a finding of green, amber, or red to indicate compliance levels. I was advised the computerized system automatically generates an emailed request for a corrective action plan (CAP) to Corizon to address each individual deficient finding. However, I was provided only a handful of proposed CAPs for medical care, and the documents provided were insufficient to identify which CAPs had been approved and/or implemented at each prison.

23. In my first report, I explained that this system (then referred to as Monitoring Green-Amber Red or MGAR), was flawed for a number of reasons including that the results were unreliable, and that there was no meaningful enforcement to ensure deficiencies were actually corrected in a sustainable manner. Doc. 1104-1 at 227-229.

24. In December, 2015, Defendants provided the plaintiffs with a chart purporting to show their revised method they will use to evaluate each of the performance measures. I have reviewed it and determined that the chart fails to address fundamental reliability problems with the data that, in some cases, result in inflated compliance scores.

25. For example, Measures # 50 and # 51 evaluate whether patients are seen timely for urgent and routine specialty care appointments. Doc. 1185-1 at 11. These measures should examine whether, once a specialty appointment is ordered, it happens within 30 days (urgent) or 60 days (routine). To measure this, the monitors should select orders written more than 30 or 60 days before the month targeted for review, and determine how many of the appointments have been completed timely. Instead, the defendants' methodology with the CGARs I reviewed calls for selecting patients who had a specialty consultation in the target month, and working backwards to see whether the consultation happened timely. Ex. 2 at PLTF-PARSONS-036234-35. This method is fundamentally flawed because it introduces a significant selection bias by starting with consultations that do occur and methodologically ignores patients for whom consults were ordered but have not occurred. Based upon my review of records two years ago, and my review for this report, it is clear that many specialty consults that are ordered simply never occur. Thus, in order to derive an accurate assessment of the overall timeliness of

specialty consults, the monitors must begin their inquiry by examining all of the consultation requests. I consider the CGAR scores for these two Performance Measures to be particularly unreliable.

26. Similarly, the monitors assessing data for Performance Measure # 39 (routine referrals to provider by nurse's line seen within 14 days), (Doc. 1185-1 at 10), measure compliance in two different ways, one of which also inflates compliance scores. For the month of December 2015, the Phoenix, Douglas, and Eyman monitors identified the referrals that were made in the month of December, and evaluated whether they had occurred at the time of the audit in late January, and as a result found multiple referrals that had not yet been seen. Ex. 14 at ADCM322756-57; Ex. 9 at ADCM322461; Ex. 10 at ADCM322510. This approach captures all of the patients who were referred during a set period. In contrast, the Florence and Perryville monitors identified a sample of all completed provider encounters that occurred in the month of December, and looked backwards to see when the nurse's line referral occurred. Ex. 11 at ADCM322705-06 and Ex. 13 at ADCM322574. As a result of using this retrospective approach, the Florence and Perryville results do not capture any late referrals that simply had not yet occurred at the time of the audit, tainting the results with selection bias.

(b) CGARs Reveal Systemic Problems

27. Although CGARs are flawed measures of compliance, they do contain valuable information about deficiencies, and many of my conclusions are informed by the problems they describe. As was true when I drafted my first report, I still see no evidence that the monitoring process has contributed to lasting solutions for these problems. There is still no evidence that the monitors or anyone else takes appropriate action to permanently correct problems, even if they find chronic noncompliance month after month. There is also no evidence of an effective Continuous Quality Assessment process wherein problems are identified, process changes are implemented, and then the problems

are studied again using the same methodology to ensure that the changes have rectified the deficiencies.

2. Consistently followed policies and procedures

28. As indicated in my previous report, policies and procedures are fairly standardized across correctional healthcare systems. As was true two years ago, the Arizona system violates its own basic healthcare policies – including those governing sick call timelines, chronic care management, healthcare records filing, and specialty consultations – on a consistent basis. For the sake of space, I will not repeat here the evidence set forth throughout this report, particularly in Sections II.C.1-4, II.D.1 and 3, and II.E.1-3.

3. Adequate staffing

29. A system cannot deliver adequate medical care without a sufficient number of medical staff. The number and composition of the health care staff will depend on a number of factors, including the age and acuity of the prisoner population, the nature of the prison (e.g., reception center vs. long-term housing vs. work camp), the availability of telemedicine and a host of other issues. Thus, it is impossible to specify precise minimum staffing ratios in the abstract. What is clear is that there must be a sufficient number of staff to ensure that patients do not suffer unreasonable delay in receiving necessary medical care. As was true two years ago when I prepared my first report, there are clearly too few medical staff to ensure that the patients receive timely care.

30. With approximately 35,550 prisoners in the ten ADC prisons, there are just 14 staff physician positions allocated, and only 12.8 were filled as of December 2015 according to Defendants' staffing data. Ex. 20 at ADCM274691. The ratio of patients to physicians is approximately 1:2500, if all positions are filled. Including the 26 mid-level providers (nurse practitioners), the system has approximately one primary care provider for every 890 patients, if all of the positions are filled. The ratio is closer to 1 to 1000 when the vacancies are considered.

31. Although it can be difficult to compare staffing in different correctional systems, for the same reasons that it is impossible to identify precise minimum staffing ratios, comparison to Alabama, another medium-sized state prison system where Corizon also provides care, has significantly more physicians per capita. According to the 2012 Corizon contract, Alabama has 14.60 physicians. Ex. 7 at PLTF-PARSONS-036312. According to their website,[4] Alabama housed approximately 25,000 prisoners in December, 2015, which works out to a staffing ratio of roughly 1 staff physician for every 1,700 prisoners, compared to Arizona's ratio of one staff physician to more than 2,500 prisoners. Clearly, Corizon does not apply a standard staffing analysis to the delivery of care in prisons which underscores the need to determine appropriate staffing using mathematical principles and recognized healthcare metrics.

32. Corizon's primary care provider team in Arizona is problematic because there are too few providers overall, and because the ratio of physicians to mid-levels is too weak. Physicians are obligated to proctor/monitor mid-levels, which means they have less time to provide treatment to patients. Furthermore, many of the physicians at the various facilities have significant administrative duties, which means that effectively there is very limited physician time to perform actual clinical care.

33. I observed clear evidence of inadequate staffing during my visit to the Tucson complex. According to the facility's Continuous Quality Improvement Meeting minutes for 9/3/15, the staff were "working down" the backlog of overdue chronic care appointments to 800. Ex. 21 at ADMC197765. By 11/5/15, staff reported that the backlog had been reduced to 200. *Id*. at ADCM197785. I questioned staff about how this reduction had been accomplished, and was told the prison had run additional tele-med lines using telemed providers, had hired additional contract providers, and had conducted weekend sick call lines. Tucson health care staff noted, however, that the additional resources had been available only for the months of September and October 2015. Staff

[4] See http://www.doc.state.al.us/docs/MonthlyRpts/2015-12.pdf at 3.

reported to me that, as of 12/2/15, the backlog of overdue chronic care patients had spiked back up to 714.

34. The CGARs document backlogs for access to providers and nursing staff. In the Corrective Action Plans, health care staff have acknowledged that the failure to meet some Stipulation performance measures is related to staffing vacancies. *See, e.g.* 7/15 CAP, Douglas (Failure of provider to see patients timely after sick call and to review specialty consult reports timely is staffing issue) (Ex. 19 at ADCM199411, ADCM199413); 7/15 CAP, Eyman (Lacking RN onsite 24/7 because of nursing vacancies) (Ex. 19 at ADCM199414); 5/15 CAP, Eyman (Failure to timely and accurately file medical records based on need to hire clerk) (Ex. 19 at ADCM199318); 8/15 CAP, Florence (Failure to renew prescriptions timely based on need to hire nurse) (Ex. 19 at ADCM199496); 8/15 CAP, Lewis (To remedy untimely RN sick call, need to "work on filling vacancies") (Ex. 19 at ADCM199553); 5/15 CAP, Lewis ("Actively recruiting RNs" to address untimely sick call; one nurse covering three posts; and need to "continue to recruit" provider level staff) (Ex. 19 at ADCM196868).

35. As I explained in previous reports, staffing shortages endanger patients. They do this in a variety of ways: they lead to excessive delays in access to care (Section II.C.1 below), healthcare staff acting outside the scope of their licenses (Section II.D.2 below), the failure to carry out providers' orders (Section II.E.2, below), and the failure to review and file diagnostic test results (Section II.E.3, below).

4. Adequate physical facilities

36. My observation of the physical facilities I toured at ASPC-Tucson in December 2015 was that basic elements are there: equipment, exam rooms, storage facilities, lab draw rooms, and medication storage rooms were generally acceptable. The patient care areas I saw were generally clean at the time of my visit. Many patients that I spoke to reported that the staff had undertaken an extensive cleaning campaign during the two weeks before we arrived, suggesting that the acceptable level of hygiene that I observed may not be the usual condition of the facilities.

C. Timely access to care

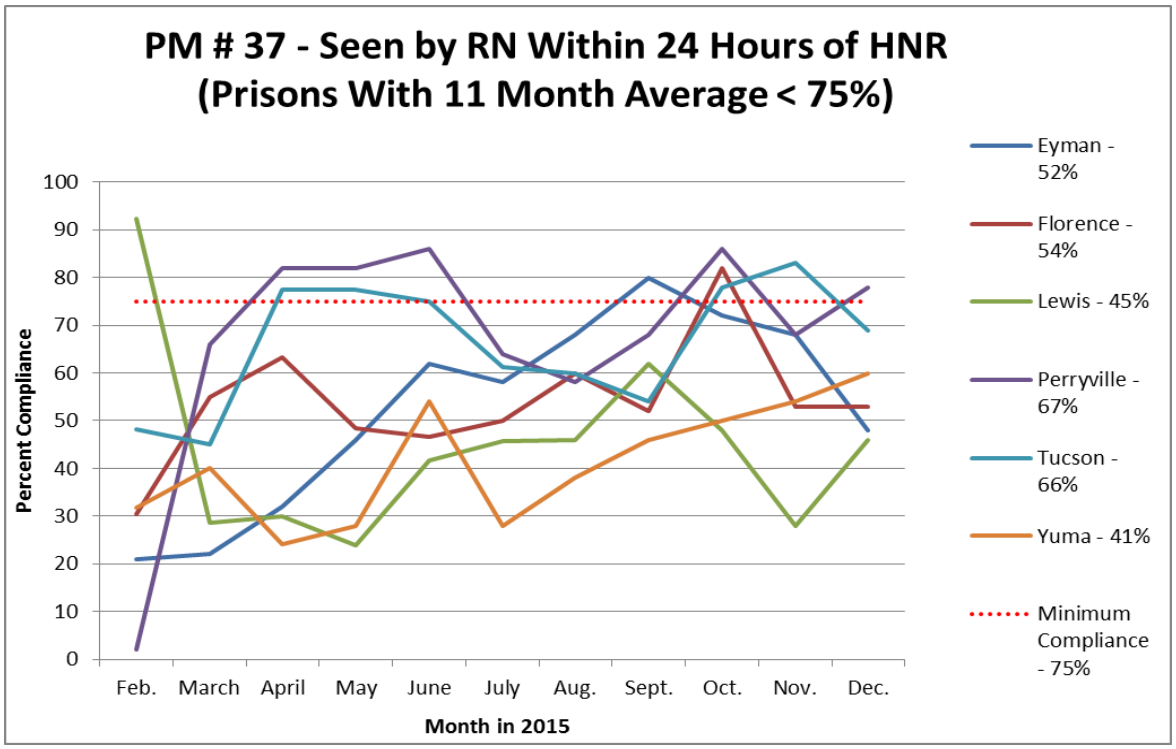
37. As I explained in earlier reports, access to care, *i.e.,* the task of getting patients to see nurses and providers is a basic building block in the structure of a functional health care system. Arizona failed at this fundamental task two years ago when I first evaluated the system, and it fails today. Having interviewed ASPC-Tucson patients and reviewed an extensive number of medical records from Tucson and other facilities, I found a shocking number of delays in access to care and complete denials of care in Arizona's prisons. These delays and denials harm some patients and place all patients at an unreasonable risk of serious harm.

1. Sick Call/HNR System

38. Pursuant to Arizona's policies, prisoners in need of medical care must file written HNR forms, which are required to be triaged within four hours of the time they are stamped as received. Ex. 5 at ADC010827. As I explained in my first report, ADC's policies and Performance Measure # 37 require that patients who submit sick call slips be seen the same day for urgent needs, and immediately if emergent; otherwise, they are to be seen by nurses for sick call ("nurse line") within 24 hours of the triage (or up to 72 hours if it is a weekend and clinically appropriate). *Id.* If higher level attention is warranted, patients must be seen by providers within fourteen days after that ("provider line"), as monitored on the CGARs as Performance Measure # 39.

39. Two years ago, my review of healthcare records, documents, and depositions and my interviews with patients demonstrated to me that Arizona's sick call process was deficient on a system-wide basis, and that prisoners with serious conditions, including extremely fragile patients with chronic conditions, simply could not get seen by the appropriate medical personnel on a consistent basis. Regrettably, based on my review of the CGAR results, death records and my site visit to Tucson, I have concluded that the sick call system remains profoundly deficient.

40. Defendants' CGAR reports document an ongoing and persistent failure to provide timely sick call triage for patients who submit sick call slips. For the eleven month period of February through December 2015, none of the six largest ADC prisons achieved an average score of 75% or higher, and at Yuma, on average, just four in ten patients were seen timely during that period. For the month of December, two large prisons, ASPC-Eyman and ASPC-Lewis scored under 50%. Ex. 1 at PLTF-PARSONS-36223.



41. The failure to respond timely to patients' health care requests can have devastating consequences. The case of [redacted] a Yuma prisoner, is illustrative. He was a 59-year-old male who had been diagnosed with end-stage liver disease. The patient clearly had severe end-stage liver disease with significant complications of that disease including massive fluid retention, groin wounds, and sepsis. Despite Mr. [redacted]'s serious condition, the nursing staff repeatedly failed to respond to his desperate Health Needs Requests. For example, on 3/6/15, he submitted an HNR that indicated "my legs were bleeding with open weeping wounds sticking to my prescription

socks. I am in severe pain. I cannot wear my socks nor get them on. I am in pain." Ex. 46 at ADCM039111. The nursing response to this sick call request indicates that it is a "duplicate from 3/3/15." However, there is no health needs request dated 3/3/15 in his medical record. There is a triage note entered by a licensed practical nurse that urgently referred him to the nurse line at an unspecified time in the future. Ex. 46 at ADCM039213.

42. Mr. [redacted] filed another HNR on 3/17/15 for shortness of breath and painful abdomen. This was scheduled for a nurse line appointment at an unspecified time that apparently did not occur. Ex. 46 at ADCM039103. He filed a subsequent HNR on 3/21/15 for worsening fluid retention and shortness of breath. Again, the HNR was essentially screened out with the notation "duplicate same as 3/17, you are on nurse line." Mr. [redacted]'s condition deteriorated and his fluid retention worsened to the point that his skin split open and became infected. By 3/31/15 Mr. [redacted]'s situation deteriorated to the point that he was being swarmed by flies, which he reported in a HNR. The next day, 4/1/15, instead of investigating why this might be the case in a patient with split skin that oozes serum, the nurse instead decided that this problem did not need to be seen. Ex. 46 at ADCM039197. The flies were attracted to his massively infected wounds and proved to be a harbinger of his death. He was ultimately transferred to the hospital more than a week later, on 4/9/15 where he died on [redacted].

43. The ADC Mortality Review determined there were multiple triage mistakes made by Corizon nurses that impeded and delayed care for Mr. [redacted] Ex. 47 at ADCM044568. I agree with their finding but I add the conclusion that this case falls well below the standard of care, and that the poor care hastened his death. ADCM044566.

44. I interviewed [redacted] at ASPC-Tucson, a patient with polymyositis (a chronic inflammatory disease causing muscle weakness) and interstitial lung disease. He likewise has had inexcusable delays in nursing and medical care that, while not fatal yet, have caused him serious harm and certainly place him at risk for deterioration and death. On 4/6/15, he submitted a sick call for shortness of breath, severe

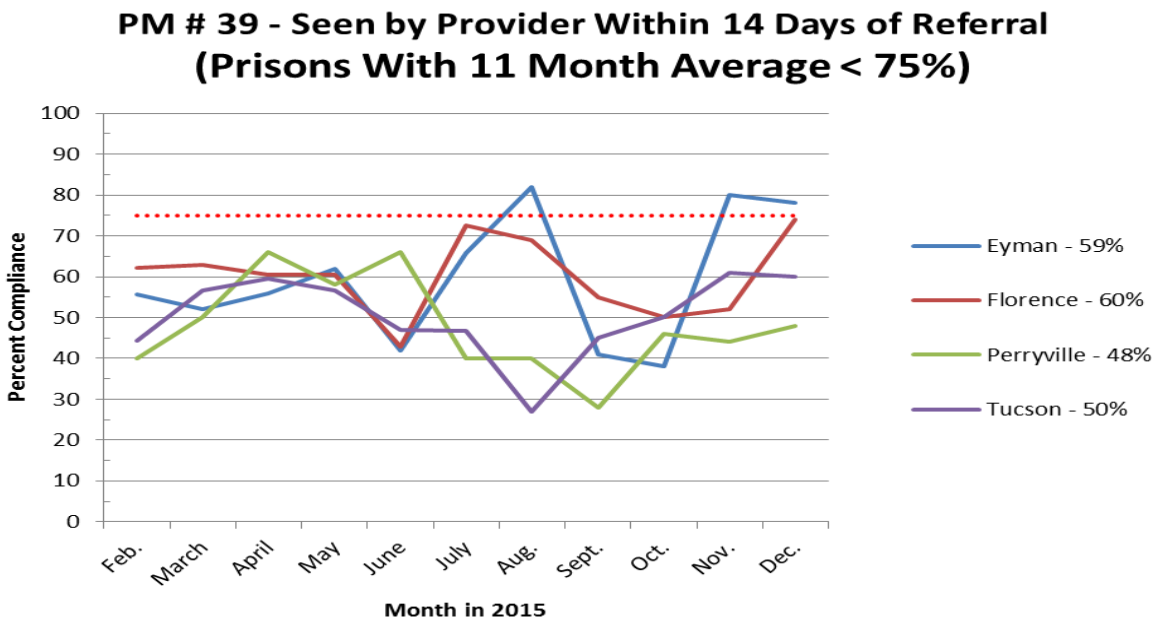
cough, temp elevated at 99.0, but was not seen by nursing. Six days later, he submitted an emergency HNR for heavy coughing, vomiting, sweating, and breathing. Still, he was not seen by nursing. Finally, on 4/20/15, Mr. [redacted] presented in person to the medical clinic with a fever, rapid pulse and respirations and a low level of blood oxygen. At that point, he had developed sepsis, and was immediately transferred to an offsite hospital, where he almost died. Had his symptoms been addressed two weeks earlier he would almost certainly have avoided hospitalization. Mr. [redacted] is immunocompromised because of the medications he has to take to treat his polymyositis. Staff should be on extra high alert if he develops any signs or symptoms of infection, and should evaluate him promptly. Instead, his serious symptoms were virtually ignored for days.

45. As was true two years ago, ADC prisoners still frequently do not see a provider within fourteen days of sick call with a nurse. This is not surprising – Corizon has not increased its medical provider staff, and there are simply not enough providers to treat the number of prisoners in the ADC facilities and the process for seeing patients has become increasingly inefficient with the introduction of the electronic health record.

46. The lack of sufficient primary care staff drives delays in access to care, as reflected in the CGAR measures regarding timeliness of primary care routine appointments. According to defendants' methodology chart, the monitors assess compliance with Measure # 39[5] by reviewing a sample of records for the previous month for patients who a nurse referred to the primary care line. Ex. 2 at PLTF-PARSONS-036233. Review of this sample will show whether the referrals made in the previous month were completed within 14 days. It will not shed light on the length of the delays experienced by those patients who are not seen timely, or indeed whether they are seen at all. The CGAR results for the months of February through December demonstrate widespread non-compliance with the 14 day benchmark, particularly at the five largest

[5] Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointment will be seen within 14 calendar days of the referral. Doc. 1185-1 at 10.

men's prisons and at Perryville, the women's prison.[6] At three of the five largest men's prisons, during eleven months from February through December, 2015, the average compliance rate for Measure 39 was below 75%, with Tucson scoring 50%. Perryville scored at 48%. Ex. 1 at PLTF-PARSONS-36224.



47. The CGAR results indicate that patients often wait six weeks or more to see their Primary Care Provider following a referral. See e.g. Ex. 13 at ADCM226165-66 (11/20/15) (some patients at Perryville wait six weeks to see provider); Ex 16 at ADCM226312-13 (11/26/15) (at Tucson's Winchester, six of ten patients referred to the provider in October had not been seen at the time of the 11/26 audit; at Catalina, five of ten referred in October had not seen the provider at the time of the audit, and an additional patient had been seen, but not in relation to the referral; at Santa Rita, five of ten patients referred in October were not seen timely, and three had not been seen at all); Ex. 11 at ADCM226035-36 (11/30/15) (at Florence, three of four East Unit patients referred in October not seen as of time of audit; at Kasson, six of eight patients not seen

[6] ASPC-Eyman, ASPC-Florence, ASPC-Lewis, ASPC-Tucson and ASPC-Yuma.

timely, and three had not been seen at all); Ex. 10 at ADCM22585-586 (11/30/15) (at Eyman, six of six Browning patients, three of six Meadows patients, and three of five Cook patients referred in October had not been seen at time of audit); Ex. 16 at ADCM322847 (1/30/16) (Tucson complex-wide compliance rate of 60%; eleven patients simply not seen by the time of the audit, and in one case, a three month delay for a patient to see a provider); Ex. 18 at ADCM322923 (1/29/16) (Yuma complex-wide compliance rate of 68%); Ex. 10 at ADCM322510 (1/31/16) (at Eyman, six of 10 Browning patients and one Cook patient referred in early December had not been seen at time of audit); Ex. 9 at ADCM322461 (1/29/16) (Douglas patient referred to provider on 12/3/15 still not seen as of time of audit); Ex. 11 at ADCM322574-75 (1/28/16) (Florence complex-wide compliance rate of 74%; at North Unit, three of six patients referred in December not seen at time of audit; and three of five South Unit patients referred in December not seen at time of audit); Ex. 16 at ADCM322756-57 (1/29/16) (Phoenix complex-wide compliance rate of 72%; multiple prisoners referred in early to mid-December still not seen at time of audit).

48. The CGAR results also document that some patients are scheduled and rescheduled for appointments that do not happen. See e.g. ADCM226312 (11/26/15) (Some sampled patients in each of Tucson's eight housing units were scheduled for appointments that did not happen.)

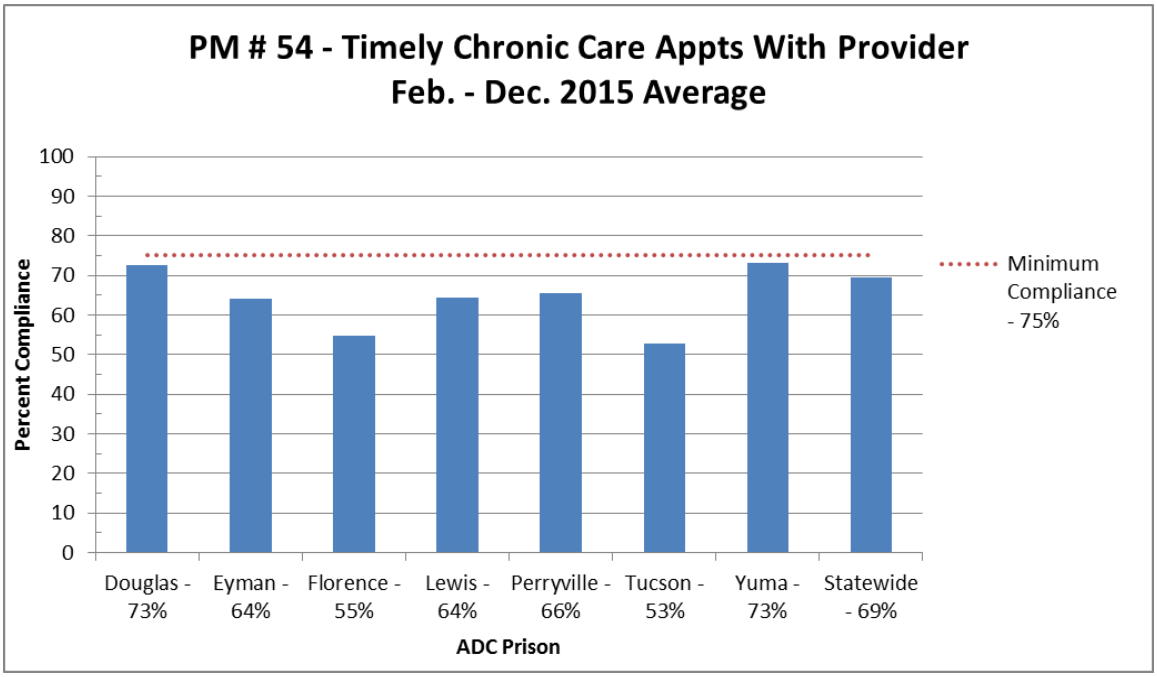
2. Chronic care

49. Chronic care clinics are a major focus of healthcare in a well-functioning correctional setting. Regularly scheduled appointments allow providers to track the progress of patients with chronic illnesses and ensure appropriate levels of treatment.

50. Monitors assess compliance with Measure 54[7] by generating a scheduled appointments list from their database, and selecting the first ten patients to review whether

[7] Chronic disease inmates will be seen by the provider as specified in the inmate's treatment plan, no less than every 180 days unless the provider documents a reason why a longer time frame can be in place. Doc. 1185-1 at 11.

their chronic care appointments occurred within the timeframe specified by the provider. Ex. 2 at PLTF-PARSONS-036235. As with the primary care appointments, the CGAR results reflect overwhelming failure at the five largest men's prisons and the primary women's prison to reliably schedule timely chronic care appointments. From February through December 2015, the average compliance rate at each of those prisons was under 75%, with Tucson and Florence at barely over 50% compliance. Ex. 1 at PLTF-PARSONS-026225.



51. The CGAR scores do not reveal the magnitude of the delays for those patients whose chronic care appointments are not scheduled timely. In some cases, however, the data underlying these poor scores reveals a shocking pattern of failure, where some chronic care appointments lapse for over a year. *See e.g.*, Ex. 16 at ADCM226324-325 (11/27/15) (at Tucson, on Santa Rita, one patient had two year lapse between chronic care appointments, and at least two lapsed for over a year; on Cimarron, a patient with diabetes lapsed for over a year; on Manzanita, patient with active cancer, ordered to be seen monthly, was not seen for four months); Ex. 16 at ADCM322858-59 (1/27/16) (Tucson complex-wide compliance rate of 52%; seven out of ten files

noncompliant at both Cimarron and Santa Rita Units where multiple patients experienced gaps of 7 to 11 months between chronic care appointments; three patients with "active cancer" at Manzanita and Rincon Units who needed to see provider monthly had gaps of 2 to 6 months between chronic care appointments); Ex. 13 at ADCM322712-13 (1/29/16) (Perryville complex-wide compliance rate of 64%; at Lumley Unit, a woman with "active cancer…with plans for radiation therapy" for thyroid cancer not seen for eight months for chronic care appointment, and another Lumley patient with rheumatoid arthritis not seen for a chronic care appointment for 19 months after her diagnosis; patient at Santa Rosa Unit with blood disorders and anemia not seen for a chronic care appointment for 14 months); Ex. 9 at ADCM322466 (1/29/16) (Douglas complex-wide compliance rate of 45%); Ex. 10 at ADCM322518 (1/25/16) (at Eyman's SMU-I unit, five of ten files reviewed showed delayed chronic care appointments including prisoner seen four months late; Rynning prisoner with seizure disorder seen four months late; Browning patient with hypertension with nine month gap between chronic care appointments); Ex. 11 at ADCM322584 (1/27/16) (Four of ten files reviewed at Florence's North Unit showed delayed chronic care appointments, including 8 month gap in chronic care appointments for patient with thyroid disorder and hypertension; at Central, patients with 9 and 14 months gap between chronic care appointments; at Central Unit, patient with seizure disorder, Hepatitis C, and asthma with no chronic care appointment between early March 2015 and mid-December); Ex. 18 at ADCM322930 (1/29/16) (At Yuma's La Paz Unit, two different patients with seizure conditions seen late, and no documentation in health records to justify not complying with CGAR's 180 day requirement); Ex. 17 at ADCM322885 (1/20/16) (patients at Winslow seen six weeks and three months later than indicated).

3. Emergency care

52. The problems identified regarding sick call access and inadequate staffing are also barriers to timely emergency care in the ADC. The lack of sufficient staff

competent to respond to emergencies places the class members at an unreasonable risk of harm and, in some cases, death.

53. In a system where there are simply not enough providers and medical staff to handle the patient load, critical errors are likely to occur. At Perryville, for example, I found two tragic cases where staff simply failed to recognize that their patients were suffering life-threatening conditions requiring emergency care. [redacted] who had a history of deep vein thrombosis (blood clots), pulmonary embolus (blockages in her lungs), abscesses and osteomyelitis (bone infection). On 9/6/15, she complained of radiating pain down her leg, abdominal pain and the inability to urinate. Although she was able to void after receiving IV fluids that day, she was unable to urinate the following day. The standard of care in this situation requires an immediate and full assessment to determine whether the patient is in renal failure or has a different condition interfering with urination. Instead, on 9/8/15, Ms. [redacted] was given Flomax, a drug that was inappropriate, and Toradol, a drug that was actually contraindicated and potentially dangerous.

54. The next day, she complained of chest pain and the inability to move her legs. Instead of sending her offsite for emergency care, which was clearly warranted, Ms. [redacted] was taken to the prison's central medical clinic, where her temperature was recorded as 91.9 degrees Fahrenheit, which is a critical vital sign abnormality suggestive of sepsis and requiring emergency assessment. She was eventually taken to the hospital, where she died the following day of a staph infection, spinal meningitis and pneumonia. Ex. 68 at ADCM228194. Had she been sent to the hospital emergently on 9/6/15, her infections would have been treated sooner and she very likely would have survived. The Mortality Review Committee's report indicates that her presentation was confusing and concludes that her care met community care standards. Ex. 68 at ADCM228195-96. For the reasons explained above, I strongly disagree.

55. Another woman, [redacted] clearly should have been sent offsite for emergency care when she fell from her bed early in the morning on [redacted] and

staff found her with bloody fecal matter on her legs and body, a racing pulse and alarmingly low blood pressure. The on-call nurse practitioner ordered Ms. [redacted] be taken to Perryville's central medical complex, where she was provided an IV, but her blood pressure continued to drop. Her blood pressure fell dramatically at the complex, and she clearly required emergency care. Instead, despite her life-threatening blood pressure readings, Ms. [redacted] was returned to her housing unit by nursing staff after receiving her IV fluids. Ex. 26 at ADCM228173. Shockingly, the practitioner did not document an abdominal exam or any explanation for the fecal matter on her body. In the late afternoon that same day, custody staff called another ICS (ADC code for emergency incident) when they noticed Ms. [redacted] had vomited blood. *Id.* Although her blood pressure again was dangerously low, the staff did not call for an emergency transport for almost 40 minutes. She died shortly thereafter. The ADC Mortality Review Committee classified this death as preventable, and I agree. Ex. 26 at ADCM228171. The emergency response and decision making were beneath the standard of care and the delay in definitive care proved fatal.

56. [redacted], a patient at ASPC-Lewis with a history of Type 2 diabetes, should have been sent to a hospital on [redacted] when he reported left sided chest pain with radiation into his neck, left arm and left shoulder blade. He also was sweating heavily and short of breath. He also had very low blood pressure and a racing pulse. Ex. 57 at ADCM196768. Seen together, these are signs of serious cardiac pain. Rather than send him to a hospital emergency room for lab tests, the nurse treating him had labs drawn at the prison and waited hours for the results, a treatment decision clearly beyond the nurse's scope of practice. When they were reported as abnormal, Mr. [redacted] was taken to the hospital in the mid-afternoon, where he died the following day. Although his record is limited, it is very likely that the delay in providing him with definitive care and nursing staff's decision to delay his emergency transport hastened his death.

57. The MRC report recognized the delay, and recommended an in-service training on assessment, evaluation and treatment of chest pain. Ex. 57 at ADCM196770.

While I agree that training in this case is certainly warranted, the care in this case is so grossly substandard that it warrants an investigation to determine whether employee discipline is appropriate.

58. [redacted] illustrates the tragic consequences of poor access to the appropriate level of health care and the disorganization of the electronic medical record system. Mr. [redacted] died on [redacted] of a gallbladder infection that would have been easily treated had he received timely care. Instead, the last three months of his life were marred by a series of lapses and missteps, including three mishandled emergencies, that resulted in the denial of medically necessary care.

59. Mr. [redacted] who suffered from very poorly controlled diabetes (Ex. 31 at ADCM172397), developed alarming symptoms that should have prompted a thorough work up. He submitted an HNR on 4/6/15 complaining of blood in his urine. *Id.* at ADCM173275. Lab tests dated 4/9/15 revealed multiple critically abnormal values demonstrating significant liver dysfunction, but the record contains no indication that these results were ever communicated to Mr. [redacted]'s physician at the time they were received. The patient's labs were reviewed on 4/16/15 and the critically abnormal tests were acknowledged. *Id.* at ADCM172737. The patient was seen by a gastroenterologist on 4/30/15 but the consultant's report was not reviewed by his physician until three weeks later (ADCM172430), resulting in delayed implementation of critical care recommendations.[8]

60. Mr. [redacted] was becoming increasingly ill, resulting in custody calling three ICS's in a period of ten days. The first ICS, on 5/27/15, was based on his shortness of breath. The healthcare provider who examined him noted he was short of breath, his abdomen was distended with ascites and he had 3+ edema in his legs (*Id.* at ADCM172790). The provider failed to recognize the severity of this patient's new

[8] Performance Measure # 52 requires a medical provider to review and act upon a specialty report within seven calendar days of receiving the report. Doc. 1185-1 at 11.

symptoms and merely ordered him a diuretic and a 1-month followup. *Id.* at ADCM172793.

61. The second ICS was called on 6/4/15, at which point an RN documented that he had full body pain, swelling and hyperactive bowel sounds. Although the nurse writes that the physician examined the patient, there are no exam notes by a physician in the record. The patient was prescribed Tylenol, which was contraindicated in light of his liver failure, and was likely ineffective for his pain. *Id.* at ADCM173216.

62. The following day, Mr. [redacted] was assessed by an LPN, who performed a complete examination of the patient, despite the fact that this level of care is well out of her scope of licensure. Although she referred the patient's chart for provider review, there is no evidence that the review occurred. *Id.* at ADCM173212.

63. Finally, on 6/6/15, a third ICS was called. The RN noted that Mr. [redacted] had a critical lab value. At this point, the Nurse Practitioner ordered him transferred to the outside hospital. It is unclear what critical lab value prompted this transfer because there are no orders for labs in this date range (*id.* at ADCM172725), there are no lab reports from this date range in the medical record, the LPN note does not indicate what lab value was critical (*id.* at ADCM173204), and the practitioner who received the critical lab value (NP Mulhern) did not put a note in the chart indicating what critical information was conveyed to her.

64. Overall Mr. [redacted] s care was disorganized, delayed, haphazard, and inadequate and the sum total of his treatment does not meet the standard of care. His medical record is extremely confusing and I agree with the Mortality Review Committee that his course of care was difficult to follow because of what was documented, what occurred and was not documented, and what was documented in the wrong sections. The provider failed to work up the sudden and significant changes in his health status and the provider's oversight of the healthcare team was delayed and inappropriate. This patient had critical labs that were never addressed, major changes in his bloodwork, multiple ICS responses with ominous physical exam findings that were completely ignored, and

consults that gave appropriate guidance that were not reviewed or implemented in a timely fashion to facilitate his workup. While it is clear that he had a number of tests and consults completed during this three month span, the care was so fragmented and scattered that nobody really put together the overall picture of his healthcare issues. By the time he was finally transferred to the hospital, he was so physically sick and compromised that his treatment at the hospital was ineffective and limited and he ultimately had fatal medical complications as a result. The ADC Mortality Review Committee concluded that it could not determine whether this death was preventable. Ex. 30 at ADCM173601. Had Mr. [redacted] been properly worked up in April 2015, I believe he might have survived.

65. I encountered [redacted] in the inpatient unit at ASPC-Tucson. He is an insulin-dependent diabetic who has had a kidney transplant. He has also had a right leg amputation, finger amputation and he was in the IPC with a diagnosis of Fournier's Gangrene. This diagnosis was given to him by the Corizon physician. There is a note on 12/1/2015 from Dr. Burciaga indicating that he had Fournier's Gangrene and he was to be a direct admit to Mt. Vista Hospital with Dr. D'Silva accepting on 12/1/2015. However, when we toured on 12/2/2015 he was still in his prison bed. This is a problem because Fournier's Gangrene is a surgical emergency that carries a very high morbidity rate. Usually surgery is required to save the patient's life within hours after diagnosis and hyperbaric oxygen treatment is frequently necessary as well. So it is appropriate that Dr. Burciaga sent him to be a direct admit to the hospital; it is completely inappropriate for this emergency case to have waited. In my brief time at Tucson, I was not able to identify the reason for this inexcusable delay. I suspect that it is related to staffing – had Tucson allocated sufficient health care staff to the inpatient unit in which Mr. [redacted] is housed, someone would have been tasked with ensuring his prompt transfer. The failure to timely transfer him greatly increased his chances of requiring yet another amputation or of dying. This is abysmal care.

66. [redacted] is another Tucson prisoner I spoke to who failed to receive competent emergency care. He slipped in the shower on 9/6/2015, and an x-ray

ordered confirmed a "comminuted depressed tibial plateau fracture and proximal fibula fracture." Inexplicably, he was not referred to Mountain Vista Hospital until four days later on 9/10/15, but the hospital did not admit him because, due to the delay in referral, his fracture had resulted in massive swelling around the knee to the point that surgery was not possible. Moreover, the on-site x-ray was not reviewed by a provider until 9/14/2015 which is well beyond the injury time. Even after his swelling resolved, his care was delayed. By the time he finally had surgery on 10/16/15, his leg had healed improperly and had to be re-broken. When I saw him at Tucson, he was on bedrest, but had not been prescribed medically necessary anticoagulation therapy, placing him at risk of a post-surgical deep venous thrombosis and possible death from pulmonary embolism.

4. Inpatient care

67. Many of the patients housed in the ADC infirmaries are seriously, and often acutely, ill and require regular visits from their Medical Providers. However, Medical Provider staffing for the infirmaries is inadequate and they do not see the patients frequently enough. ADC agreed to ensure that infirmary patients are seen by a Medical Provider at least every 72 hours. Performance Measure # 66, Doc. 1185-1 at 12. The average audit results for two of the three men's prisons with infirmary units over eleven months in 2015 show shockingly poor compliance for this critical measure – 32% for Tucson and 19% for Florence. Ex. 1 at PLTF-PARSONS-037225-26.

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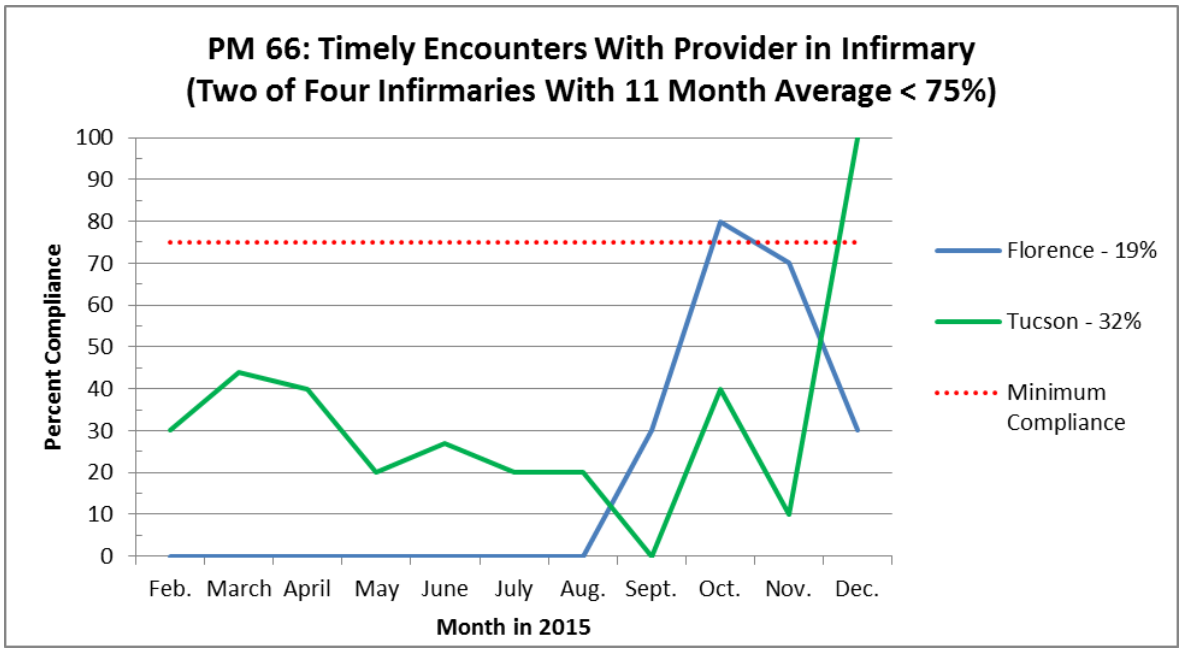

68. When fragile infirmary level patients are not seen sufficiently often, many will suffer harm, and some may die. The case of [redacted] for example, is one of shocking neglect. Mr. [redacted] arrived at prison on 9/14/15 with a daily heroin habit and was housed in the ASPC-Tucson infirmary to go through opiate withdrawal. Although he was seen by several nurses over the next few days, who documented that he was experiencing serious withdrawal and was at risk of dehydration due to excessive vomiting, he was apparently never referred to a medical provider, as he should have been. He was ordered medications that were far too weak for his advanced withdrawal, and the medications that were ordered were provided only intermittently. He should have been, but was not, prescribed IV medications in light of his severe vomiting. Staff failed to monitor his condition, failed to order appropriate labs, and failed to refer him to a higher level of care. Consequently, Mr. [redacted] died unnecessarily [redacted] days after his arrival at prison, at age 44. The Mortality Review Committee correctly classified this as a preventable death. Ex. 58 at ADCM225738-40.

69. Some patients experience unnecessary pain and injury because they are not seen frequently enough. ASPC-Florence prisoner [redacted] died on [redacted] of metastatic colon cancer, after experiencing inexcusable delays in diagnosis. When he was admitted to the hospital shortly before his death, the hospital staff reported that he had a complex decubitus ulcer on his tailbone. Ex. 51 at ADCM018596. A complex ulcer takes time to develop, thus Mr. [redacted] clearly had been suffering with this painful wound for a considerable time. Shockingly, the ADC nursing documentation during the period leading up to his hospitalization contains not a single mention of the ulcer.

70. Infrequent provider visits result in lapses in care. Mr. [redacted], discussed above, received grossly inadequate care while housed in the Tucson infirmary unit while awaiting his overdue emergency transfer to the hospital. At the time that I saw him, he was receiving vancomycin IV to treat his gangrene pending his hospital transfer. I verified the medication by looking at the label on the IV bag. When I reviewed his electronic medical chart immediately after seeing him, there was no order for vancomycin. No patient, in an inpatient or outpatient setting, should be receiving medications absent a prescription, and why he received this medication without a physician's order is a mystery. Equally important, this medication by itself is grossly inadequate for the treatment of this condition. He should have been on two additional classes of antibiotics in addition to the vancomycin at a minimum.

5. End-of-life care and waivers of treatment

71. End of life planning and compassionate palliative care are important components of the practice of medicine, but they must be done with extreme caution in a correctional setting, with assiduous attention to detail, multiple independent reviewers, meticulous observation of informed consent requirements, and continual review of the appropriateness of the end of life plans given the condition of the patient. This requires spending significant amount of time face-to-face with the prisoner reviewing his care with him, and providing appropriate end of life counseling and guidance. The cases that I reviewed involving DNRs lacked any documentation showing these basic principles were

observed. This is not surprising, given the very low staffing levels in the ADC. Complying with these essential patient care standards is time-consuming, and with the limited number of providers on staff it is predictable that these duties would be neglected.

72. The case of [redacted] a ASPC-Lewis prisoner, is illustrative. Mr. [redacted] was a 60 year old with a history of hepatitis C who developed pancreatic cancer. His medical care proceeded in a manner to be expected with this diagnosis. His "do not resuscitate" order first appears in the record on 6/10/2015 and it is merely listed in the assessment notes by Dr. Malachinski. Ex 56 at ADCM087345. While I do not have an issue with the implementation of a "do not resuscitate" order in a patient with his diagnosis, I do have an issue with how it was carried out. The listing of this order as a one line entry in an assessment is simply inadequate. There is no evidence of any discussion with the patient or any evidence of an informed choice made by the patient. There is no evidence of a second opinion by a clinician not involved in this patient's care to validate his choice for a do not resuscitate order. This patient's death was inevitable given his diagnosis but this does not excuse the method by which the DNR was implemented and the lack of documentation.

73. Furthermore, in my review of the death charts, there clearly were patients who had significant compromise and predictable decline from terminal illnesses. I was surprised that in most medical records there was no mention of end of life planning and recording of medical directives made while the patient is mentally competent to make such decisions.

D. Exercise of professional medical judgment

1. Medical records and access to medical histories

74. In my initial investigation, I concluded that the medical records were "a gigantic mess." Doc. 1104-1 at 260. Since then, Corizon has implemented an electronic medical record called eOMIS. When I asked Tucson's medical director, Dr. Lucy

Burciaga, to describe the system, she called it "horrific." Unfortunately, she is correct. The system is an unqualified disaster.

75. A reasonable electronic health record unifies medical information in an organized and inter-connected manner which speeds up care and makes documentation easier. This system really does the opposite. For example, when lab reports come back, the providers get a notice in their Outlook email that is not connected to the electronic health record. They have to log into each system and manually navigate between them in order just to evaluate one lab result. This is true with medication renewals as well. A proper system should be interfaced so that internal messages are contained within the system and linked to a process for easy review. Furthermore, the medical director confirmed that there is no ability to communicate within the system about clinical care. They have to utilize Outlook email for this communication which actually produces a separate electronic medical record that is not accessible to anyone except the sender/receiver of the email. This is highly problematic.

76. This medical record system uses templates to create encounter notes. Most of the templates are auto-generated and populated with questionably meaningless data that takes up a significant amount of space. It is difficult to read these notes as they contain bits and pieces of information scattered throughout instead of in one cohesive and consistent location. Another major issue is the presence of ghost encounters in the system that are generated by the system for some reason but the patient was not actually seen. This just confuses the documentation process and makes reading the charts very burdensome.

2. Use of nurses as primary care providers

77. Patients are denied a clinician's professional medical judgment if nurses or other staff are called upon to make decisions they are not qualified to make or exceed professional licensing requirements. I reported that this was a significant problem in my first report, and it continues to occur, placing patients at serious risk of harm or death.

78. [redacted] discussed in paragraph 68 above, was in crisis during his brief stay in the infirmary, leading up to his death. He should have been under the care of a provider who was seeing him regularly while he withdrew from his daily heroin habit. Instead, he was repeatedly seen by LPNs and RNs who assessed his condition, but failed to address it or to refer him to a provider who was qualified to treat his life-threatening condition.

79. [redacted] died on [redacted] at age 55 at ASPC-Tucson, after his cancer of the head and neck recurred. When he reported his symptoms returning, he was seen for sick call by an LPN on 12/29/2014, rather than an RN, who noted his history of optic nerve cancer, but failed to refer him to a provider. Ex. 71 at ADCM118615-20. Mr. [redacted] was finally seen by a provider, and, on 5/11/15 by an oncologist who diagnosed him with recurrence of his cancer via PET scan. He was ordered to have chemotherapy ASAP. ADCM120514. Although he was finally provided treatment after seeing the oncologist, his recurrent cancer was in an advanced state, and he declined rapidly. While he may have died in any case, the delay in seeing a provider, and subsequently an oncologist, certainly shortened his life. The mortality report indicates that this care met community standards and I disagree. Ex. 83 at ADCM196779-82. The delays in care certainly do not meet community standards, nor does assessment of possible recurrent cancer by a Licensed Practical Nurse.

3. Specialty care

80. The exercise of professional judgment sometimes requires more in-depth knowledge than primary care providers possess. In these cases, the provider must be able to refer patients for specialty consultations. This essential step often was not happening two years ago, when I first reviewed care, and there continue to be major barriers for specialty access. In addition, the specialists who see the prisoners are authorized to recommend treatment, but not to order it. Thus, it is critical that the prison health care system ensures that prison health care providers promptly review the consultant's

treatment recommendations and either order the treatment or document why it is not appropriate. This essential coordination is often missing in ADC patient care.

81. The failure to ensure that patients see specialty consultants for medically necessary diagnosis and treatment places patients at an unreasonable risk of harm. Indeed, in some cases, patients will die because they did not have access to medically necessary specialty care. Sixty-five year old [redacted] for example, was referred multiple times to a cardiologist while at ASPC-Eyman, but the appointments did not occur timely because of multiple operational glitches in the referral process and lack of communication between the referring clinicians and the approval authority. Ex. 45 at ADCM135400. He was ultimately referred for an implantable defibrillator, but he died on [redacted] before that visit was arranged. Had his diagnostic consults been approved by Utilization Management and scheduled in a timely manner, he would likely still be alive. The ADC Mortality Review reached the same conclusion. *Id*.

82. I spoke to a number of Tucson prisoners regarding longstanding barriers to specialty care, and brought their urgent situations to the attention of ADC officials, and their attorneys. Thirty-two year old [redacted], was a patient in the Tucson infirmary when I spoke to him. He had been placed there after he developed a decubitus ulcer on his buttocks as a result of long-standing diarrhea caused by an infection in his GI tract. Although the infection had been identified more than a year earlier, I found no evidence that he had ever been treated for it. Moreover, he had been referred to general surgery to repair the wound on 6/25/15, but has been told that Corizon has not been able to find a surgeon with whom to schedule surgery. In the meantime this otherwise relatively healthy young man has been bedridden for months.

83. [redacted] 78 years old, has a transplanted kidney and has been on his immunosuppression medications for many years. He developed an allergy to one of his medications that is causing him to have a terrible whole-body rash. His medical record shows he has submitted many HNR's about his issues and Corizon has not sent him to a transplant physician for evaluation. As a result, he stopped taking his Prograf

and Cellsept on 10/29/2015 because the rash had become so intolerable. Instead of sending him to a transplant physician as medically indicated, Corizon referred him for a psychiatric consult to see if he is competent. In conversing with this gentleman it was obvious that he is intellectually keen and well informed about his situation. Competency is not the issue in this case and a referral to psychiatry to assess competency for refusing to take medication is a shameless cover-your-behind maneuver by the prescriber that clearly demonstrates that the provider did not speak to Mr. [redacted] in any detail, and does not know how to deal with a patient of his complexity. Mr. [redacted]'s providers have failed to understand that he urgently needs to go see a transplant physician to manage his medications and to assess the kidney. Without this care, he will undoubtedly reject his kidney, which will ultimately hasten his death.

84. [redacted] is a 47 year old ASPC-Tucson patient with sick sinus syndrome and Wolf-Parkinson-White Syndrome, a condition that causes rapid heartbeat. He has had a pacemaker placed and has had two cardiac ablations. He has had such bad complications from his disease that he filed for a restraining order against Corizon and forced them to house him in IPC because his heart rate fluctuates, and he loses consciousness. He indicates that his cardiology consult to address this was submitted by his provider in August 2015 and he has yet to be seen. Review of his chart demonstrates that despite his multiple issues, his chronic care appointments were just not done and he has not been seen in a timely fashion.

85. [redacted], is a 25 year old who developed a slipped disc in his back. While at ASPC-Lewis, he submitted HNRs about this but his care was delayed. Ultimately, he became paralyzed and incontinent before he was finally sent to the hospital for treatment. This constitutes abysmal care. He has a lot of residual nerve damage and can only walk short distances because of weakness and balance issues. When I reviewed his medical record, it stated that he was transferred to Tucson from Lewis in order to receive physical therapy. None had occurred as of my December visit, and he is understandably upset that he has not made progress towards independence.

86. Another Tucson prisoner, [redacted] underwent an above knee amputation April 2015. No prosthesis had been provided to him, so when I met him he was stuck in a wheelchair despite the fact that he is otherwise physically vigorous and could be up walking which would be much healthier for him and enable him to keep his muscle mass in his legs. He was sent back to the prison following his amputation and was not seen by his provider for five months. Then, on 10/19/15 a consult for a prosthesis was submitted, but that appointment has not yet occurred. When we interviewed the "consult specialist" for Corizon, she verified the consult was approved, but had no explanation for the delay in scheduling the appointment.

87. Finally, Mr. [redacted] the young man with testicular cancer who I described at the beginning of this report, has experienced unconscionable delays in receiving treatment even after I first brought him to the attention of ADC during the tour in early December 2015. Plaintiffs' counsel randomly met him while walking through a housing unit at Tucson, speaking cellfront with prisoners, and while I was at Tucson I reviewed his medical records and spoke with him. I also raised his case in a meeting with ADC staff and their attorneys on the last day of the tour. Since visiting Tucson, I received updated medical records for him, up until 2/10/16. These records clearly demonstrate the colossal systemic issues that exist within the ADC healthcare system.

88. Mr. [redacted] was originally diagnosed with testicular cancer by ultrasound on 8/6/15. Ex. 67 at ADCM340110. An urgent request for a CT scan was submitted to Corizon Utilization Management by Dr. Goodman at the time, but that was not completed until 9/23/15. Ex. 67 at ADCM340368. Mr. [redacted] was subsequently scheduled for an orchiectomy on 10/30/15. In the discharge plans for that surgery, the surgeon (Dr. Daley) requested a two week follow-up after the surgery, along with a CT scan so the pathology could be reviewed and the tumor could be staged appropriately to determine additional care. The specialist's request for a follow-up consult and CT scan was submitted by Dr. Goodman, and she indicated the ordered timelines. Unfortunately, Corizon did not

complete the CT scan until 11/24/15, and the post-op follow-up with Dr. Daley was not until 12/2/15, more than a month after the surgery. *Id.* at ADCM340344.

89. Critically, only one out of three pages of the specialty consult report from Dr. Daley inexplicably is included in the medical file. *Id.* at ADCM340349. The pages that are notably missing are those that detail the diagnosis and the plan. Furthermore, I can find no evidence in the medical record that a provider at the prison reviewed the incomplete specialist report from Dr. Daley, to realize that the most critical components of the note were missing. As such, Mr. [redacted] has had no care for biopsy-proven, CT-proven, surgical pathology-proven cancer.

90. Since the appropriate documentation does not exist in the chart and we have no idea what the plan was for Mr. [redacted]'s care, we have to rely on the data that does exist. I know that he had a pure seminoma and that he has CT-proven evidence of mediastinal (chest) adenopathy that measures 2.1 cm x 2.0 cm. *Id.* at ADCM339817. Applying a standard grading scale to this scenario, this patient has a Grade IIB tumor. *See* Oh, W.K., Overview of the treatment of testicular germ cell tumors; Uptodate, Kantoff, PW (ed), Waltham MA (accessed March 28, 2016), available at http://www.uptodate.com/contents/overview-of-the-treatment-of-testicular-germ-cell-tumors. The current treatment recommendations for a Grade IIB seminoma are surgery to remove tumor (already done) and chemotherapy (not done). *Id*. Seminomas are a highly treatable and generally curable form of testicular cancer, but the appropriate treatment has to be done and it has to be done in a timely fashion. Unfortunately, nothing about Mr. [redacted]'s care has been timely, only part of the recommendation treatment has been accomplished, and there is no evidence that he is on anybody's radar within ADOC because the last date he had a provider encounter was 10/30/2015—the date of his surgery. Ex. 67 at ADCM339815. He has never been seen by a provider since returning to the facility.

91. We encountered Mr. [redacted] on my tour of the Tucson facility. I was so concerned at the time after I reviewed his file on-site about his lack of care that I made a

request to conduct an exit conference meeting on 12/4/15 to call his situation (and the critical situations of several other patients) to the attention of Corizon administrators and health care staff. I was clear with the ADC attorneys about the purpose of the meeting and the seriousness of the issues. Unfortunately, despite my clarity about the purpose of the exit conference, not a single staff person from Corizon showed up to hear my concerns about Mr. [redacted] and other prisoners, and my concerns were directed to ADC monitoring staff and attorneys for Defendants. As such, my admonitions for Mr. [redacted] to have emergency oncology consultation and treatment went unheeded, and he never received appropriate care. I am professionally disturbed by this case because he is a young man who has a very treatable and curable condition that is being totally mismanaged, and Corizon and the ADOC know of his situation. If anybody with clinical training had looked at his chart and tracked his care, the deficits in care would have been obvious. Unfortunately, Corizon's healthcare delivery is so broken that this patient's life is on the line from systemic incompetence despite my detailed description of his problems and his needed care.

92. Mr. [redacted] also attempted to call his situation to the attention of Corizon officials. He submitted an HNR on 12/29/15 stating "I was supposed to see the oncologist over a month ago for treatment. I need to know what's going on." *Id.* at ADCM340317. This HNR was responded to on 12/29/15 by RN Rynders with "You are scheduled for f/u with the provider." This HNR never made it into the master list of Health Services Requests, (*Id.* at ADCM339817), and as of February 10, 2016 he still had not seen a provider.

93. Mr. [redacted] submitted another HNR on 1/16/16 that stated "I need to speak to Doctor Goodman ASAP. I was supposed to be scheduled to seen an oncologist over two months ago to start my chemotherapy treatment but I haven't heard a thing back so I need to know what is going on very soon!!!" *Id.* at ADCM340315. This HNR was responded to on 1/18/16 by RN Rynders stating that "You are scheduled to see the Provider." This HNR is not recorded in the master list of "Health Services Requests" and it appears that it

never got implemented, because there is no evidence he ever saw a provider despite the serious nature of the HNR request. *Id.* at ADCM339817.

94. If we triangulate the standard treatment recommendations for his condition with the information that he conveyed in his two separate HNR's about the treatment plan he was expecting, it is completely reasonable to assume that the missing pages of Dr. Daley's consult note contain recommendations for an oncology visit and chemotherapy that have not been carried out. Mr. [redacted] has notified Corizon with clear language about his dilemma on two separate occasions and despite the dire nature of the notifications, Corizon has never scheduled him for any provider follow-up.

95. Mr. [redacted]'s case is sadly illustrative of the systemic issues that plague the ADC health care system:

- The specialty consult system is broken.
- Continuity of care does not occur as patients return from outside care.
- The internal provider scheduling process is inadequate.
- The HNR process is broken and does not result in appropriate care.

96. The sum total of all of this is a system that denies prisoners access to care at all levels and needlessly puts them at elevated risk for serious healthcare complications and death. Mr. [redacted] needs a STAT oncology consultation and all of the treatment ordered by the oncologist. He probably needs to be re-staged, because I am afraid that the extreme delays in his care have resulted in spread of his cancer, and he is probably in a much higher risk category than he would have been in if the care had been accomplished in a timely fashion.

4. Substandard care decisions

97. As I explained in previous reports, treatment decisions must be consistent with community standard of care. As was true two years ago in the Arizona system, the providers continue to make treatment decisions that are clearly substandard and endanger their patients. Because the system lacks a viable quality assurance program to root out

and address patterns of poor care, substandard treatment is widespread in the Arizona system, and as a result, some patients suffer harm, while all are subject to an unreasonable risk of harm.

98. Two particularly egregious cases involve patients who both starved to death in June, 2015, while housed in so-called "inpatient" prison units, [redacted] at ASPC-Florence and [redacted] at ASPC-Tucson. Mr. [redacted] was a 57 year old man with a history of pancytopenia (a shortage of all types of blood cells), Hepatitis C, end stage liver disease, and peripheral vascular disease. His long-term management of his end-stage liver disease was poorly done but the patient became acutely ill around 4/23/14, having developed significant ascites (excessive accumulation of fluid in the abdominal cavity). Ex. 32 at ADMC080751. He was sent to see a gastroenterologist for management of his end-stage liver disease nine months later on 1/30/15 and several recommendations were given by the specialist (*id*. at ADCM080898), but ultimately most were not followed by the Corizon providers, or were very delayed. Mr. [redacted] developed hepatic encephalopathy and was admitted back into the hospital, with swelling so great in his scrotum that he developed scrotal abscesses. *Id*. at ADCM085845.

99. Mr. [redacted] ultimately experienced gastrointestinal failure that manifested itself with his inability to eat and extreme weight loss, and he died on June 21, 2015. *Id*. at ADCM081372 and ADMC085831. His baseline weight on 3/28/13 was 180 pounds. The last recorded weight in his chart prior to his death was 93 pounds on 4/27/15, which represents almost a 50% decrease in weight. *Id*. at ADCM081647. The healthcare staff at ASPC-Florence failed to address this substantial weight loss and he ultimately died of significant malnourishment that occurred while they watched and documented it. Had the staff managed his end-stage liver disease adequately the gastrointestinal failure would not have occurred and he would have lived a much longer life. I was shocked to see the ADC Mortality Review Committee's conclusion that Mr. [redacted]'s death was unpreventable and that his care met community standards. *Id*. at ADCM225754, 225756.

100. Mr. [redacted] was a 64-year-old who had a history of left sided hemiplegia as a result of a gunshot wound to the head. He also had pulmonary fibrosis which was evaluated by a pulmonologist on 11/20/14. At that point in time the pulmonologist requested that Mr. [redacted] be returned to his clinic in one month in order to initiate treatment. Ex. 36 at ADCM078963. I found no evidence in the chart that this requested follow-up appointment occurred. The failure to treat his pulmonary fibrosis ultimately caused him to develop gastrointestinal failure and severe malnourishment. On 7/29/14 he called attention to his weight loss in a health needs request (*id.* at ADCM079103) wherein Mr. [redacted] stated, "I have lost a lot of weight, too much, and do not know why or how because I eat all of my meals. I am 5'6" and weigh only 104 pounds. My weight continues to drop and I am unable to gain weight. Please do labs to test for cancer and any other illness that can be causing this. There's something very wrong with me." The medical staff failed to address his weight loss.

101. Mr. [redacted] was placed in the Tucson infirmary in November 2014, weighing 94 pounds. *Id.*at ADMC079373. On 4/15/15, he was sent out for tube placement through his abdominal wall to facilitate feeding. The interventional radiologist felt that the placement of a feeding tube was too risky due to his untreated pulmonary fibrosis. *Id*. at ADCM079335. As a result, his nutritional needs were not addressed and the last recorded weight in this chart was 85 pounds on 5/24/15. *Id.*at ADCM079429. Mr. [redacted] needlessly died of malnourishment not long after, on [redacted]

102. [redacted] was another Tucson patient who presented with alarming symptoms, who saw providers sporadically, yet was not evaluated and diagnosed for cancer for many months. In October and November 2014, he was seen for complaints of rapid weight loss, dropping from 175 to 138 pounds in a few months. No work up was initiated. Ex. 50 at ADCM228185. Eight months later, on 7/14/15, he was finally diagnosed with squamous cell carcinoma of the lung. He was referred to an oncologist at that time, and he finally saw an oncologist two months after that, on 9/14/15. Mr. [redacted]

died on [redacted]. *Id*. at ADCM228168. Although his death may have been inevitable, it is clear that he could have lived longer had his diagnosis not been delayed.

103. Similarly, [redacted] died at age 32 after experiencing repeated and inexcusable delays by Perryville medical staff in her work up for leukemia. She began submitting HNRs in September 2014 complaining of lumps on her legs. Ex. 53 at ADCM246406. On 5/13/15, she submitted an HNR stating, "you ordered lab work to be done in regards to the lumps on my leg. I have not had it done yet. And I also found 2 more lumps on my pelvis area." *Id*. at ADCM246399. Although her records are confusing, it appears she did not receive a diagnosis of leukemia until 7/8/15, ten months after her initial complaint. *Id*. at ADCM246856; ADCM246116. She died [redacted] months after her diagnosis, on [redacted]. What is clear from her records is that her initial work up was inadequate, her labs were delayed, and ultimately, her diagnosis and treatment were delayed, and these serious lapses resulted in hastening her death.

104. [redacted], died at ASPC-Eyman on [redacted] at age 43 of cardiogenic shock (inadequate circulation of the blood), secondary to bacterial endocarditis, an infection of the heart. Although he had been seen at sick call multiple times reporting very alarming symptoms, including that he was vomiting 20 times a day, he never had an adequate work up. His lab results dated 5/27/15 were highly suggestive of an infection, yet they were not signed off by his provider, a physician's assistant, for three weeks,[9] and even then, it does not appear that the physician's assistant understood the significance of the abnormal results. Ex. 54 at ADCM086498. The PA's plan to order a variety of tests and follow up with Mr. [redacted] in two weeks was wholly inadequate. Given Mr. [redacted]'s fevers, elevated white blood cell count, anemia and history of IV drug abuse, the PA should have been able to diagnose the infection, or at least have recognized the need to confer with a physician for further direction.

[9] Performance Measure # 46 requires review of diagnostic test results within five calendar days.

105. Mr. [redacted]'s death was preventable, had his diagnosis been timely. The mortality review committee identified the delay in care, but called it "a difficult diagnosis." Ex. 55 at ADCM120646. Based on the data available, however, I classify this as a missed diagnosis.

106. The case of [redacted] an ASPC-Lewis prisoner who has also been housed at Yuma and Tucson, is likewise disturbing. I first raised serious concerns about Mr. [redacted]'s treatment in my November 2013 report, explaining that his HIV had been mismanaged and that he was in "desperate need" of management by an HIV specialist. Doc. 1104-1 at 271-272. Since I first met Mr. [redacted] he has apparently been seen by an HIV specialist a couple of times. Unfortunately, my review of his chart in early December 2015 makes it clear that his AIDS is still unmanaged. The HIV specialist had recommended follow-up appointments at three month intervals, but it appeared he had not been seen since 6/16/15. At that appointment, the specialist had ordered a critical lab test for determining whether he had developed resistance to any medications, but that apparently had not been done. On 10/16/15, his lab tests revealed a very high viral load, indicating that his prescribed HIV medication was not working and that his virus was continuing to damage his immune system. This ongoing pattern of inadequate treatment is particularly shocking given that, since my first meeting with Mr. [redacted] I understand that plaintiffs' counsel have submitted advocacy letters to defendants on at least five occasions, notifying them of Mr. [redacted]'s condition.

107. [redacted] was in obvious pain when I met him at Tucson in December. According to his medical record, he was referred for a GI consult on 10/12/15 for rectal bleeding. At the time of my visit and interview with him, this consult had yet to occur. He was finally seen by a facility medical provider the day before my site visit, because he had staged a protest and refused to leave the clinic until seen. At that appointment, Mr. [redacted] was given an injection of Toradol, which is absolutely contraindicated in a patient with gastrointestinal bleeding of unknown cause and could have killed him by causing his stomach to perforate.

108. [redacted], would likely not have died on [redacted] at age 57 had she been provided competent care. Ms. [redacted] had a history of chronic obstructive pulmonary disease and congestive heart failure. She was admitted to the Perryville infirmary on 7/6/15, when pulmonary disease became acute. Her situation was never well-controlled from that point forward, and she declined fairly rapidly. On 7/7/15, her lab results showed she was in congestive heart failure. Ex. 39 at ADCM107998-7999. She was managed unsuccessfully and incompetently for her breathing problems: she was given three liters of oxygen by nasal cannula, which is a significantly low dose of oxygen delivered in a highly unreliable way. Her blood oxygen level was dangerously low, even on those three liters of oxygen. As such she had significant "air hunger" and struggled to breathe for a long period of time.

109. The Perryville healthcare staff struggled with her for an inordinately long period of time before they finally sent her out to the hospital on 7/12/2015 in full respiratory distress. On 7/12/15 Dr. Seth Stabinsky entered a late note which documents care that he rendered three days earlier, on 7/9/15. This note outlines his logic in treating this patient from a retrospective standpoint. It is interesting that this note was entered shortly after Dr. Stabinsky gave the order to send this patient to the hospital. Given the circumstances and the timing it appears as if this note is a delayed justification and rationalization of poor care. *Id*. at ADCM108024. Ms. [redacted] died on [redacted] While this ultimately was not a preventable death, the delays in care and the failure to make an accurate diagnosis over months of management certainly hastened her death.

110. The ADC Mortality Review Committee concluded that [redacted] died because of inadequate medical care, and I concur. Ms. [redacted] who was 44 years old when she died on [redacted] had a history of gastroesophageal reflux disease (GERD), as well as significant mental illness. While at Perryville, she was treated with indomethacin and ibuprofen, two nonsteroidal anti-inflammatory drugs (NSAIDS) that are contraindicated for prisoners with a history of GERD, because they cause ulcers and perforation of the gastrointestinal tract. She received the highest recommended dose of

indomethacin and her risk of NSAID ulcer with subsequent perforation was extraordinarily high. Ex. 26 at ADCM228171-8175.

111. Ms. [redacted] complained on 6/13/15 of constipation and abdominal pain. She was referred to the nursing line, and saw the nurse several times in the following weeks but did not have an abdominal exam. Three weeks later, she bled to death, due to a gastric ulcer. She should never have been prescribed the NSAIDS for any extended period, and the way that she was prescribed it caused her death.

112. Grossly substandard nursing care hastened the death of 51 year old [redacted] at ASPC-Tucson. Mr. [redacted] had a history of hepatitis C as well as hypertension and Type II diabetes. He submitted HNRs on 3/16/2015 (Ex. 48 at ADCM040007), 3/22/15 (ADCM 040006) and apparently on 3/25/2015 (not found in chart but referenced in a nurse note at ADCM040047) for swelling and back pain. He was not seen for nurse triage for any of these HNRs. His HNR for back pain on 3/25/15 was answered by nurse Dadasiewicz with "No action needed" and "already scheduled with a provider 3/27/15."

113. On 3/27/15, he saw NP Daye who did not address his back pain but did document shortness of breath. *Id*. at ADCM040163. NP Daye did not order appropriate diagnostic labs or studies for the complaint she listed. On 4/5/15 Mr. [redacted] was seen on nurse line by RN Patterson who documented a fever and a very low blood oxygen level indicating he was seriously ill. The RN did not notify anyone or intervene, and her assessment of this critical abnormal data is inadequate. *Id*. at ADCM040212-216. She did refer Mr. [redacted] to the provider line and he was seen by NP Daye on 4/6/15 with a complaint of "IM states is dizzy, headaches, cannot breathe, gets winded walking 2 ft, wants to go to a Dr." Despite this ominous presentation, there is no blood oxygen level recorded on that visit, nor is a respiratory rate. Mr. [redacted] did have an increased temperature and an increased heartrate, both of which suggest possible infection. NP Daye also documented decreased breath sounds in his lungs which also suggests possible infection. Despite all of this data indicating Mr. [redacted] was very seriously ill, NP

Daye's plan was to continue with daily weights and abdominal measurements and for him to submit an HNR for any further health needs. *Id*. at ADCM040152-156. He was finally admitted to the hospital later the same day and found to have a high white cell count and an extremely low oxygen level. *Id*. at ADCM040022 and 040025. Mr. [redacted] was critically ill, well beyond what anyone in the system recognized. He ultimately died of severe bilateral pneumonia and sepsis the following day, on [redacted]

114. The nursing staff, including the Nurse Practitioner, repeatedly failed Mr. [redacted] As early as 3/25/15 the patient complained of back pain which is a common presentation for pneumonia. Unfortunately his complaint was not evaluated by a clinician, which resulted in a missed opportunity to intervene in a timely fashion and avoid his death. More egregiously, he presented with a fever and a very low blood oxygen level on 4/5/15. These objective findings should have triggered a much more intensive response to determine the reason for such an abnormal finding. Unfortunately, they did not.

115. The provider visit on 4/6/15 with NP Daye is well below the standard of care for this problem. Mr. [redacted] presented with ominous symptoms of respiratory distress including dizziness, a complaint that he could not breathe, and report that he gets winded within two feet of walking. These complaints at a minimum require an assessment of his respiratory status including respiratory rate and a pulse oximeter reading. These were not done. In addition, he was febrile and with a racing pulse, which should have led to additional inquiry as well. Using the hospital data as a reference point for how sick Mr. [redacted] presented just hours after he was seen by NP Daye illustrates the inadequacy of NP Daye's assessment and clinical decision-making.

116. The ADC Mortality Review Committee recognizes that "there was some delay in patient care," and recommends that "significant abnormal findings should be communicated to HCP [health care provider] by nursing." Ex. 49 at ADCM120639 – 640.. Given the magnitude of the errors in this case, this response is grossly inadequate.

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E. Delivery of care that is ordered

117. The third major component of an adequate medical care system is the right to treatment. As I explained in my first report, patients must not only be seen by appropriate clinicians and given appropriate diagnoses and treatment orders; they must actually receive the care that is ordered, including medications, diagnostic tests and specialty referrals. As was true when I first visited the ADC prisons, the Arizona system has multiple barriers that interfere with care delivery.

1. Providers' orders

118. Orders written by providers must actually be carried out. Throughout the Arizona system I saw a consistent pattern of ordered care – medications, labs, nursing care, follow-up appointments, and/or specialty referrals – not getting done. This is another symptom of a badly understaffed medical care system.

119. While at ASPC-Tucson, I spoke to a number of patients who were referred for specialty care who never received it, and had predictably poor outcomes. For example, [redacted], was bedridden in the infirmary unit with a decubitus ulcer resulting from long-standing diarrhea caused by a C. Difficile infection in his GI tract. His ulcer was not healing because of an exposed vein in the base of the wound that kept bleeding. I asked Mr. [redacted] why he had not had the relatively common surgery for decubitus ulcers to deal with this problem definitively. He indicated that the Corizon staff had told him they could not find a surgeon willing to treat him. I confirmed in his medical chart that a 6/25/15 surgery referral request for wound care had not been carried out. The surgery that he needs is routine and not that difficult. Any competent plastic surgeon would handle his issue easily. It is difficult to believe that no surgeon is willing to treat him unless the problem is with payment from Corizon for that care.

120. During the Tucson visit, I also observed that the process for alerting providers to diagnostic test results and consult reports for their patients through the electronic medical record had essentially collapsed under its own weight. Because providers daily receive dozens of emails, and because the process for signing off on

results was unduly time-consuming and inefficient, many of the providers had simply allowed their mail boxes to fill without reviewing them. I observed that Tucson's NP Daye, for example, had almost 2,500 unread emails in her inbox on the day of my visit, many of which were lab results and specialist's reports. Dr. Burciaga had approximately 5,600 unread clinical emails in her inbox. Reviewing medical records at the facility, I found numerous examples of cases where patients with abnormal labs were never followed up, and where patients who saw the consultant did not receive the recommended treatment because the consult reports had not been reviewed by the provider.[10]

121. Mr. [redacted], discussed above, required monitoring for the immunosuppressive medication, tacrolimus, which he takes to maintain his transplanted kidney. His provider ordered a STAT tacrolimus lab drawn 11/27/15—there was no result in the chart by 12/2/15 which is an unacceptable delay for a STAT lab. That result should be back within hours. On 9/3/15 a regular tacrolimus level was ordered and a result was delivered 9/8/15. This lab result was never reviewed by anyone. The failure to review these lab results, and the failure to obtain timely results for a STAT order, put the patient at significant risk of harm.

122. The failure to follow orders can produce tragic results, as demonstrated in the case of [redacted] who died on [redacted] at age 50 at ASPC-Florence. Mr. [redacted] had a history of renal failure, type II diabetes, cirrhosis, foot amputation, and peripheral vascular disease. It appears that he was significantly compromised when transferred to the Department of Corrections on 6/10/15. He was evaluated by a physician on 6/12/15 and sent immediately to the hospital as a direct admit for a high white blood cell count and a draining left foot amputation wound. Mr. [redacted] was stabilized at the hospital but noted to be in acute renal failure. That was addressed at the hospital, and he

[10] Performance Measure 46 requires providers to review diagnostic reports, and act upon abnormal results, within five calendar days of receipt. Doc. 1185-1 at 11. PM 52 requires that providers review and act on specialty consult report within seven calendar days of receipt. *Id.*. ASPC-Tucson's average scores for these two measures over the months of February through December 2015 are 38% and 52%, respectively.

was discharged back to ADC on 6/17/15, and his discharge plan included prescriptions for critical medications. Although these medications were ordered by prison staff on 6/17/15, he did not receive a dose until 6/20/15. Ex. 37 at ADCM107446, 107448. Without these medications, Mr. [redacted] decompensated quickly and was ultimately admitted into the infirmary. On [redacted] the infirmary nurses called Dr. Vukcevic at 11:35 to inform him that Mr. [redacted] was not doing well. Instead of sending this critically ill patient back to the hospital immediately, Dr. Vukcevic instructed nursing staff to apply supplemental oxygen and to continue to observe him. The doctor stated he would be in within an hour to assess the patient. However at 12:55 Mr. [redacted] was declared dead and the treating physician at the time was Dr. Chris Johnson. *Id*. at ADCM107543. Dr. Vukcevic never came to assess the patient who he blocked from going to the emergency room.

123. This case raises a number of questions. First of all it appears that Mr. [redacted] was significantly medically compromised at the time and he was transferred to the Department of Corrections and I have no way of knowing where he came from or how it was possible for someone to transfer a patient this sick to ADC. This case also raises questions about the intake process at the ADC reception center and its capacity to identify patients who are too sick to be in a prison environment. Furthermore, this case shows a failure to coordinate care when a very sick patient transfers from the hospital back to the prison. Here, he was ordered critical medication at the hospital as part of his discharge plan but went three days without that medication upon transfer back to the prison, ultimately causing him to destabilize and contributing to his death. I also question the delay in emergency care, and why the physician did not send this patient to the hospital immediately upon hearing that he was having difficulty. Clearly Dr. Vukcevic's instructions were inadequate for this patient, and the delay in obtaining definitive care proved fatal. Given the magnitude of Mr. [redacted]'s medical conditions his death was inevitable. However it is clear that systemic issues abound in this case and his care was compromised significantly as a result. I concur with the ADC Mortality Review finding that "more timely intervention was clearly warranted." Ex. 38 at ADCM130868.

124. In the charts I reviewed at Tucson, and the charts of deceased prisoners from across the prisons, I saw that labs are routinely ordered but never done, medications ordered but not approved, medications ordered but not administered by the nurses, ADA accommodations ordered but not provided, consults ordered but never approved or scheduled, and follow-up appointments requested by providers but never scheduled. Recommendations from specialists regarding follow-up and additional care were frequently not done or were substantially delayed. Tucson prisoner [redacted], [redacted], for example, has a condition, inclusion body myositis, which results in significant weakness of his muscles. Tucson referred him to a neurologist, who recommended on 4/16/14 that he be provided a back brace, supportive shoes, elevated shower chair, handicapped bed rails with bars, a multi-vitamin per day, a wedge pillow, an electric hospital bed, and a wheelchair assessment. NP Daye finally ordered these items for him on 11/10/15, a year and a half later. Corizon's Utilization Management Department has denied all of the requests for these medical devices.

2. Medication administration and monitoring

125. Prescribed medications must be provided to patients in a timely, consistent manner. The ADC monitor reports document consistent and persistent problems delivering medications to patients on time. Performance Measure # 11 requires that new prescriptions be provided to the patient within two business days of the prescription, or the same day, if prescribed STAT. The average scores over the months of February through December, 2015 were below 75% at six of the ten prisons, including at all five of the largest men's prisons. The chart on the next page highlights in yellow each month in 2015 where the prison's compliance level was less than 75%. For each month in 2015, the statewide level of compliance for all of ten institutions on Performance Measure # 11 was less than 75%. Lewis was non-compliant every month. Ex. 1 at PLTF-PARSONS-036222.

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	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	11 Mth avg.
Douglas	97	60	97	85	78	79	83	63	70	85	85	**80**
Eyman	30	32	34	48	50	64	30	46	48	30	76	**44**
Florence	85	54	54	58	59	71	54	62	80	63	72	**65**
Lewis	53	63	71	74	57	70	47	44	36	39	40	**54**
Perryville	80	76	78	84	88	92	66	74	66	76	59	**76**
Phoenix	76	86	96	98	90	92	89	100	90	100	96	**92**
Safford	95	100	100	100	100	85	95	100	95	80	97	**95**
Tucson	76	54	58	54	53	58	62	61	68	76	66	**62**
Winslow	85	75	65	50	50	80	75	95	70	80	87	**74**
Yuma	77	76	78	60	78	74	78	76	76	70	70	**74**
Statewide	**75**	**68**	**73**	**71**	**70**	**77**	**68**	**72**	**70**	**70**	**75**	**72**

126. Medications must be renewed regularly and without interruption, and prisoners must be able to transfer housing locations without medication interruptions. ADC monitors' reports show that administration of prescription medication is frequently delayed or missed, and that prescriptions for chronic care medications frequently lapse despite the patients refill requests.

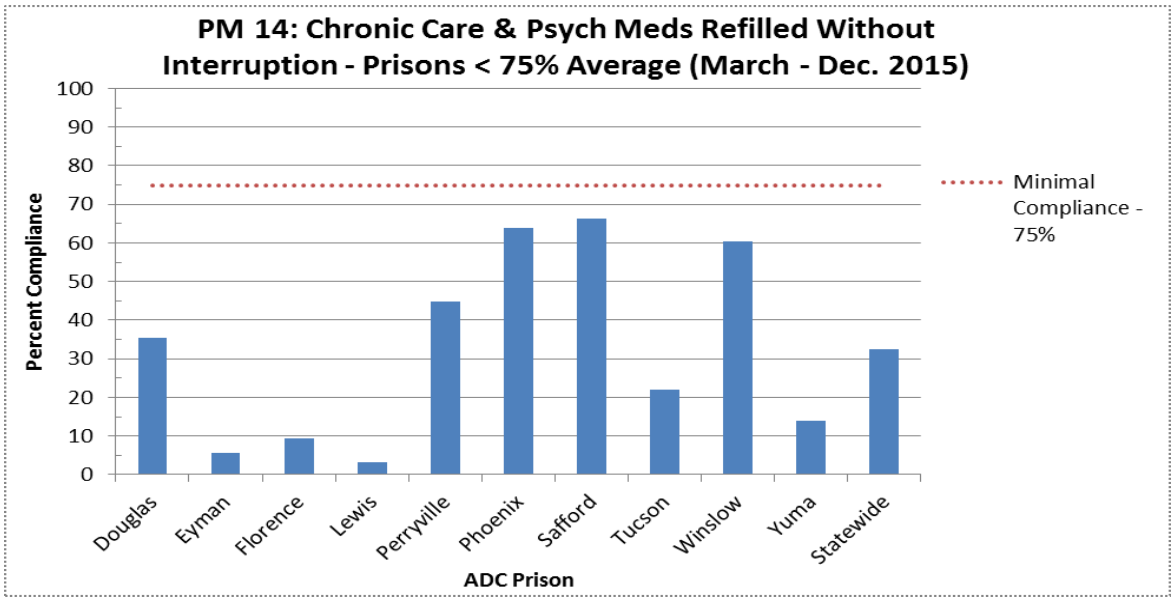
127. As a preliminary matter, I have long maintained that, in a prison or jail setting, an automatic refill system for chronic care and psychotropic medications is critical, and I so advised the parties in this action. ADC's system of requiring patients, some of whom are on psychotropic medications for disabling mental conditions, to file health needs requests to refill their prescriptions practically guarantees they will have gaps in receiving medications. This is particularly true in a system like ADC's, as the Corizon pharmacy responsible for filling the prescriptions is not local, but in Oklahoma.

128. Performance Measure # 14 requires that refills of chronic care and psychotropic medications requested by the patient three to seven days before the medication runs out are filled so that the patient will suffer no lapse. Not one of the ten prisons averaged a passing score (75%) for this measure over the ten months from March

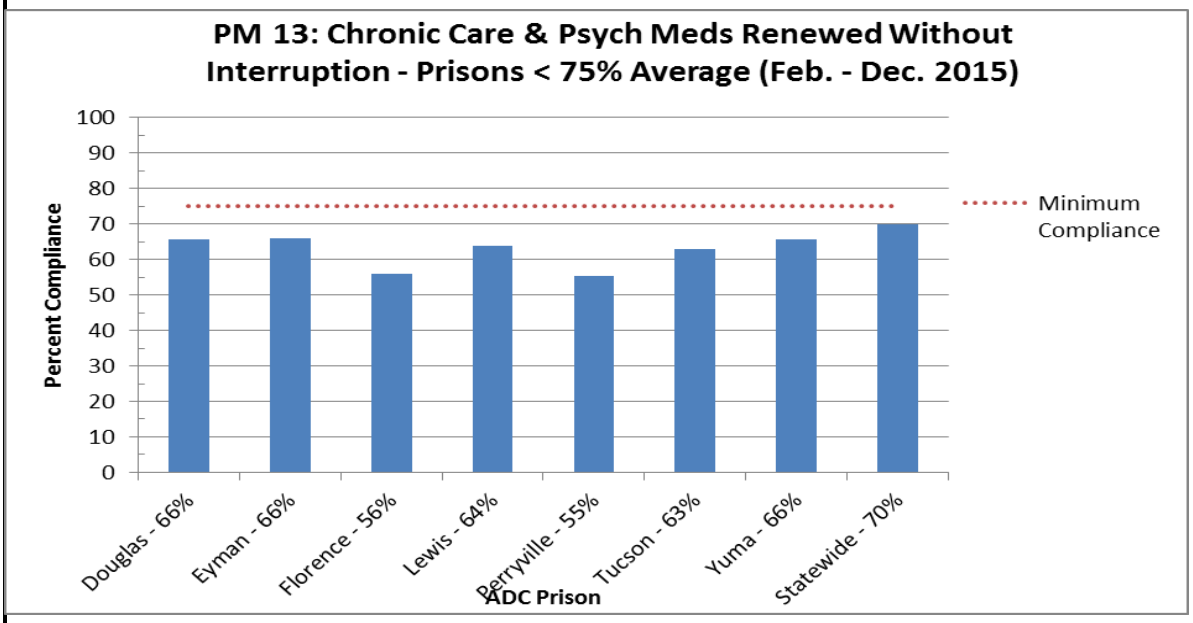
to December 2015. (Every facility was given a score of "NA" in February 2015.) Again, non-compliance is shown in yellow in the chart below. Ex. 1 at PLTF-PARSONS-036223.

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	10 Mth. avg.
Douglas	NA	0	0	100	80	60	6	0	0	38	69	**35**
Eyman	NA	0	0	6	10	0	0	0	0	0	39	**6**
Florence	NA	0	0	20	2	14	5	0	12	17	23	**9**
Lewis	NA	0	0	0	0	0	0	0	0	0	33	**3**
Perryville	NA	92	92	76	0	81	8	12	35	8	NA	**45**
Phoenix	NA	93	94	100	90	50	19	45	59	33	55	**64**
Safford	NA	100	100	91	80	80	65	0	0	67	80	**66**
Tucson	NA	0	68	41	34	3	0	0	0	0	73	**22**
Winslow	NA	100	90	92	88	75	10	0	30	20	100	**60**
Yuma	NA	0	0	32	24	32	0	0	0	10	42	**14**
Statewide		**39**	**44**	**56**	**41**	**39**	**11**	**6**	**14**	**19**	**57**	**32**

129. ASPC-Lewis registered a 0% compliance rate for nine of the ten months, and only three small prisons, Phoenix, Safford and Winslow, had an average score of over 50%. Of the five largest prisons, not a single one achieved a passing score at any time during the measured period. As illustrated below, none of the ten prisons achieved a passing average score during the relevant time period. Ex. 1 at PLTF-PARSONS-036223.



130. ADC's record for ensuring that prescriptions for chronic care and psychotropic medications are renewed by the prescribing provider, such that there are no lapses, is also dismal. (Performance Measure # 13.) For the eleven month period of February to December 2015, seven of the prisons, including all of the largest facilities, had average scores well under 75% compliance, as illustrated in the chart on the next page. Ex. 1 at PLTF-PARSONS-036222.

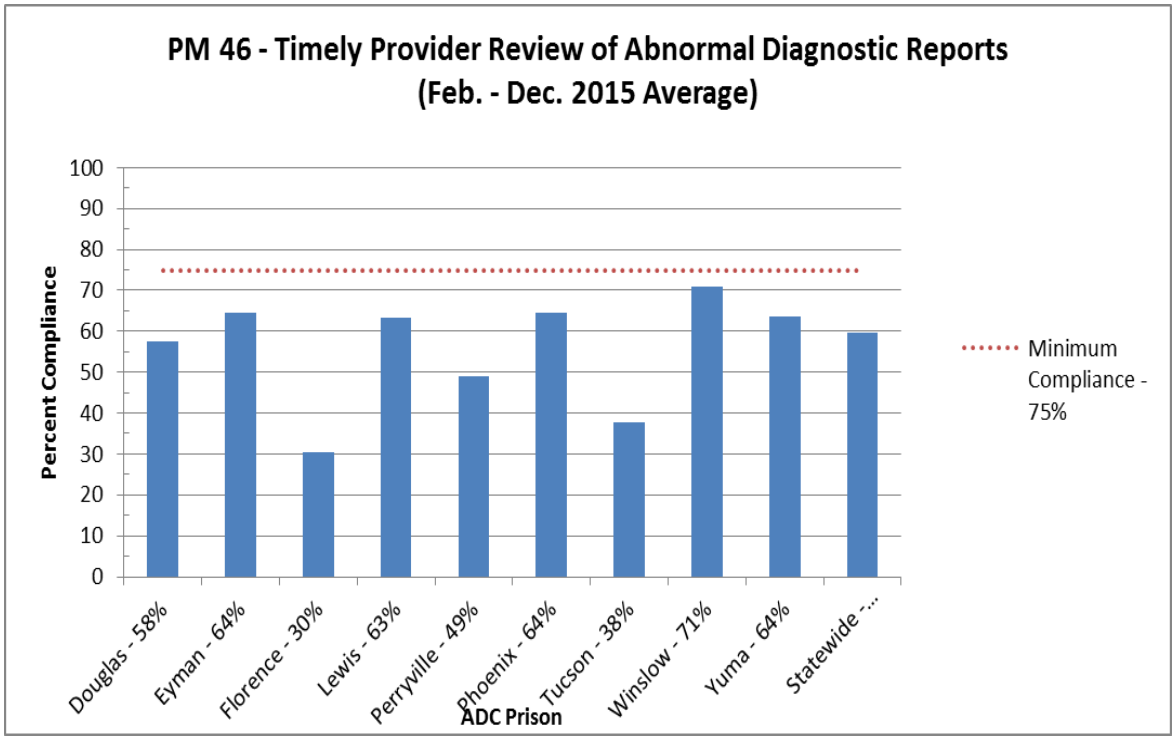


3. Labs, imaging, and other diagnostic tests

131. Diagnostic tests are an essential part of any medical care system. Such tests must be performed timely, based on the provider's order, and must be reviewed and, if abnormal, acted upon promptly. Arizona fails all too often to ensure that labs and diagnostic tests performed are promptly reviewed and acted upon, due in part to the lack of an effective system for reporting such results in the eOMIS system.

132. Once the diagnostic reports are available, the medical provider is required to review the reports, including pathology reports, and act upon those with abnormal values within five calendar days. (Performance Measure # 46.) Nine out of ten of the prisons averaged scores well below passing for this measure, from February to December, 2015. Indeed, the only prison that averaged a passing score was ASPC-Safford, a smaller prison

that ADC previously has reported does not house prisoners with high medical needs. *See, e.g.*, Ex. 11 at ADCM226253 (11/30/15) (at Florence's, North unit, just one report of 10 reviewed timely, with half not reviewed a month or more after receipt; Central unit, only half of 10 reports timely reviewed, with three not reviewed six weeks after receipt); Ex. 16 at ADCM226321 (11/27/15) (at Tucson, in Inpatient Unit, only half of ten records in audit showed timely review); Ex. 13 at ADCM226171 (11/25/15) (at Perryville, San Pedro unit, for ten pap smear tests, only one had result timely reviewed).



133. The failure to act timely on abnormal labs and diagnostic imaging places patients and enormous risk of harm. Given ADC's widespread non-compliance on this measure, it is not surprising that I found numerous examples of patients who were suffering unnecessarily because their providers had failed to act upon their abnormal results. Among them was Mr. [redacted] (see *infra* at ¶¶ 82 and 119), who tested positive for C. Difficile toxin on 9/18/14. There was no evidence in his record that the results were ever reviewed, or that Mr. [redacted] was ever treated for this condition. *See also*, Ex. 54 at ADCM086498 (high white blood cell count for Mr. [redacted] 096480,

suggestive of infection performed 5/27/15, not signed off by provider until 6/16/15; patient died eleven days later); (per my onsite chart review, STAT test for immunosuppressant ordered 11/27/15 for Mr. [redacted] 073659, not performed as of 12/2/15; regular lab ordered 9/3/15, performed 9/8/15, results never reviewed).

E. Protection from preventable negative outcomes

134. Healthcare administrators know that a significant number of negative outcomes can be prevented through carefully implemented quality assurance, patient feedback, and screening mechanisms. Two years ago, I saw no evidence that any of these measures had been meaningfully implemented in the Arizona system, and I still see no such evidence.

1. Quality assurance

135. As I explained in my initial report, people will make mistakes. This is unavoidable. So, in any functioning health care system, there must be a mechanism created and used to find and correct errors to minimize patient harm.

136. An effective quality assurance process requires structured and systemic review of the healthcare processes throughout the whole system. This is typically done by identifying a problem to be investigated, developing a hypothesis, performing a review of a statistically significant number of charts by a qualified individual or group to assess the evidence of care, calculating appropriate statistics to prove or disprove the hypothesis, formulating proposed action plans to improve the item being reviewed if necessary, developing policy and procedure to implement the new action plans, and then reassessing the results of the changes in the future to determine that the identified problems have actually been corrected.

137. Although ADC agreed to monitor certain Quality Assurance functions as part of the Stipulation, review of the CGARs reveals very poor compliance. For example, Performance Measure # 29 requires that the Director of Nursing for each ASPC facility conduct and document annual performance reviews of nursing staff, as recommended by

National Commission on Correctional Health Care Standard P-C-02.[11] According to ADC staffing data, as of December, 2015, the system employed over 300 Nurse Practitioners, Registered Nurses and Licensed Practical Nurses. Ex. 20 at ADCM274691. Based on review of the monthly CGAR results from February through December, however, it appears that just 52 nurses, i.e., less than 20%, had undergone an annual clinical performance review during those eleven months, and that nurse reviews were not performed at all at three of the facilities (Florence, Winslow and Yuma). The overwhelming majority of the CGAR entries indicate that, "no nursing clinical performance reviews were due during the reporting period." *See, e.g.*, Ex. 9 at ADCM228222, November 2015 (QI results for Douglas). The system is virtually ignoring a powerful quality assurance tool, thereby placing patients at risk of harm or death due to incompetent care.

138. Similarly, the Stipulation requires ADC to monitor whether each prison is conducting monthly Continuous Quality Improvement meetings, in accordance with NCCHC Standard P-A-06. Performance Measure # 27. This NCCHC standard defines a CQI Committee as one that "designs quality improvement monitoring activities, discusses the results, and implements corrective action." NCCHC Standards for Health Services in Prisons 2014, at 12. The Standard further explains that the "standard is intended to ensure that a facility uses a structured process to find areas in the health care delivery system that need strategies for improvement…. CQI minutes should provide sufficient detail to guide future decisions." *Id.* at 13. Typically, minutes may include problems identified, the person responsible for the corrective action and a time frame for completion.

139. The CGAR results report consistent full compliance with this performance measure. I reviewed some the CQI minutes for the months of September through November, 2015 for eight of the prisons. I found that the minutes, however, were often

[11] NCCHC Standard P-C-02 at 41 requires "a clinical performance enhancement process [that] evaluates the appropriateness of services delivered by all direct patient care clinicians and RNs and LPNs."

grossly deficient. For example, the CQI minutes for ASPC-Tucson for the months of September through November frequently describe problems, yet fail to specify correction action, a timeline for correction or the person responsible for effecting it. *See e.g.*, Ex. 21 at ADCM197765 (9/3/15 Minutes state "Nursing orders are not being done in a timely manner across the facility." No CAP, person responsible, or timeline); Ex. 21 at ADCM197776 (10/8/15 Minutes state "We recently had a problem with Tucson Fire Department. They arrived at Rincon gate then turned around and refused to go back on complex. This puts the patient and Corizon at risk. Christina will be following up with TFD." CAP is vague, and no timeline); Ex. 21 at ADC197786 (11/5/15 Minutes state "Medication administration not being reflected in MAR. Med passes not being completed." No CAP, person responsible or timeline).

III. Conclusion

Medical care in Arizona prisons continues to be inadequate to meet the basic needs of many of the prisoners who experience illness and injury while in custody. Many of the barriers to care that I identified in November 2013, and in my subsequent reports, continue to plague the system. ADC's own audits demonstrate month after month that many of the prisons are failing to comply with critical performance measures, even at the first year level of 75%. Fewer still will meet the current 80% benchmark. The treatment delays and backlogs point to a shortage of health care staff that must be remedied to create an adequate health care system. Defendants should be required (1) to immediately develop a plan to increase nurse and physician staffing to enable each prison to achieve passing CGAR scores of at least 80% for access to RN triage, primary care and chronic care appointments (Performance Measures # 37, # 39 and # 54), timely inpatient encounters (Performance Measure # 66) and timely provider review of diagnostic test results (Performance Measure # 46) ; and (2) to develop a plan to perform a workload study for all health care positions, and to create and implement a staffing plan based upon the results of the study. Additionally, they should be required to develop a plan to automatically refill prescriptions for chronic care and psychiatric diagnoses.

I declare under penalty of perjury under the laws of the State of Arizona and the United States of America that the foregoing is true and correct.

Executed this 5th day of April, 2016, at Salt Lake City, Utah.

Todd Wilcox

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CERTIFICATE OF SERVICE

I hereby certify that on April 8, 2016, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al., Plaintiffs, v. Charles L. Ryan, et al., Defendants.	No. CV-12-0601-PHX-DKD **ORDER**

Plaintiffs have alleged that certain facilities were in substantial non-compliance with the parties' Stipulation and, in their Citation Summary, Plaintiffs provided the Court with citations of when and how they informed Defendants of which facilities were in substantial non-compliance with which performance measures. (Doc. 1562) Defendants have raised a challenge to a subset of those facilities. (Doc. 1580) Plaintiffs counter that Defendants are misapplying the Stipulation's standard for the termination of monitoring. (Doc. 1581)

Plaintiff's opposition is well-taken. It appears that Defendants are referring to the Stipulation's standard for "Termination of the duty to measure and report on a particular performance measure." (Doc. 1185 at ¶ 10(b)) This is not the same as the Stipulation's standard for "Determining substantial compliance with a particular performance measure at a particular facility." (Doc. 1185 at ¶ 10(a)). The current issue pending before the Court is whether Defendants are in substantial compliance and, therefore, the Court will

rely on the standard for substantial compliance as established by the Stipulation at ¶ 10(a)(i):

> For the first twelve months after the effective date of this Stipulation, meeting or exceeding a seventy-five percent (75%) threshold for the particular performance measure that applies to a specific complex.

Accordingly, as discussed with the parties during the May 18, 2016 status conference, Defendants will be required to submit a remedial plan for the following facilities and performance measures:

- Performance Measure 11: Eyman, Florence, Lewis, Tucson, Winslow, and Yuma.
- Performance Measure 13: Douglas, Eyman, Florence, Lewis, Perryville, Tucson, and Yuma.
- Performance Measure 14: Douglas, Eyman, Florence, Lewis, Perryville, Tucson, and Yuma.
- Performance Measure 37: Eyman, Florence, Lewis, Tucson, Winslow, and Yuma.
- Performance Measure 39: Eyman, Florence, Lewis, Perryville, and Tucson.
- Performance Measure 46: Douglas, Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma.
- Performance Measure 54: Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma.
- Performance Measure 66: Florence, Lewis, and Tucson.
- Performance Measure 85: Eyman, Florence, Lewis, Perryville, Tucson, and Yuma.
- Performance Measure 92: Eyman, Florence, Lewis, Perryville, and Tucson.
- Performance Measure 93: Eyman, Florence, Lewis, Tucson.
- Performance Measure 98: Eyman, Florence, Lewis, and Winslow.

IT IS THEREFORE ORDERED that Defendants shall submit a plan to be approved by the Court to remedy the deficiencies as identified by the Court by June 8, 2016. Plaintiffs shall have until June 15, 2016 to file any comments. The Court will then

address those measures at a hearing set for June 24, 2016 at 9:00 a.m., courtroom 305, 401 West Washington Street, Phoenix, AZ.

Dated this 19th day of May, 2016.

David K. Duncan
United States Magistrate Judge

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF PABLO STEWART, M.D.

I, PABLO STEWART, M.D., DECLARE:

1. I am a physician licensed to practice in California and Hawaii, board certified in psychiatry, with a specialty in clinical and forensic psychiatry. My background and experience as relevant to my expert testimony in this proceeding is summarized in my March 30, 2016 report. (Doc. 1538-1, at 1-4).

2. I have served as an expert witness and consultant to the plaintiffs in this case since 2012. In that capacity I have conducted on-site inspections of the Arizona State Prison Complexes at Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma. I have prepared the following expert reports:

- Expert Report of Pablo Stewart, M.D., November 8, 2013 (Doc. 1104-2);
- Supplemental Expert Report of Pablo Stewart, M.D., December 9, 2013 (Doc. 1104-6, Exhibit 8);
- Rebuttal Expert Report of Pablo Stewart, M.D., January 31, 2014 (Doc. 1104-6, Exhibit 9);
- Second Supplemental Expert Report of Pablo Stewart, M.D., February 24, 2014 (Doc. 1104-6, Exhibit 10);
- Third Supplemental Expert Report of Pablo Stewart, M.D., August 29, 2014 (Doc. 1538-1, Exhibit 2); and
- Expert Report of Pablo Stewart, M.D., March 30, 2016 (Doc. 1538-1).

3. When settlement discussions began in this case in the fall of 2014, I consulted with plaintiffs' counsel in formulating the remedies they would seek regarding mental health care. Each of the mental health Performance Measures in the Stipulation is designed to protect prisoners with serious mental health needs from unnecessary risk of harm or death, and to ensure that they receive minimally adequate mental health care.

4. Unfortunately, it appears that ADC is misinterpreting and misapplying a number of Performance Measures in a way that poses a significant risk of serious injury or death to prisoners with serious mental health needs.

Requirement that a prisoner be seen, or other care be provided, every "X" days

5. Mental illnesses, like physical illnesses, are dynamic conditions that change over time. Acute conditions may appear and worsen, and even chronic conditions, like Schizophrenia, wax and wane over the course of the illness. For this reason, it is essential that patients with mental illness receive periodic assessments of their clinical condition and treatment modifications, if required by their clinical presentation, from qualified mental health professionals.

6. The frequency with which the patient needs to be seen varies according to the patient's condition, and that frequency itself may need to be adjusted depending on the course of the illness. The Stipulation recognizes this principle by requiring that patients be seen by different levels of mental health staff and at different frequencies depending upon their illness. What is uniform, however, is the requirement that the patient be seen repeatedly and periodically.

7. It is my understanding that ADC takes the position that the Stipulation's requirement that (for example) "MH-3B prisoners shall be seen a minimum of every 90 days by a mental health clinician" (Performance Measure 82) is satisfied if the patient has been seen by a clinician on a single occasion. This is an extraordinary and very dangerous assertion.

8. It is essential that the patient be seen periodically so that the course of his or her illness and the ongoing efficacy of any treatment can be properly evaluated. This is particularly vital for patients who are prescribed psychotropic medications. It is critically important that these patients are seen on a regular basis so that the effectiveness of the medication can be assessed and any toxicity or side effects promptly detected and addressed.

9. It is also necessary that non-medication treatment modalities, such as psychotherapy with a mental health clinician, be performed on a periodic and consistent basis. These types of non-medication treatment modalities are only beneficial for the patient if administered on a regular basis. Finally, the treatment plan must be periodically

reviewed and updated to take account of changes in the patient's condition and response to treatment.

10. In summary, I am not aware of any mental health professional taking the position that it is sufficient that a patient with an ongoing mental illness be evaluated or treated only on a single occasion. Such a position does not meet any standard of care with which I am familiar and is completely indefensible.

Definition of "Seen"

11. Confidentiality is essential to accurate mental health diagnosis and effective treatment. The patient must feel free to disclose to mental health staff thoughts, experiences, and other information that may be the source of great embarrassment or shame. Confidentiality is particularly important in the prison context, where disclosure of certain kinds of information can place the prisoner at risk of harassment or victimization by others. Thus, it is critically important that prisoners' interactions with mental health staff take place in a setting that provides confidentiality both from other prisoners and from staff.[1]

12. For these reasons, the Stipulation defines "seen" or "seen by" as follows:

> Interaction between a patient and a Medical Provider, Mental Health Provider or Mental Health Clinician that involves a treatment and/or exchange of information in a confidential setting. With respect to Mental Health staff, means an encounter that takes place *in a confidential setting outside the prisoner's cell, unless the prisoner refuses to exit his or her cell for the encounter*.

Stipulation, Appendix A (emphasis added) [Doc. 1185-1 at 5].

---

[1] As I said in my November 8, 2013 report:

> The presence of custody staff may also cause the patient to self-censor or alter his or her communications with the provider, depriving the provider of critically important information. For example, if a patient is bothered by intrusive thoughts of harming or killing corrections officers, he is unlikely to disclose that to his mental health provider in the presence of a corrections officer.

Doc. 1104-2 at 50-51.

13. It is my understanding that ADC counts a prisoner as being "seen" when he participates in a mental health group with other prisoners present. It is also my understanding that ADC counts a prisoner as being "seen" if a mental health staff member interacts with him while the prisoner is in his cell, and the staff person is outside ("cell-side" encounters). Neither of these encounters is confidential, and both are of little or no value as a clinical encounter.

14. Mental health treatment groups are a valuable component of a mental health treatment program. They are not, however, a substitute for confidential encounters with mental health staff. A group meeting is obviously not a confidential setting. Even if prisoners in the group are admonished to treat the group's discussions as confidential, such an admonition is unenforceable and is highly unlikely to be followed by all prisoners at all times. Accordingly, prisoners in a group setting can be expected to withhold information that may be crucial to the effective diagnosis and treatment of their mental illness.

15. In addition, the purpose of group meetings and the purpose of individual clinical encounters is fundamentally different. The primary purpose of a treatment group is to provide a particular type of treatment for the patient. An example of a treatment group is a psycho-educational group. In this type of group the clinician would provide the patients with general information about various aspects of mental illness so as to help the patients more effectively deal with their own mental disorders. This is in sharp contrast to the purpose of an individual clinical encounter. The purpose of this type of patient interaction is for the clinician to perform a clinical assessment of the patient, evaluate the efficacy of the current treatment plan and modify this plan if necessary. Treatment groups and individual clinical encounters are not a substitute for one another.

16. Cell-side conversations are of little to no value as a clinical encounter. Of note, they are also potentially dangerous as patients often withhold important clinical information about psychiatric symptoms and impending self-harm. During my inspections of seven ADC facilities, I found it extremely difficult to communicate with

prisoners while standing in front of their cells. Due to background noise and the barrier of a solid cell door, it was difficult for me to hear the prisoner, and to make myself heard. I often had to shout my questions to the patients, which were then easily overheard by custody staff, which further inhibited the patients from being open and honest with me. Sometimes the only way to communicate verbally was to talk through the tiny space at the side of the cell door, meaning that it was impossible to talk with the prisoner while simultaneously maintaining eye contact through the window in the cell door. Observation of facial expressions and body language is an important part of any clinical encounter, but I found it very difficult to do while speaking to prisoners at cell-side. In addition, in some units I was required by ADC staff to wear a plastic visor covering my entire face, which made effective communication impossible.

17. In no sense can a cell-side encounter be considered a confidential setting. During my inspection tours, many of the prisoners with whom I spoke had cellmates who were just a few feet away while I was attempting to communicate with the prisoner. In addition, ADC custody staff were often close enough to hear what I was saying. Finally, it seems likely that prisoners in adjacent cells were sometimes able to overhear, especially given that both the prisoner and I often had to raise our voices to make ourselves heard.

18. For all of these reasons, it is my opinion that a correctional mental health system that permits required mental health contacts to be routinely carried out through group meetings or cell-side encounters falls below the standard of care.

Follow-up after removal from suicide watch

19. Patients who have recently been removed from suicide watch are at significant risk of self-harm or suicide. They must be closely and periodically monitored by qualified mental health staff for signs of decompensation or increased lethality, so that any necessary interventions can be promptly undertaken.

20. For this reason, the Stipulation's Performance Measure 95 requires in part that "any prisoner discontinued from a suicide or mental health watch shall be seen by a mental health provider, mental health clinician, or psychiatric registered nurse between 24

and 72 hours after discontinuation, between seven and ten days after discontinuation, and between 21 and 24 days after discontinuation of the watch."

21. It is my understanding that ADC counts a record as compliant with this Performance Measure even if only one or two of the three required post-watch contacts have occurred. This is a highly dangerous practice, creating a very real possibility that a patient's decompensation will go undetected and unaddressed. ADC's failure to ensure that patients who have been removed from suicide watch are seen as required by this Performance Measure poses a substantial risk of self-harm or suicide.

Suicide of Armando Aguilar

22. I have reviewed the medical record of Armando Aguilar, ADC #77204, who committed suicide at the Tucson facility on March 9, 2016; that record is attached hereto as **Exhibit 1**. I have also reviewed the ADC notice of Mr. Aguilar's death, attached hereto as **Exhibit 2**, which states that Mr. Aguilar "recently returned to ADC custody for a parole violation."

23. The medical record provided by ADC covers the period from March 5 through March 9, 2016, which I assume is the period Mr. Aguilar was in ADC custody after violating parole. Mr. Aguilar's record shows that he received no intake screening, and indeed no attention of any kind from health care staff, before he hanged himself on March 9, 2016. The failure to conduct any kind of intake screening on a prisoner returning to custody falls far below the standard of care.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8TH day of July, 2016, at HONOLULU, Hawaii.

PABLO STEWART, M.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L Ryan, et al.,

Defendants.

No. CV-12-00601-PHX-DKD

ORDER

Pending before the Court is Plaintiffs' fully briefed Motion to Enforce. (Doc. 1863, 1900, 1998) During the briefing, Plaintiffs withdrew some of their allegations of non-compliance for specific location/performance measures. (Doc. 1911 at n.1) Plaintiffs then reasserted some of these allegations. (Doc. 1998 at n.5 and p.6) Because the withdrawal and reassertion were close in time and because these location/performance measures had already been part of the Stipulation's dispute resolution process before the Plaintiffs' withdrawal, the Court concludes that Defendants will not be prejudiced by Plaintiffs' reassertion of non-compliance.

Part of the dispute between the parties is that they do not have a shared standard to determine when a location/performance measure is non-compliant. Accordingly, the Court has concluded that a location/performance is non-compliant when (1) 6 of 24 months are non-compliant; and (2) three consecutive months are non-compliant. *See* Stipulation at ¶ 21(b).

Applying this standard to the location/performance measures in the Plaintiffs' Motion to Enforce, the following are non-compliant:

PM 35: Eyman, Florence, Lewis, Phoenix, Tucson

PM 39: Yuma

PM 40: Eyman, Tucson

PM 44: Eyman, Florence, Lewis

PM 45: Lewis, Tucson

PM 50: Florence

PM 51: Eyman, Florence, Tucson

PM 52: Florence, Perryville, Tucson

PM 94: Perryville

Defendants submitted a proposed remediation plan for certain of the above-listed location/performance measures and Plaintiffs have raised objections to the proposed plan. (Docs. 1977, 1998, 2013) The Court will wait for Defendants' reply before issuing a ruling on the remediation plan.

Finally, the Court has relied on the parties for information about location/performance measure compliance. Both parties have experienced missteps in the accurate transmittal of this data. Accordingly, the Court will require Defendants to transmit monthly reports also directly to the Court so that the Court can timely and easily review any possible future discrepancies.

IT IS THEREFORE ORDERED that Defendants shall reply in support of the proposed remediation plan (Doc. 1977) within 14 days from the date of this Order with a plan that covers all of the locations/performance measures identified in this Order.

IT IS FURTHER ORDERED that, effective immediately, Defendants shall file with the Court the monthly CGAR data at the same time that it is provided to Plaintiffs.

Dated this 24th day of April, 2017.

David K. Duncan
United States Magistrate Judge

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF PABLO STEWART, M.D.

I, PABLO STEWART, M.D., DECLARE:

1. I am a physician licensed to practice in California and Hawaii and a board-certified psychiatrist, with a specialty in clinical and forensic psychiatry. I have served as an expert consultant to the Plaintiffs in this case since 2012. My experience and background as relevant to my testimony have previously been provided to the Court. *See* Doc. 1538-1 at 3-6 and Ex. 1 thereto. I have personal knowledge of the matters set forth herein, and if called as a witness I could competently so testify.

2. I have been asked by Plaintiffs' counsel to comment on the four recent suicides in the Arizona Department of Corrections (ADC), and on how to improve ADC's compliance with Performance Measures designed to protect patients who are suicidal.

Four suicides in less than three weeks

3. Throughout my involvement in this litigation, I have repeatedly expressed my grave concern about ADC's chronically inadequate suicide prevention program, and the high rate of completed suicides in Arizona prisons. *See* Doc. 1104-2 at 53-60. As I have noted in my previous reports, ADC's suicide rate is higher than the national average for state prisons. *See* Doc. 1104-2 at 53-54; Doc. 1104-6 at 7-8, 24-25. I have also repeatedly noted the frequency of avoidable suicides in ADC, including those that ADC's own mortality reviewers found to be avoidable. *See* Doc. 1104-2 at 56-60; Doc. 1104-6 at 8-12, 49-56; Doc. 1538-1 at 17-20, 22-31. In addition, I have specifically expressed concern about inadequate care of patients who are on suicide watch. Doc. 1104-2 at 54-55; Doc. 1104-6 at 8.

4. I have learned that between April 23 and May 13, 2017, four ADC prisoners died by suicide:

https://corrections.az.gov/article/inmate-death-notification-arvizo
https://corrections.az.gov/article/inmate-death-notification-krauss
https://corrections.az.gov/article/inmate-death-notification-gonzalez-0
https://corrections.az.gov/article/inmate-death-notification-mills

This is an extraordinary and extremely alarming series of events. Four suicides in a twenty-day period is a very rare occurrence, and is a sign of significant deficiencies in ADC's suicide prevention and mental health care more generally.

5. I have reviewed the medical records of these four prisoners. Many problems were encountered in the care of Patient 1.[1] He was classified MH-3B, and killed himself less than two months after arriving at ADC. Patient 1 was a monolingual Spanish speaker. Throughout his short stay in the ADC a variety of interpreter services were utilized including the "language line," "health staff," and a "Spanish speaking officer." Of note, the use of a "language line" is not recommended when performing a mental health evaluation and certainly custody staff should never be used as interpreters. He received an extremely cursory mental health evaluation performed by a "MH Midlevel" after he expressed suicidal ideation upon admission. This evaluation was performed via the "language line." For reasons that are not clear from the record, Patient 1 ended up in segregated housing in the Eyman Special Management Unit (SMU).

6. In the days leading up to his death he was on a suicide watch. Although offered opportunities to be seen by mental health staff in a confidential setting, Patient 1 consistently refused. Mental health staff did not appreciate these refusals as worsening symptoms of his underlying mental illness. This is especially bothersome given that staff documented on the last day of his life that Patient 1 was paranoid in that he "felt like his life was being threatened by an officer." Once again, Patient 1 refused to come out of his cell and was noted to have an anxious mood, labile affect and bizarre thought content. Nevertheless, he was taken off suicide watch, and hanged himself a few hours later. He should have never been taken off watch status and should have been removed from segregated housing. At no time during the last week of his life was Patient 1 referred to a psychiatrist even though he was noted to be psychotic. This suicide was completely avoidable.

[1] A key identifying these patients is attached to this Declaration as Exhibit 1 and filed under seal.

7. Patient 2's mental condition at the time of his suicide is difficult to ascertain from the medical record due to extremely poor documentation. He was a male with a history of Bipolar Disorder and a number of serious medical problems including a seizure disorder, chronic hepatitis C and asthma. He was classified as MH-3A and Seriously Mentally Ill. At the time of his death he was not prescribed any psychotropic medications. His mental condition at the time of his suicide is difficult to determine in that the last mental health chart entry, four days before his death, by an unlicensed "Mental Health Clerk" stated "I/M was laying down, was alright." The preceding mental health note by the Mental Health Clerk, 11 days prior to his death, also stated "I/M was laying down, said he was good." Patient 2 had also been refusing to attend groups in the week prior to his death as documented one week prior to his death. Of note, no reason was given for his refusing to attend these groups. Finally, a Treatment Plan Review 13 days before his death inexplicably stated both "no psych meds at this time" and "compliant with medications." The care as reflected in the medical record was very poor and likely contributed to his suicide. The severity of his medical problems may have also contributed to his suicide. Chronic medical problems are a known risk factor for suicide.

8. At the time of his death, Patient 3 was a male with multiple serious medical problems including HIV and hepatitis C, reflected in his medical classification as M-4. The chart did not reflect his having a history of mental illness. As with Patient 2, Patient 3's medical problems likely contributed to his suicide. Staff has a duty to evaluate the suicidality of inmates with serious medical problems.

9. The final suicide reviewed was of Patient 4. His medical record stops in November 2015, so I was unable to review the events immediately preceding his suicide. At the time of his death he was a male with multiple medical problems and, at least as of November 2015, an absence of mental health history. His death was similar to Patient 3's in that his medical problems may have played a role in his suicide.

Chronic and severe understaffing

10. I have repeatedly expressed my concern about the chronic understaffing in ADC's mental health program. *See* Doc. 1104-2 at 13-20; Doc. 1538-1 at 7-12. This understaffing has continued since the settlement of this case; for example, between April and December 2015, the fill rate for psychologists never exceeded 52%; for mental health nurse practitioners, it never exceeded 49%. Doc. 1538-1 at 11-12. It also appeared that the psychiatric director position had been continuously vacant from the effective date of the Stipulation in February 2015 through December 2015. Doc. 1538-1 at 12.

11. These staffing shortages persist today, and in some respects are even worse. As of March 2017, the fill rate for psychologists was 52%; for psychiatrists, 67%; for recreational therapists, 20%; for the psychiatric director, 0%; and for the mental health RN supervisor, 0%. *See* Doc. 2061 at 82.

12. This understaffing directly contributes to ADC's high rate of suicide. Due to the large caseloads that staff are assigned, they don't have the time to perform adequate visits with the mentally ill patients, especially those in segregated housing. In the suicides of both Patient 1 and Patient 2, the patient had been refusing to come out of his cell prior to his suicide. Given more staff, these patients could have been encouraged to leave their cells and the staff would have been in a better position to evaluate these refusals as symptoms of a possible worsening of their underlying mental illness. Also, with an adequate number of staff, time could be taken to obtain proper interpreter services instead of using the language line or a custody officer.

Improving compliance with Performance Measure 94

13. I have been asked to recommend ways of improving ADC's compliance with Performance Measure 94, which requires that "All prisoners on a suicide or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays, by a registered nurse." I understand that the Court has ruled that this Performance Measure requires that the patient be seen in a confidential setting outside the cell, unless (1) the patient has been offered such a confidential meeting and declined, or

(2) the prison is on hard lockdown. The following chart illustrates ADC's compliance with this Measure:

		Dec. 2016	Jan. 2017	Feb. 2017	Mar. 2017
PM 94 - Mental Health 22 All prisoners on a suicide watch or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays by a registered nurse.					
Mental Health 22	Douglas	100.00	100.00	100.00	100.00
Mental Health 22	Eyman	68.57	88.57	97.14	97.14
Mental Health 22	Florence	73.00	60.00	86.67	60.00
Mental Health 22	Lewis	85.00	84.00	95.00	100.00
Mental Health 22	Perryville	80.00	53.33	93.33	93.33
Mental Health 22	Phoenix	60.00	13.33	60.00	73.33
Mental Health 22	Safford	100.00	N/A	100.00	N/A
Mental Health 22	Tucson	68.00	84.00	76.00	72.00
Mental Health 22	Winslow	100.00	80.00	100.00	100.00
Mental Health 22	Yuma	73.00	86.67	100.00	100.00

14. At the outset, I must address an excuse that has been offered for ADC's poor performance on this Performance Measure. I understand that ADC's counsel has stated that "the inmates are being seen but it's not been documented appropriately" and that "this has been a situation where the non-compliance is arising out of the fact that they were not appropriately documenting that the inmate who was on the watch was offered to go out of the cell for the encounter." 5/10/17 Tr. at 844:5-6; 855:26-856:4.

15. This excuse is not acceptable. As I have previously stated:

> Accurate, reliable medical records are an essential element of mental health care. The record should be a complete history of the patient's mental health condition, diagnoses, and treatment. The record is also an essential means of communication between mental health providers. This is especially true in a prison setting, in which patients are typically treated by multiple providers and periodically transferred between institutions. For these reasons, health care providers rely upon up to date and accurate medical records. The maxim "not noted, not done,"

> meaning that if something is not contemporaneously noted in the medical record, we assume that it did not occur, is based upon this need for accurate and up to date medical records.

Doc. 1104-2 at 20-21. The medical-legal standard of care in all clinical encounters is to contemporaneously record the visit in the patient's medical record. There are no acceptable exceptions to this rule. I find it very troubling that ADC's counsel would use the excuse of "the patients are being seen but it's not being documented properly." This either implies a complete lack of understanding on counsel's part of the critical importance of accurate records, or an attempt at circumventing the requirements of this Performance Measure.

16. My recommendations for improving compliance with PM 94 are: **Determine the root cause of ongoing noncompliance.** At the risk of stating the obvious, knowing the cause of a problem is very helpful in devising a solution. But in reviewing two of ADC's remedial plans for PM 94 (*see* Doc. 1743 at 15 and Doc. 2051 at 8), I see little evidence that ADC is interested in actually getting to the root of this problem.

17. As shown in the chart above, ADC's noncompliance with PM 94 spans multiple institutions and multiple months. It is simply not credible to blame such noncompliance on a single staff member. But in ADC's first remedial plan (Doc. 1743 at 15), ADC attributes noncompliance at Tucson to the fact that a single mental health clinician was unlicensed, and implies that since she received her license, all is well. This is plainly not the case, as Tucson has been noncompliant for three of the past four months. (*See* paragraph 13 above.)

18. ADC's second remedial plan (Doc. 2051 at 8) attributes noncompliance at Perryville "during the summer months of 2016" to a "miscommunication" that "has been resolved." Again, this is plainly not true, as Perryville scored a failing 53% in January 2017, well after this remedial plan had allegedly been implemented. (*See* paragraph 13 above.)

19. In summary, it appears that ADC is more interested in persuading the Court that everything is fine and that the Court need not intervene, than in determining the actual cause of its ongoing noncompliance.

20. **Increase mental health staffing**. I have previously opined that ADC's noncompliance with PM 94 "results at least in part from the shortage of psychologists discussed above." Doc. 1538-1 at 18. Because half of ADC's psychologist positions remain vacant, it continues to be my opinion that this is a contributing factor to noncompliance with this Performance Measure. I note that ADC itself has attributed its noncompliance with PM 94 to a shortage of mental health staff. *See* Doc. 1538-1 at 10 (Yuma).

21. **Provide meaningful training and written instructions.** Any functioning healthcare system depends on a system of written instructions to ensure that staff provide care in a correct and consistent manner. While oral coaching and feedback can be useful, a system that depends entirely on oral communication of critical patient care instructions is essentially a giant game of "Telephone," where information is predictably lost and distorted in successive transmissions.

22. While written instruction is essential in any healthcare system, it is especially critical in correctional health care, because of the sprawling and decentralized nature of the system (such as Arizona's ten state-run prisons that house approximately 34,000 people); the frequent transfer of prisoners between facilities; and the often high turnover rate and use of locums staff, resulting in large numbers of healthcare personnel who are new to the system and unfamiliar with established procedures.

23. I was astonished to learn that there are virtually no written instructions, either for the healthcare staff who are expected to implement the Stipulation and the Court's orders in this case, or for the monitors who measure ADC's compliance. ADC's counsel stated that "according to what Corizon is saying, they did their training in-house and without handouts." 5/10/17 Tr. at 799:11-12. Mr. Pratt testified, "There are no documents. This is verbal. This is discussion." 5/10/17 Tr. at 801:18-19.

24. I was even more shocked to learn that, after the Court expressed concern about ADC's ongoing noncompliance with PM 94 in the context of the recent suicides, the remedial plan consists of Dr. Calcote or a colleague "go[ing] to each of the seven corridor facilities and hav[ing] a conversation with those personnel that are responsible for conducting those watches." 5/10/17 Tr. at 860:23-25. I have reviewed Dr. Calcote's subsequent declaration regarding these conversations, and it contains no reference to any written instruction. *See* Doc. 2073-1. This is entirely inadequate and very dangerous.

25. I am puzzled by this apparent reluctance to put even very basic and essential instructions to health care staff in writing. I have previously expressed concern about this mystifying and disturbing practice in ADC, which I have not encountered in any other prison system. *See* Doc. 1104-2 at 74-75 (ADC mental health monitor testified that she monitors whether suicides are preventable, but does not write anything down about her conclusions). What I can say with confidence is that it is a recipe for inadequate and dangerous patient care that increases the risk of future suicides.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 28TH day of May, 2017.

PABLO STEWART, M.D.

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CERTIFICATE OF SERVICE

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF TODD R. WILCOX, M.D., M.B.A.

I, Dr. Todd Wilcox, M.D., M.B.A., declare:

1. I have personal knowledge of the matters set forth herein, and if called as a witness I could so competently testify.

2. I previously submitted to the Court a declaration setting out my assessment of the Defendants' Remediation Plans. [Doc. 1670 (filed 9/2/16), assessing Docs. 1609-1 and 1665] My updated curriculum vitae and expert consultation were submitted to the Court at the same time. [Doc. 1670-1] Attached as Exhibit 1 is a list of the documents I reviewed in preparation of this declaration.

3. I have been informed that the Court asked that I provide specific recommendations of reforms that it could order for certain performance measures of the Stipulation where Corizon / ADC are noncompliant. To be clear, the primary reason for noncompliance is inadequate staffing. Completing a proper workload-based staffing study to determine minimum staffing levels and an accurate blend of professional employees and then hiring to satisfy those minimums is the single most important endeavor to bring the system into compliance and to remedy the deficiencies in care. Nonetheless, I offer the following recommendations for tweaks that could possibly impact compliance with the performance measures. I would be happy to answer any questions the Court may have about these recommendations.

4. As I noted in my previous report to the Court regarding Defendants' first remediation plans, many of Defendants' proposed efforts were "a series of 'band-aid' measures" that attempted to reduce backlogs and delays by redirecting existing staff, adding duties to already overworked health care staff, and setting arbitrary quotas. [Doc. 1670, ¶ 7] In order to have a successful corrective action plan to remediate systemic problems, "the state must first truly understand the reasons for the deficiencies and develop a rational method based on data to meet those needs." [Doc. 1670, ¶ 11]

5. It is not adequate to rely solely upon the monthly CGAR scores to determine if remedial plans have succeeded and remedied the entrenched systemic problems that were the root cause of the noncompliance. While the CGAR reports can serve readily as

the "canary in the coalmine" to provide some type of warnings, they are entirely insufficient to assess the success of a remedial plan or to make any credible statements about the operations of a large complex system like the Arizona Department of Corrections. Typically when you use sampling techniques to assess large systems, you must ensure that you evaluate enough records to ensure that your conclusions are statistically sound within an acceptable error range. A 5% sampling of the total population would be the absolute minimum number of records needed to assess to draw any reasonable or defensible conclusions.

6. The current methodology regarding CGAR reports is mathematically inadequate to provide any reasonable assurance that conclusions drawn on that small sample size are representative of the system. This is particularly true for "improvements" that might be inferred regarding the system. Just because there is a two or three chart improvement to pull that small sample size up into an "improved" status does not mean at all that the improvement is generalizable to the entire system.

7. I reviewed Defendants' more recent remedial plans (Docs. 1729, 1743, 1977 and 2051) submitted in the nine months since my initial report to the Court, and believe that again they are lacking specific detail. Fundamentally, in many cases they do not indicate that ADC or Corizon made any efforts to identify the root causes of deficiency, and even when they purport that an analysis was done, Defendants do not indicate what the analysis identified as the causes. From a systems management perspective, these plans also lack the granular detail necessary to ensure that each step of the remedial process is spelled out, with firm dates and deadlines, and with the persons responsible for implementation of the tasks clearly identified. Rather, they are often aspirational, and do not give dates for discrete tasks to be completed.

8. I find it impossible to believe that Defendants' contractor Corizon lacks the basic administrative knowledge and skill in their corporation to develop specific and accountable remedial action plans.

Salaries for Health Care Staff

9. Working in a prison as a health care provider[1] is not a glamorous job. As a result, it is often necessary to pay clinicians more than the prevailing community rates in order to recruit them to work in this challenging environment. I recommend that the Court order ADC and Corizon to retain the services of a nationally based healthcare consulting firm, of which there are several, to analyze Corizon's current levels of pay for provider-level staff and compare the salaries to comparable provider positions in the State of Arizona. The compensation assessment needs to take into consideration the actual per-hour rate plus any additional benefits like vacation time, sabbaticals, continuing educational time and expenses, malpractice insurance, retirement plans, healthcare benefits, relocation expenses, and any other forms of compensation. If, as I suspect, Corizon's current salaries and associated benefits are lower than those in the community, the Court should order ADC to require their contractor pay salaries that exceed the market rate and to offer comparable benefits packages to what is typically seen in healthcare settings.

The Importance of Writing Things Down

10. As a threshold matter, I observe that in their remedial plans, as well as in testimony of ADC monitors that I reviewed, Defendants often assert (without evidence or proof) that they truly are meeting the Stipulation's requirements, but that their failing scores are simply due to health care or other staff not documenting properly that they performed certain tasks. With respect to the "Trust us, care is getting done," attitude, the real issue, in addition to basic accountability, is with regard to continuity of care and follow-up. If health care staff don't document what they have done, then how does anybody seeing the patient in the future know what the problem was, and what the prior treatment was, so they can evaluate whether the past treatment worked or not? As every

[1] The term "provider" means a Physician, Nurse Practitioner or Physician's Assistant who provides primary medical care to class members. A psychiatrist (M.D.) is similarly considered provider-level; a dentist (D.D.S.) similarly is a dental provider.

good pre-med student learns, you have to show your work to get full credit, or in other words, "not documented, not done." Documentation is of paramount importance.

11. I also note that in many cases in the remedial plans, Defendants assert that they will remediate noncompliance through training and education of line health care staff.[2] However, when this is juxtaposed with written reports and testimony that Corizon has high rates of staff turnover (*see*, for example, 4/17/17 Tr. at 646:3-653:13), and recent testimony that ADC and Corizon have no written instructions to health care staff about the requirements of the Stipulation or the court's orders beyond the methodology monitoring guide, (*see*, for example, 5/10/17 Tr. at 799:11-12; 801:18-19, 860:23-25), any plans to educate staff will fail. For example, attorneys for ADC told the Court in February that noncompliance with PM 39 at Eyman was due to three nurses not documenting information correctly, but they had been retrained. [2/8/17 Tr. at 20:15-25] But as demonstrated below at paragraph 23, Defendants' monitoring data for PM 39 still shows ongoing noncompliance at Eyman.

12. I am flabbergasted to learn that Corizon and ADC do not provide any written instructions or checklists to health care staff about what the Stipulation's requirements and Court's orders say, other than a copy of the Monitoring Guide for ADC monitors. The failure to codify plans, guidelines, educational steps, assignments, and accountability is either managerial incompetence or willful blurring of any attempt to hold them accountable.

13. It's basic human nature and pedagogy that people learn and retain information in different ways, and training and education that is all lectures or talking will not stick unless there are other modalities of teaching, such as written materials and checklists, provided to staff to reference in the future in their everyday activities. Using written checklists and prompts are a standard part of the delivery of medical care:

[2] [*See*, for example, Doc. 1609-1 at 11, 13, 21; Doc. 1665 at 3:7-9, 6:19-20, 10:6-8, 11:1-3, 13:25-27, 15:28-16:2, 16:9-10, 20:13-15; Doc. 1743 at 5:5-7; Doc. 1977 at 5:16-18, 6:4-5, 6:25-27, 8:10-11, 10:1-4, 10:9-11, 10:13-14, 10:22-23, 10:28-11:1, 11:4-9; Doc. 2051 at 4:28-5:2, 5:26-28, 7:24-26]

whether it's using a written checklist of contra-indications of prescriptions, or a nursing encounter treatment workflow sheet; a cornerstone of a functional and safe health care system is written guides. Health care staff must have written prompts and reminders when treating patients so that they minimize the risk of mistakes and do not inadvertently overlook any required component of treatment.

Pharmacy Performance Measures

14. Performance Measure ("PM") 11 requires "Newly prescribed provider-ordered formulary medications will be provided to the inmate within 2 business days after prescribed, or on the same day, if prescribed STAT." [Doc. 1185-1 at 8] The Court found Defendants substantially noncompliant with this measure on May 20, 2016, at Eyman, Florence, Lewis, Tucson, Winslow, and Yuma prisons. [Doc. 1583 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 11.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	68	50	66	80	78	86	80	48	76	82
Florence	78	70	77	78	88	92	87	93	92	92
Lewis	60	63	73	71	56	67	66	73	68	72
Tucson	77	76	80	80	88	85	80	82	85	74
Winslow	93	90	87	97	93	100	93	93	90	97
Yuma	80	93	87	95	92	97	95	100	88	96

15. PM 13 requires "Chronic care and psychotropic medication renewals will be completed in a manner such that there is no interruption or lapse in medication." [Doc. 1185-1 at 8] The Court found Defendants substantially noncompliant with this measure on May 20, 2016, at Douglas, Eyman, Florence, Lewis, Perryville, Tucson, and Yuma prisons. [Doc. 1583 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 13.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Douglas	64	72	93	79	82	89	78	94	85	97
Eyman	83	58	86	60	90	84	82	90	42	62
Florence	70	44	68	65	59	59	73	88	54	51
Lewis	56	70	69	67	77	77	76	79	79	72
Perryville	65	51	63	54	53	71	72	84	90	78

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Tucson	86	92	90	75	86	87	81	79	94	95
Yuma	92	82	90	92	91	87	91	94	98	88

16. PM 35 requires "All inmate medications (KOP and DOT) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption." [Doc. 1185-1 at 10] The Court found Defendants substantially noncompliant with this measure on April 24, 2017, at Eyman, Florence, Lewis, Phoenix, and Tucson. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 35.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	76	72	80	86	54	64	56	76	57	19
Florence	48	42	43	53	69	63	44	39	55	56
Lewis	33	47	35	31	32	32	28	24	40	66
Phoenix	71	43	89	75	44	67	100	80	91	38
Tucson	27	19	16	14	10	50	33	25	10	28

17. Defendants' original remediation plan for PM 11 included the development of multiple logs for tracking purposes. [Doc. 1609-1 at 4 (citations to page numbers of Court filings is to the page number at the top of the page)] Their second remediation plan of August 2016 involved creating new files and books after conducting a "SWOT (Strength, Weakness, Opportunity, and Threat) analysis." [Doc. 1665 at 3] In November 2016, they reported they had performed "a Failure Mode Effects Analysis (FMEA) of the medication management process" that "identified the factors and procedures that contributed to low performance scores" and that "improvement measures began in July 2016." [Doc. 1743 at 7] Notably, they do not indicate what the "factors and procedures" were that contributed to the noncompliant scores.

18. ADC's remediation plan for PM 13 included a variety of technical and systems fixes that I agree would be helpful, but many of the proposals state that tasks "will be" done or that changes have been requested. Without dates it is unclear whether or not these changes occurred. For example, I agree with the June 2016 plan that health

care staff get off-line access to the electronic records system so that nurses passing medication in housing units can document in the Medication Administration Record ("MAR") the delivery of medication at the time it occurs. [Doc. 1609-1 at 6] But it is unclear if this has occurred, as Defendants' subsequent remediation plan two months later said that "Corizon is still working with its Electronic Medical Record (EMR) vendor." [Doc. 1665 at 7]

19. ADC's remediation plan for PM 35 states that Corizon has hired a pharmacy monitor who will tour facilities and vaguely describes that he will "implement successful processes and underperforming facilities." [Doc. 1977 at 5] This does not tell you much. More concretely, they propose that at Eyman, Florence, and Lewis, intake nurses will see each incoming prisoner to ensure he has his medications. [Doc. 1977 at 5, 6] It is unclear why this isn't already standard practice, and why this isn't being done as a remedial effort at the other noncompliant prisons. With regard to Phoenix prison, which is the intake center for all adult male prisoners, the remedial plan only appears to address intra-system transfers (i.e. prisoners coming from other Arizona prisons), but prisoners coming in from county jails need continuity in medication as well.

20. I repeatedly have informed Defendants, to no avail, that the entire structure that Corizon and its subsidiary PharmCorr have put in place for pharmacy services leads to inevitable delays in the provision of prescription medication. In my April 2016 declaration to the Court, (Doc. 1539, ¶ 127), I stated:

> As a preliminary matter, I have long maintained that, in a prison or jail setting, an automatic refill system for chronic care and psychotropic medications is critical, and I so advised the parties in this action. ADC's system of requiring patients, some of whom are on psychotropic medications for disabling mental conditions, to file health needs requests to refill their prescriptions practically guarantees they will have gaps in receiving medications. This is particularly true in a system like ADC's, as the Corizon pharmacy responsible for filling the prescriptions is not local, but in Oklahoma.

21. My opinion has not changed. In fact, upon reviewing the testimony of Martin Winland, ADC's pharmacist and pharmacy monitor, I believe this even more strongly. He testified that he is not involved in working with Corizon and PharmCorr to

implement remedial plans to address the systemic failures in the pharmacy performance measures. [March 21, 2017 testimony at 180:2-9] It is puzzling that he has failed to get involved in working with ADC's contractor and subcontractor to develop a remedial plan. He also asserted that the ongoing noncompliance, in his opinion, was due to a failure to document properly the administration of prescriptions, but he had not taken efforts to determine if this truly was the cause of the noncompliance. [*Id.* at 191:13-192:25] In any event, as explained above in Paragraph 10, if it is not documented that a patient was provided prescription medications, it is as if it was not done.

22. My recommendations for what ADC and Corizon need to do to come into compliance with the pharmacy performance measures, and to implement a functional pharmacy services system that does not have gaps in the provision of psychotropic and chronic care medications, are as follows:

a. Stop using a pharmacy located almost 1,000 miles away from the prisons for just-in-time and urgent medications. It is fine to use a remote pharmacy to handle routine medications and to restock a pharmacy stock room that is located on site, but it is always going to be a failure to utilize it for all your daily needs. I understand Corizon's financial desire to use their own subsidiary, PharmCorr, but given the timeframes of the Stipulation's requirements, they are setting themselves up for failure because system-wide delays will continue to occur due to basic geography.

b. Create and operate local stock pharmacies at each prison site. Correctional healthcare formularies are pretty well worked out and predictable, so they should have a 2-3 day supply of all of the common medications utilized in stock so that when disruptions occur to deliveries from the remote pharmacy or when medications are ordered STAT, they can just bridge the patient with the local supply quickly and without fuss.

c. Implement an automatic refill system for all chronic care and psychotropic medications, and discontinue the practice of requiring patients

to submit a Health Needs Request every time they are close to running out of their supply and need refill. This concept of requiring patients to submit a Health Needs Request to refill chronic medications is simply illogical and guaranteed to fail given the extreme inefficiency and lack of accountability that exists in the Health Needs Request process.

d. Identify those medications in the formulary that are chronic care medications and psychotropic medications and change policy and procedure to reflect that these medications are considered "expected to be refilled" so that there is a grace period for the actual renewal instead of just cutting someone off.

e. Implement an automated "tickler" system that reminds providers of when prescriptions needed to be renewed. Defendants' June 2016 remedial plan stated that such a system was going to be put into place with regard to PM 13, but it is unclear why or how it is not working. [Doc. 1609-1 at 5-6]

f. Change the electronic medical record logic to allow for provider notification of medications that need to be renewed and an easy, quick, ergonomic method for them to do that renewal. The current methodology is inefficient, clunky, way more work than it should be, and subsequently renewals continue to be a problem.

g. Engage in a comprehensive review of the prescription medications that are administered via "Watch-Swallow" or DOT (directly observed therapy) to see if some of them can be designated as KOP (Keep on Person) medications. The focus should be on keeping dangerous medications DOT, but expanding the KOP program as much as possible. From my experience with ADC, there are many medications managed as DOT that do not necessarily need to be, and this jams up the medication administration process. This will decrease the workload of nursing staff who must administer the medications cell-front (in higher security units or during

lock-downs) or via a pill line. This will free up the staff, and reduce the margin for documentation errors.

Performance Measures Related to Access to Provider-Level Care

23. PM 39 requires "Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointment will be seen within fourteen calendar days of the referral." [Doc. 1185-1 at 10] The Court found Defendants substantially noncompliant with this measure on May 20, 2016 at Eyman, Florence, Lewis, Perryville, and Tucson; and found Yuma substantially noncompliant on April 24, 2017. [Doc. 1583; Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 39.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	60	59	46	54	58	58	68	52	69	86
Florence	66	60	41	48	70	75	70	79	68	90
Lewis	71	100	75	76	98	98	55	82	69	90
Perryville	66	33	51	71	82	86	84	83	91	76
Tucson	58	54	69	81	76	72	79	94	97	95
Yuma	51	51	42	47	63	72	88	90	94	86

24. PM 40 requires "Urgent provider referrals are seen by a Medical Provider within 24 hours of the referral." [Doc. 1185-1 at 10] The Court found Defendants substantially noncompliant with this measure on April 24, 2017 at Eyman and Tucson prisons. [Doc. 2030] Defendants' CGAR reports show ongoing noncompliance with PM 40.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	34	13	13	83	85	65	100	100	100	46
Tucson	50	0	83	100	N/A	86	91	71	67	100

25. Although Defendants' more recent CGAR reports show improvements at some institutions with PM 39, the numbers may overstate compliance. Richard Pratt testified that he was not aware that Corizon had apparently re-implemented a policy that requires all patients be seen a minimum of two times on Nurse's Line for the same health care complaint before the nurse could make a referral for the patient to see the provider.

[5/10/17 Tr. at 736-739] However, Corizon proposed in a Corrective Action Plan ("CAP") for PM 39 at Perryville, that ADC approved on October 29, 2016 doing precisely that. Attached as Exhibit 2 is a copy of that CAP.

26. Implementing a policy whereby patients have to submit sick call requests twice per problem in order to even qualify to be seen by a provider is just absurd and it represents an unreasonable barrier to access to care. The entire HNR to nurse to provider cascade that is currently in place is inefficient, slow, and unpredictable. The entire process needs to be fixed so that it runs properly and fosters appropriate accountability.

27. I have been informed that Corizon has proposed eliminating Health Needs Requests (HNRs) entirely for accessing healthcare at medium-security and minimum-security prisons. *See* Exhibit 3. I oppose this change with the strongest sentiments possible. This amounts to nothing more than a blatant attempt to avoid accountability and to eliminate the only traceable audit trail of patient requests for care.

28. This practice would guarantee a decrease in actual access to healthcare within the system, and it would make it virtually impossible to recreate the timeline of care that is critical in many cases for providers (and for monitors) to review. Indeed, what should be happening is that the HNRs remain the cornerstone of requesting access to care and that the forms be assigned a serial number so that the disposition of those requests can be tracked for timeliness and for completion.

29. This Corizon policy has the intended effect of reducing the number of referrals made to providers, but this reduction comes at the price of denying patients access to providers. While reducing the number of referrals potentially decreases delays because of a reduced number of patients waiting to be seen, this means that patients who need to see a provider are not getting to do so because they have to keep coming back to the nurse's line about the same ailment. This will overestimate and inflate compliance with the timeframe requirements for providers to see patients in PMs 39 and 40, as it suppresses the true number of patients who needed to be seen by the provider.

30. This requirement that the patient see the nurse twice on the same problem

erects a barrier to care because patients will be charged $4.00 each time they are seen on nurse's line, before seeing the provider. I previously noted ADC's $4.00 copay creates a disincentive for patients to request care. I wrote in my November 8, 2013 report (Doc. 1104-1 at 246), that

> the existing HNR process imposes a barrier to medical care. Prisoners soon recognize that the system is efficient at charging $4 to file HNRs, but not at responding to their healthcare needs. This creates a disincentive for prisoners to turn in HNRs: they know they will not get seen by medical staff but they do know that they will be charged. Prisoners delay asking for care until they are sicker and sicker, at greater risk of negative outcomes, and far more difficult to treat.

31. This is especially true when one considers that ADC prisoners, if they have a job, are paid pennies an hour. Minimum wage for functionally literate Arizona prisoners is 15 cents an hour, and 10 cents an hour if the person is illiterate. [*See* ADC Department Order 903: Inmate Work Activities §§ 903.02.1.3.1, 903.02.1.3.1.2, 903.02.1.5.1, *at* https://corrections.az.gov/sites/default/files/policies/900/0903-effective_102216.pdf)] If a person has a job and is earning minimum wage of 15 cents an hour, each nurse's line visit costs the equivalent of 26 hours and 40 minutes of work; a patient would have to work the equivalent of 53 hours and 20 minutes to pay $8, for two nurse's line visits, before he or she would be referred to see a provider—which, of course, would cost another $4, for a total of 80 hours of work for $12, for these three encounters.

32. Defendants' first remedial plan for PM 39 called for requiring providers to see an increased number of patients each day. [Doc. 1609-1 at 10] I noted in my previous report to the Court that "assigning additional duties to staff who, in my opinion, were already fully engaged with their existing duties cannot simultaneously build a functional and sustainable healthcare delivery system." [Doc. 1670, ¶ 10] Defendants' second remedial plan for PM 39 reiterated the previous plan. [Doc. 1665 at 11-12] Defendants' third remedial plan for PM 39 filed in November 2016 reiterated the same. It said that Corizon's own monitors (who were hired to monitor ADC's monitoring, rather than "favor[ing] front-line physicians who see patients on a daily basis as opposed to adding another layer of administrations," (Doc. 1670 ¶ 9)) "are personally visiting each facility,

speaking to staff, and observing procedures to evaluate the effectiveness of the previous corrective actions, if necessary." [Doc. 1743 at 10]

33. This passage from the November 2016 remedial plan, like many other elements of the plan, lacks the granular specificity needed to implement sustainable systemic change. I read that sentence full of bureaucratic words and wonder, among other things: When are they visiting? Do they visit on all days of the week and shifts of the day? Which levels of staff are they speaking to? What procedures are they observing? How is "effectiveness" measured? What are the component parts of the previous corrective actions? Who is responsible for implementing the previous corrective actions? What are the deliverables from this group and how do they differ from the current ongoing monitoring? None of these questions are answered by Defendants' remedial plan. In March 2017, their fourth remedial plan for PM 39 finally hit on the obvious: to hire an additional telemedicine provider and additional telemedicine kiosks. [Doc. 1977 at 6]

34. My recommendations for ensuring that providers see routine and urgent referrals from nursing line in a timely manner are as follows. These recommendations apply to Health Needs Requests for medical, mental health, and dental care.

a. Perform a face-to-face nursing encounter with any patient submitting a Health Needs Request within 24 hours.

b. Complete an appropriate and thorough triage assessment of that patient and assign a triage score to the Health Needs Request.

c. Use the triage scores to prioritize who sees the providers and track the aging report for the different levels of triage to determine if additional provider time is needed at a given location.

d. Assign a tracking number (serial number) to the Health Needs Request and use that number to track the disposition of the Health Needs Request all the way through the system until final disposition.

e. Maintain reports on Health Needs Requests completion using the

tracking numbers.

35. Access to care, particularly access to providers, is the single most important element of a system that meets minimum legal requirements. Anything that impedes access to care or obscures the ability to monitor access to care should be vigorously resisted. ADC's and Corizon's plans to eliminate Health Needs Requests, or a policy that requires two nursing evaluations prior to seeing a provider, are perfect examples of policies that move this system further away from compliance with minimum standards.

Performance Measures Related to Diagnostic Procedures

36. Defendants continue to be out of compliance on a variety of performance measures related to timely provision of, and review of, diagnostic tests and procedures. Defendants are also noncompliant in reviewing and acting upon discharge recommendations from hospitals. Both of these deficiencies place patients at elevated risk for bad outcomes and they need to be solved. In modern medicine, at least 80% of all diagnoses are based on objective testing and procedures. As such, the delay in reviewing the results is really tantamount to a delay in diagnosis. Additionally, when care is elevated to the level of outside hospital and specialist care, that care by definition is critical and medically necessary. Failure to review and implement the recommendations of outside specialists and care rendered at the hospital multiplies the risks of a bad outcome, because the patient is clearly sick enough to require care beyond what is available in a correctional facility and it is of singular importance to review the recommendations and to continue the care recommended.

37. PM 44 requires "Inmates returning from an inpatient hospital stay or ER transport with discharge recommendations from the hospital shall have the hospital's treatment recommendations reviewed and acted upon by a medical provider within 24 hours." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant on April 24, 2017 with this measure at Eyman, Florence, and Lewis prisons. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 44.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	37	44	46	72	85	89	72	50	58	50
Florence	60	58	89	84	91	76	67	71	53	100
Lewis	80	71	29	48	38	43	50	38	22	94

38. PM 45 requires "On-site diagnostic services will be provided the same day if ordered STAT or urgent, or within 14 calendar days if routine." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant on April 24, 2017 with this measure at Lewis and Tucson prisons. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 45.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Lewis	69	85	78	80	81	69	77	64	69	68
Tucson	71	70	79	79	73	80	84	71	48	97

39. PM 46 requires "A Medical Provider will review the diagnostic report, including pathology reports, and act upon reports with abnormal values within five calendar days of receiving the report at the prison." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant on May 20, 2016 with this measure at Douglas, Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma prisons. [Doc. 1583 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 46.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Douglas	67	78	78	69	65	80	80	98	98	97
Eyman	78	82	82	60	34	70	64	78	74	34
Florence	47	48	43	55	30	53	60	50	65	12
Lewis	76	86	84	76	90	91	90	96	85	49
Perryville	40	32	60	52	28	28	42	50	94	70
Phoenix	82	76	81	93	65	85	72	81	98	90
Tucson	51	57	50	50	66	59	63	68	82	73
Yuma	82	80	78	84	76	76	74	96	94	86

40. PM 47 requires "A Medical Provider will communicate the results of the diagnostic study to the inmate upon request and within seven calendar days of the date of the request." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant on October 7, 2016 with this measure at Douglas, Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, Winslow, and Yuma prisons. [Doc. 1709] Defendants'

CGAR reports show ongoing noncompliance with PM 47.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Douglas	67	88	89	80	44	100	100	100	83	85
Eyman	65	32	38	47	55	25	45	55	54	47
Florence	53	31	49	68	64	41	63	59	23	40
Lewis	51	61	56	64	71	78	77	25	83	44
Perryville	43	72	61	47	64	70	79	89	74	88
Phoenix	100	67	100	100	75	0	N/A	67	67	100
Tucson	15	29	6	41	41	45	44	56	67	59
Winslow	50	100	50	100	100	100	N/A	86	50	100
Yuma	50	59	66	80	79	55	48	80	83	89

41. Defendants' initial remedial plan for PM 44 was submitted in March 2017. [Doc. 1977 at 6-7] It states that the Facility Health Administrator (FHA) at Eyman will be exclusively responsible for reviewing and acting upon hospital treatment recommendations. This is a serious problem for two reasons: first, the information contained in those reports is medical treatment, and therefore must be reviewed by a treating provider who is familiar with the patient as opposed to an administrator with no medical training; and second, the Stipulation requires that it be a Provider who reviews the reports, which is as it should be.

42. Defendants' remedial plan for PM 46 was originally submitted in June 2016. [Doc. 1609-1 at 11] It was wholly inadequate—it discusses improvements with the electronic medical record with respect to only one facility (Phoenix) when the Court found Defendants noncompliant at seven additional facilities. It is unclear to me why statewide electronic medical record would contain improvements isolated to one facility. It also again piles more work on providers already stretched thin by requiring them to dedicate an hour a day to nothing but reviewing diagnostic reports. Additionally, it required site medical directors to sign a written statement acknowledging what they should have already known is among their duties—to hold staff accountable for meeting requirements.

43. Defendants' second remedial plan for PM 46 was submitted in August 2016. [Doc. 1665 at 12-14] The proposal included adding nursing staff at Perryville to assist

providers in reviewing diagnostic reports. While this plan is certainly possible to implement, I think it is poor use of limited nursing time and that improvements in efficiency and data handling would be much more productive in helping achieve compliance. Defendants' third remedial plan was paper thin, acknowledging ongoing noncompliance, and again repeating verbatim the same "plan" as PM 39, as I discussed in paragraph 33 above, of having Corizon's monitors visit facilities and talk to staff.

44. Defendants' remedial plan for PM 47 consisted of Corizon's monitors visiting facilities and talking to staff. [Doc. 1743 at 11] Clearly, this is not working, given the ongoing noncompliance.

45. My recommendations for improvements include:

a. It should be standard practice that any patient arriving back at a correctional facility be checked in by the nursing staff, including a set of vital signs and an assessment. Any paperwork or orders for care should be reviewed at that time with the doctor on call so that the treatment plans can be implemented in a timely manner.

b. All diagnostic tests, including labs, radiology reports, outside records should be reviewed the day they arrive by a provider, preferably the one who ordered the tests or specialty consult. This is a minimum requirement for safe practice.

Specialty Care Performance Measures

46. As I previously have noted, "the provider must be able to refer patients for specialty consultations. … In addition, the specialists who see the prisoners are authorized to recommend treatment, but not to order it. Thus, it is critical that the prison health care system ensures that prison health care providers promptly review the consultant's treatment recommendations and either order the treatment or document why it is not appropriate." [Doc. 1539, ¶ 80]

47. PM 50 requires "Urgent specialty consultations and urgent specialty diagnostic services will be scheduled and completed within 30 calendar days of the

consultation being requested by the provider." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant with PM 50 at Florence prison on April 24, 2017. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 50.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Florence	77	72	76	78	93	71	53	55	48	59

48. PM 51 requires "Routine specialty consultations will be scheduled and completed within 60 calendar days of the consultation being requested by the provider." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant with this measure at Eyman, Florence, and Tucson prisons on April 24, 2017. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 51.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	82	52	76	89	72	66	68	72	78	80
Florence	66	80	82	80	77	81	90	74	52	87
Tucson	70	81	77	84	82	88	59	76	83	76

49. PM 52 requires "Specialty consultation reports will be reviewed and acted on by a Provider within seven calendar days of receiving the report." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant with this measure at Florence, Perryville, and Tucson prisons on April 24, 2017. [Doc. 2030 at 2] Defendants' CGAR reports show ongoing noncompliance with PM 52.

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Florence	45	50	61	56	71	69	73	76	56	52
Perryville	76	79	70	70	82	71	90	92	96	95
Tucson	43	47	42	39	13	57	57	59	82	85

50. Defendants submitted their remedial plans on March 17, 2017 and May 8, 2017 for these three performance measures. [Doc. 1977 at 8-11; Doc. 2051 at 6-8] They describe anecdotally some minor changes of practice that were well intentioned but ultimately do not really address the critical issue of having the results of these appointments reviewed by an appropriate provider in a reasonable amount of time. Specialists' recommendations may be critical to a patient's treatment plan, thus all outside

documentation should be reviewed by a registered nurse upon return to the prison. Moreover, the recommendations should be reviewed immediately with the local provider or the on-call provider if it is after hours to ensure orders are implemented in a timely fashion.[3]

51. Defendants' remedial plans refer to "challenges in establishing long-term relationships with community-based specialty service providers." [Doc. 2051 at 6] That is an understatement. In 2009, reimbursement rates for specialists contracted with ADC were capped so as to be no higher than those paid by the State's Medicaid program, the Arizona Health Care Cost Containment System. [Doc. 1, ¶ 63]; Ariz. Rev. Stat. § 41-1608 (2009). Unsurprisingly, at the time this went into effect, the number of specialists willing to accept ADC prisoners plummeted.

52. This restriction on how much community specialists are paid is, in my opinion, the single biggest cause for the failures in complying with PMs 50 and 51. (According to Defendants' own data, there are more institutions with failing scores than the ones the Court found noncompliant, according to Doc. 2041 at 50-51.) With certain specialties, Corizon will be lucky to find one or two doctors in the entire state willing to accept Medicaid rates. Unless and until ADC (or its contractor) can pay higher rates to subcontracted specialists in the community, they will continue to face serious problems in recruiting and retaining specialists. A basic first step to address this failure is to enlist the State's publicly-funded medical schools and their affiliated practice groups to provide their expertise and assistance, including delivery of specialty care, to persons who are wards of the State.

53. The constant turnover in subcontracted specialists also leads to fragmented and delayed treatment for serious medical conditions, as I recently observed in relation to the delays in treatment of the recurrence of prostate cancer for named plaintiff Shawn

[3] The Court noted with regard to the remedial plan for PM 50, that it consisted of sending a memo to the field, and that it was not until a month after ADC told the Court the memo would be sent that it was actually issued. [5/10/17 Tr. at 830:13-831:12]

Jensen. [Doc. 1958-1 at 3-6] A contributing factor to the delays in his recurrence (besides Corizon's convoluted utilization management process, see below), is that there is no continuity of care because he often is seeing a different urologist or oncologist than the one who saw him previously, and the specialists often do not have copies of past reports.

54. The second biggest contributing factor to problems around specialty care is Corizon's convoluted Utilization Management process. In my past experience reviewing hundreds of class members' medical records and the records of prisoners who died in custody, it takes UM weeks to review and approve the provider's request. The Stipulation's performance measure that looks at the timeliness of Utilization Management review of a request, PM 48, only measures the review for denials, and gives UM 14 days to review and reject a request.[4] If it is taking UM two or three weeks to review and approve a request, a scheduler hoping to comply with the Stipulation would be running into the 30 day and 60 day deadlines set out by the Stipulation by the time they are directed that the request was approved and that they can go ahead and schedule the appointment. I noted in a past report to the Court that Corizon's regional medical director testified that he was the only person at the Corizon regional office who reviewed all specialty requests submitted statewide, (*see* Doc. 1104-1 at 274), and I don't know if that has changed. But clearly having only one or two persons with the authority to decide whether to approve or deny requests will inevitably lead to a delay in reviewing the requests. My recommendation is that rather than have one person review all requests, Corizon empower more individuals to make these reviews. This not only has advantages for spreading out the work, but it affords the valuable opportunity for clinicians with

[4] PM 48 states, "Documentation, including the reason(s) for the denial, of Utilization Management denials of requests for specialty services will be sent to the requesting Provider in writing within fourteen calendar days, and placed in the patient's medical record." [Doc. 1185-1 at 11] For a year and a half, Defendants reported "Not Applicable" in their reviews of PM 48 (and 49), because they took the position that since Corizon labeled denials as "Alternate Treatment Plans," then no review was necessary. [5/10/17 Tr. at 701:1-703:3] Since they started monitoring these measures correctly, they have shown widespread noncompliance, although apparently the Court has not yet officially found them noncompliant. [*See* Doc. 2041 at 50]

direct knowledge and access to the prisoner to make the decisions as opposed to a disembodied administrator. My recommendation would be to empower the facility medical directors to approve these requests.

55. The Stipulation includes a requirement that ADC and its health care contractors review requests for specialty care using InterQual or another equivalent industry standard utilization management program. [Doc. 1185, ¶ 11] Defendants have represented that Corizon is now using InterQual. If that is the case, then the analysis from InterQual should be available for all to see, so that there is transparency in the decision-making system. InterQual can be an excellent tool when used as one data point for making evidence-based treatment decisions; I suspect, however, that Corizon staff use the service primarily to justify denying care.

56. My recommendation is that the Court order ADC and Corizon to include the actual clinical analysis (InterQual or other) on the referral for care so the referral and reasons for whatever disposition is assigned to the referral can be viewed in the same document. In other words, show your work!

Chronic Care and Infirmary Care Performance Measures

57. Chronic care clinics are a major focus of healthcare in a well-functioning correctional setting. Regularly scheduled appointments allow providers to track the progress of patients with chronic illnesses and ensure appropriate levels of treatment. I previously described to the Court the importance of a functioning infirmary/inpatient hospital system, and the horrifying deaths and suffering that class members have experienced due to inadequate care at the infirmaries. [Doc. 1539, ¶¶ 67-70]

58. PM 54 requires "Chronic disease inmates will be seen by the provider as specified in the inmate's treatment plan, no less than every 180 days unless the provider documents a reason why a longer time frame can be in place." [Doc. 1185-1 at 11] The Court found Defendants substantially noncompliant with this measure on May 20, 2016 at Eyman, Florence, Lewis, Perryville, Phoenix, Tucson, and Yuma. [Doc. 1583 at 2]

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Eyman	82	66	86	78	82	74	72	62	46	50
Florence	92	92	97	98	92	92	90	80	88	85
Lewis	78	89	84	99	93	89	93	89	91	78
Perryville	94	96	92	92	98	96	96	92	96	94
Phoenix	100	96	98	97	93	98	95	92	96	98
Tucson	80	69	76	90	87	91	92	79	96	89
Yuma	90	92	98	94	98	92	98	96	98	98

59. PM 66 requires that "In an IPC, a Medical Provider encounters will occur at a minimum every 72 hours." [Doc. 1185-1 at 12] The Court found Defendants substantially noncompliant with this measure on May 20, 2016 at Florence, Lewis, and Tucson prisons. [Doc. 1583 at 2] Defendants remain shockingly out of compliance with PM 66.

	June	July	Aug	Sept[5]	Oct	Nov	Dec	Jan	Feb	Mar
Florence	70	80	100	100	96	84	40	40	60	10
Lewis	30	60	90	90	90	100	60	90	20	60
Tucson	40	20	20	100	94	98	30	30	80	70

60. Defendants' original remedial plan of June 14, 2016 for PM 66 blamed noncompliance on providers' failure to document their rounds. Doc. 1609-1 at 13. And again, as described above at Paragraph 42, part of the remedial plan was to have site medical directors sign acknowledgments that they are supposed to hold providers accountable, a meaningless remedial plan, in my opinion. The original remedial plan states that "[a]dditional resources have been provided to all IPC units to ensure that there are enough provider resources to document the rounds being conducted by providers," but it is unclear what "resources" means – more providers? Hand-held tablets? Scribes? Video recorders? It is a mystery. Defendants' August 2016 remedial plan for PM 66 reiterates the June 2016 plan. [Doc. 1665 at 15-16] Patients who are admitted to an inpatient setting are sick—that is the reason they are there. As such, they should be seen by providers in accordance with their acuity level. For patients who are acutely sick and

[5] I have been informed that in September and October 2016 CGARs, Defendants used a "partial credit" methodology for PM 66, which of course would overstate compliance those months.

where IV medication is being utilized, they should be seen daily. Period. For patients who are stabilized and completing a course of treatment, they should be seen at least every three days.

61. My recommendation for both PM 54 and PM 66 is that Corizon hire more on-site providers and to implement business practices that make them more efficient. Provider time is precious, and there are things that only they can do – specifically, diagnose and treat. Everything else can be assisted or delegated, including documentation. One of the biggest barriers to provider productivity is the ergonomics of the electronic health record and the inefficiency of the documentation. If the system were to relieve the documentation burden on the providers, the provider productivity could be significantly enhanced. The most common techniques for doing this, widely used in private practice, include hiring scribes to follow the clinicians and complete the documentation of the visits, and/or using dictation / transcription services. Dictation / transcription is my preferred method personally, and it is what we have used in my system for 18 years. It is fast and reliable, and the quality of the notes is superior to anything a provider types. Additionally, the providers all know how to dictate, and transcription staff are inexpensive compared to provider time. Dictation / transcription easily increases provider productivity at least by 40% in our internal studies.

Executed June 9, 2017, in Salt Lake City, Utah.

Todd R. Wilcox, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on June 9, 2017, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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UNITED STATES DISTRICT COURTS
DISTRICT OF ARIZONA

VICTOR PARSONS VS CHARLES RYAN	NO: CIV12-0601 DKD Notice of IMPENDING DEATH

ADOC AND CORIZON DELAYED TREATING MY CANCER. NOW BECAUSE OF THERE DELAY, I MAY BE LUCKEY TO BE ALIVE FOR 30 DAYS. THE DELAYED TREATMENT THEY GAVE ME IS CAUSING MEMORY LOSS, PAIN. TOO MANY INMATES IN EAST UNIT HAVE THE SAME ISSUE (WITHERS, JENSEN, FIGUEROA, TRIPATI, ORTIZ, THRASHER, RICHARDS ETC. ALL THESE ARE INMATES DENIED TREATMENT BY CORIZON AMONG OTHERS AND ALL FALLING, YELLING, SCREAMING OF PAIN,

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

PLAINTIFFS' STATEMENT REGARDING DEFENDANTS' REMOVAL OF HEALTH NEEDS REQUEST (HNR) BOXES

INTRODUCTION

On May 15, 2017, Defendants unilaterally announced that they were going to discontinue the use of Health Needs Request (HNR) boxes at minimum and medium security institutions and units as an avenue for class members to request and access medical, dental, and mental health care. [Doc. 2106-1 at 11-12] Instead, Defendants stated, prisoners would have to go to the nurse's line "open clinics" with a HNR and wait to be seen on a first-come, first-served basis.

Plaintiffs objected to the unilateral decision to remove the HNR boxes because it created an unnecessary barrier to access to health care, and repeatedly have expressed their concerns to Defendants and the Court since the announcement. Dr. Todd Wilcox informed the Court that the removal of the HNR boxes "amounts to nothing more than a blatant attempt to avoid accountability and to eliminate the only traceable audit trail of patient requests for care" and "would guarantee a decrease in actual access to healthcare within the system. . ." [Doc. 2103 at ¶¶ 27-28] Dr. Wilcox's declaration remains entirely uncontradicted.

The Court ordered the parties to bring forth witnesses and evidence regarding whether the removal of the HNR boxes would reduce class members' access to health care, and/or adversely impact the accuracy of CGAR results for some performance measures. [6/14/17 Tr. at 111:23-25] The Court has ruled that the burden would be on the Defendants to show that the removal of HNR boxes does not impact the reliability of CGAR results, or access to care. [*Id*. at 111:15-18 ("I do think that the burden is on the defendants to show me how it is that the stipulation's enforcement is not encumbered by the removal of something that is specified in the stipulation.")]

Defendants clearly have failed to meet the burden. The evidence shows Plaintiffs' concerns are well-founded. Defendants' witnesses reported, and documents show, that they now only track the HNRs of people who are actually seen on the nurse's line, which therefore falsely inflates the compliance scores of multiple performance measures that are triggered by the submission of an HNR. This limitation negatively impacts the reliability

of CGAR data.

The evidence also showed that under this new system, (a) at some prisons, there is a severely limited window of time to access care each day and people are turned away from the clinic if they come outside their allotted time slot; (b) people seeking dental or mental health care are made to see a nurse without relevant training and are charged $4 before their HNR is even referred to the appropriate discipline; (c) there are often long waits, sometimes in harsh conditions, to see a nurse; and (d) people with disabilities face additional physical barriers to accessing care.

Therefore, Plaintiffs seek an order directing Defendants to re-install the boxes so that class members can request medical care either by going to the open clinic and waiting to see the nurse, or by submitting a HNR and being called to the nurse's line the next day. Such a dual system of accessing medical care would ensure people have multiple avenues by which they can seek medical care, and address the recordkeeping and CGAR reliability concerns inherent in only logging the HNRs of people who are actually seen by a nurse. Patients seeking mental health or dental care should be able to submit their HNRs in the boxes so the requests are referred to those disciplines for scheduling in accordance with the requirements of PMs 98, 102, and 103, and so people are not charged $4 to see a nurse with no mental health or dental training before being referred to the appropriate discipline. This dual-track approach to access care comports with the Court's prior suggestion of "moving to the new system but then preserving as the fallback position for those who might otherwise find this to be an obstacle. . ." [6/14/17 Tr. at 111:19-21]

I. The Removal of HNR Boxes Impacts The Accuracy of Multiple Performance Measure Results and Inflates CGAR Compliance Rates

Plaintiffs' counsel and their expert repeatedly have expressed concern that the removal of the HNR boxes and Defendants' practice of only accepting and logging the HNRs of the patients who ultimately are seen on nurse's line inflates rates of compliance

for multiple performance measures that have their compliance timeframes connected to when a prisoner submits a HNR or is seen by a nurse.[1] [*See, e.g.*, 6/14/17 Tr. at 78:18-20; 81:23-25; 85:21-23] Dr. Wilcox observed that removing the boxes where all HNRs were collected "would make it virtually impossible to recreate the timeline of care that is critical in many cases for providers (and for monitors) to review. [. . .] This will overestimate and inflate compliance with the timeframe requirements for providers to see patients in PM 39 and 40, as it suppresses the true number of patients who needed to be seen by the provider." [Doc. 2103 at ¶ 28-29] This concern was shared by the Court:

> THE COURT: […] my original concern when I saw that, is because there are a number of provisions in the stipulation, or in the performance measures, that are triggered [and] that are put in play by this HNR deposit of a request. . .
>
> [. . .] [Y]ou can't decide that a performance measure that requires this thing to be monitored by when an HNR is deposited, you can't just remove the mailbox unilaterally. [. . .]
>
> I need to hear how it is that I have an assurance that the performance measure that was going to let me know whether or not a requirement of the

---

[1] The relevant performance measures include:

- PM 36 (A LPN or RN will screen HNRs within 24 hours of receipt)
- PM 37 (Sick call inmates will be seen by an RN within 24 hours after an HNR is received (or immediately if identified with an emergent need, or on the same day if identified as having an urgent need)
- PM 39 (Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointment will be seen within fourteen calendar days of the referral.)
- PM 40 (Urgent provider referrals are seen by a Medical Provider within 24 hours of the referral.)
- PM 41 (Emergent provider referrals are seen immediately by a Medical Provider)
- PM 42 (A follow-up sick call encounter will occur within the time frame specified by the Medical or Mental Health Provider.)
- PM 98 (Mental health HNRs shall be responded to within the timeframes set forth in the Mental Health Technical Manual (MHTM) (rev. 4/18/14), Chapter 2, Section 5.0.)
- PM 102 (Routine dental care wait times will be no more than 90 days from the date the HNR was received.)
- PM 103 (Urgent [dental] care wait times, as determined by the contracted vendor, shall be no more than 72 hours from the date the HNR was received.).

[Doc. 1185-1 at 10, 15]

> stipulation was being satisfied is going to fail now because a single side has decided to remove the triggering mechanism.

[6/14/17 Tr. at 74:5-75:2]

Counsel for Defendants at the June 14, 2017 hearing assured the Court that the HNR would be "processed just like it usually is." [*Id*. at 75:10; *see also id*. at 75:11-12 ("THE COURT: So they get docketed in the same way? MR. BOJANOWSKI: Right.")] However, this was not true, as Defendants subsequently admitted that the only HNRs that are logged (or "docketed," to use the Court's term) and processed are those of the people who are actually seen by the nurse:

> THE COURT: [I]s there a sign-in sheet for people that show up in the new sick call method? Do people sign in when they arrive?
>
> MR. BOJANOWSKI: [. . .] Apparently not.
>
> THE COURT: Wouldn't that be a good idea? Wouldn't that be a good way to give you at least something to counter plaintiff's [sic] concerns with? It would be a trackable document as to when somebody showed up. Not saying it's ideal.
>
> MR. PRATT: [. . .] "[I]t's not when they show up that they sign in and they wait to be seen.
>
> [. . .]
>
> MR. BOJANOWSKI: At the point when they submit the HNR to the nurse, they sign a piece of paper saying I'm here.
>
> THE COURT: Okay. That doesn't address any of the problems we talked about before.

[*Id*. at 94:15-95:21]

Class member Mark Blocksom testified that at Florence East Unit, the HNR is not processed until the patient is seen by the nurse. [7/14/17 Tr. at 19:19-23] Assistant Director of Nursing Tanna Gualco confirmed that at Eyman Meadows Unit, nursing staff only record and log the HNRs of the prisoners who are actually seen by the nurses.

> THE COURT: For these people who decide after they have come, put they are name up on -- their ID on the board and they decide they want to leave and they take their ID from the board, there is no written record that exists in the clinic office that they have come and/or left?
>
> THE WITNESS: Once we get their HNR in our hand, if they leave, they have to come back and sign refusal because technically we've already

> touched that HNR, so we have to see them, especially if they have a physical complaint. But if they come in while we're seeing somebody else and they have an HNR to turn in and they realize, "I don't actually want to be seen today," and they take off, we don't have any way to document anybody like that.

[9/13/17 Tr. at 143:13-25]

Accordingly, this means that all performance measures that rely upon the "HNR log" as the source document for monitoring (not just the ones listed at footnote 1 that measure timeframes from submission of the HNR) are implicated by this incomplete universe of HNRs, because unlike the HNR boxes that collected all requests for health care made by individuals, the open clinic system only reflects the persons who were actually seen on nurse's line.[2] [7/14/17 Tr. at 190:21-191:6 (Ms. Ashworth testifying that the HNR her cellmate filled out for her on June 5, 2017, when she had an allergic reaction and chemical burns from iodine being used on her eyes (7/14/17 Hg. Plfs' Ex. 6) was not accepted by the nurse and handed back to her); *id.* at 93:22-94:3; 97:19-98:11; 98:15-22 (Mr. Oyenik testifying that with the HNR box system, prisoners had a written record of their treatment plan)].

Nurse Gualco testified she preferred not having HNR boxes because "it holds them [patients] accountable" as nurses no longer have to make lists and schedule appointments and have custody bring patients to the appointments. [9/13/17 Tr. at 152:22-25] While the removal of the HNR boxes apparently has resulted in less work for nursing and custody staff, class members in need of medical care are not the only people that should be held accountable. Defendants must also be held accountable to ensure that they are not artificially inflating their compliance rates for multiple performance measures by unilaterally eliminating the HNR submittal process that was in place and relied upon when the Stipulation was executed.

[2] The most recent version of the Monitoring Guide provided to Plaintiffs, dated August 25, 2017, lists six performance measures that use the HNR log as a source document. [*See* Doc. 2291-1 at 28, 30, 64, 65, 77, 156 (PMs 5, 7, 36, 37, 47, 98)]

II. Removal of the HNR Boxes Adversely Impacts Class Members' Ability to Access Health Care

A. Defendants' Witnesses Could Not Explain The Change in Position Regarding Maintaining HNR Boxes

In his January 18, 2017 declaration describing the newly enacted open clinic process, (Doc. 1873-1), Defendant Pratt stated that

> If an inmate wishes to submit an HNR outside of the hours in which the clinic is open for his/her housing unit, the inmate may submit the HNR in the HNR collection box. The HNR will be triaged by nursing staff, and the inmate will be seen during the next open period for his/her housing unit, such that the inmate is still seen within 24 hours of the HNR request, and the HNR is still tracked for performance measures 36 and 37.

[Doc. 1873-1 at ¶ 20]

However, at some point prior to making the May 15, 2017 announcement of the unilateral removal of the HNR boxes, Defendants obviously decided to remove them. Unfortunately, Defendant Pratt testified he was unable to remember the most basic details of the genesis of the boxes' removal, including why the decision was made, when the idea of removing the boxes was first raised, or whether the idea to remove the boxes originated with Corizon or ADC. [8/8/17 Tr. at 52:4-10] Rather than provide witnesses capable of remembering basic details of the circumstances and reasoning behind the removal of the boxes, all but one of Defendants' other witnesses designated for the HNR box evidentiary hearings were instead called in an unsuccessful attempt to contradict the July 14 testimony of prisoner witnesses. (*i.e.*, Sgt. Coleman and CO Western, the two Perryville officers who refused to call an ICS for Ms. Ashworth during her allergic reaction; Mr. Twyford and Mr. Van Winkle, deputy wardens of Perryville and Florence showing pictures of clinic space and housing units, attempting to contradict concerns raised by Ms. Keys and Mr. Oyenik about physical access for people with disabilities).

Plaintiffs' position that the removal of the HNR boxes would erect a barrier to care was shared by some of Defendants' employees. On December 7, 2016, Perryville monitor Mark Haldane emailed his supervisor, Kathy Campbell, reporting on how the new open clinic system was working in its first week of operation. He informed Ms. Campbell that

the Corizon facility health administrator ("FHA") at the prison had "reported that according to Rolly Maldonado, as soon as the open sick call is in place and implemented that the HNR boxes were going away. *I said that was in direct contradiction to what I was told today, which is that they are never going away because it is an access to care issue*." [8/8/17 Hg. Plfs' Ex. 27 at 2 (emphasis added)][3] When the HNR boxes were removed at ASPC-Safford, the FHA noted, "They tried this many years ago and changed. Why do we always go backwards?" [8/8/17 Hg. Plfs' Ex. 22 at 1]

Defendant Pratt testified expectedly that he had no memory of a December 7, 2016 meeting where monitors were told (or at least Mr. Haldane was told) that boxes "are never going away because it is an access to care issue." [8/8/17 Tr. at 48:10-16] Mr. Pratt also could not remember a December 2, 2016 teleconference of top administrators that he attended (as memorialized in an email sent that day) that was about the "12 hour nurses line effective Monday 12/5/16" where discussion included "HNR boxes must be kept – they are not going away." [8/8/17 Tr. at 44:14-16; 46:11-19; 8/8/17 Hg. Plfs' Ex. 24 at 2]

Meanwhile, Senior Vice President of Corizon Health, Roland Maldonado, who in December was telling Corizon FHAs that HNR boxes would be taken out, (*see* 8/8/17 Plfs' Ex. 27 at 2), was a proponent of removing the boxes. He contacted Mr. Pratt and ADC Deputy Director McWilliams on February 16, 2017, to complain that "the sick call process is reverting back to a HSR box system." [8/8/17 Hg. Plfs' Ex. 33 at 1] Mr. Maldonado noted that, "I suspected based on my experience in other states that *if allowed to use the box or to come to an open call that the population will always take the easiest route and go to the box*." [*Id.*] (emphasis added) Accordingly, this top national Corizon executive acknowledged that the HNR boxes provide the "easiest" access to care compared to the open clinic system.

While Mr. Pratt testified under oath that he could not remember details of what

[3] Mr. Maldonado is the Senior Vice President of Corizon Health. [*See* 8/8/17 Hrg. Plfs' Ex. 33 at 1]

might have happened between December 2016 and May 2017 to change ADC's position on HNR boxes, but on May 15, 2017 he emailed his senior staff and Corizon's regional director, and asked if other health care requests that did not require being seen by nursing could continue to use the HNR boxes, and offered a few examples. [8/8/17 Hg. Plfs' Ex. 29] His colleague Kathy Campbell from the monitoring bureau said in response that she thought the boxes should be completely removed to "eliminate this issue" of people using the HNR boxes to request and access care. [*Id.*] Nicole Taylor, the mental health monitor, wrote that she "completely agree[d]" with Ms. Campbell's sentiment to eliminate this "issue," bizarrely punctuating her support for entirely removing boxes and a relied-upon avenue for access to care with a smiley face. [*Id.*] Mr. Pratt testified that unlike Ms. Campbell or Dr. Taylor, who thought the ongoing use of the boxes to request care was an "issue," he did not think it was a problem that patients used the boxes. [8/8/17 Tr. at 54:19-20] Mr. Pratt also testified that unlike his colleagues, he does not think the boxes should be completely removed. [8/8/17 Tr. at 54:21-24]

B. The Limited Hours that Prisoners Can Obtain Medical Care at Open Clinic Creates a Barrier to Care

On January 18, 2017, Defendants assured the Court that, "To accommodate the open clinic concept and to ensure that all inmates are being seen within 24 hours of receipt of an HNR, the medical clinics at each of the participating complexes—Florence, Eyman, Perryville, Lewis, Tucson, and Yuma—are now open from 7:00 am to 7:00 pm." [Doc. 1873 at 2] Likewise, Defendant Pratt signed a declaration that same day, stating to the Court that "With the implementation of the open clinic concept, nursing lines generally run from 7:00 am to 7:00 pm at the participating complexes. . ." [Doc. 1873-1 at ¶ 15] Despite this sworn statement, he now denies ever stating to the Court that nurse's line ran for 12 hours, or that this ever actually occurred. [*See* 8/8/17 Tr. at 47:7-10 (Cross Examination of Mr. Pratt: "Q. Isn't it the case that you have previously told the Court in declarations that nurse's line runs from 7 to 7? A. No. There's availability, but nurse lines don't run 7 to 7 typically.")]

While there may not be the patient demand at some units to require that nurse's line be open and staffed from 7 am to 7 pm, the point is that Defendants repeatedly made this representation to the Court in January, while their internal documents show that it was *never* the case. The evidence and testimony presented confirms that nurse's line, indeed, did not and currently does not run for 12 hours a day as Defendants repeatedly stated. [*See e.g.*, 8/8/17 Hg. Plfs' Exs. 16 at 2-4 (Douglas Gila and Mohave Units' nurse's line from 8-10:30 am and 1:30-3:00 pm; Papago Unit 9:30-10:30); 17 at 1 (same); 19 at 1 (Florence Globe unit changed hours on January 31, 2017 to run four hours a day); 23 at 3 (Florence FHA writing on November 23, 2016 that "[t]he Warden received clarification that we DO NOT have to have Open Sick Call available for 12 hours/day. . ."); Ex. 28 (undated document showing start and stop times at Eyman, Florence, Lewis, Phoenix, and Winslow); *see also* 7/14/17 Tr. at 14:16-18; 17:14-17 (Florence East from 7 am-4 pm); 8/8/17 Tr. at 77:14-23 (open clinic at Douglas from 8:00-10:30 am and 1:30-3:00 pm)] In June 2017, as the system of no HNR boxes and open clinic was unveiled at ASPC-Douglas, the Corizon FHA noted that the hours were limited, and boasted to prison officials, "We're attempting to 'train' the inmates to report w/in the first 15 minutes of sick call. . ." [8/8/17 Hg. Plfs' Ex. 16 at 1] Defendant Pratt did not know that the prisoners at Douglas had been told that they had to appear at the clinic in the first 15 minutes that it is open, or they would be turned away, but characterized this statement to mean "it's an education to let the inmates know that if they are late they will have to wait until the next day." [8/8/17 Tr. at 77:5-8; 78:12-16; 78:21-22]

Furthermore, the practice at many institutions and units is that blocks of time are reserved for certain buildings. As a result, if people seek care outside their building's allotted time slot, they will be turned away. Among the grievances produced by Defendants from ASPC-Lewis was one from a patient with a congenital heart defect and history of open heart surgery, who filed a grievance about being turned away from the clinic the evening of December 8, 2016, when he was experiencing chest pains and his blood pressure was measured at 110/10, because he had come to the clinic once and the

complex hub once earlier in the day. [8/8/17 Hg. Plfs' Ex. 13 at ADCM959519 and AG000001] Mr. Pratt confirmed that blood pressure of 110/10 is dangerous and a person could die with such low blood pressure, but questioned the accuracy of the blood pressure, even though that was what was documented in the eOMIS medical record, and when the patient had seen a pediatric cardiologist two months earlier, the cardiologist noted that he was suffering from "profound hypotension" because the Corizon providers were (incorrectly) prescribing nitrates to treat his chest pain. [8/8/17 Tr. at 80:4-11, 81:6-19, 82:10-15; 83:6-84:21; Plfs' Ex. 13 at AG00002] Mr. Pratt testified he did not know if there was a policy or practice that a patient could not be seen more than once in the same day at the clinic. [Id. at 78:23-25]

Mr. Oyenik testified that he had observed ADC staff at the Florence South clinic turn prisoners away because they were not there during their building's allotted time slot. [7/14/17 Tr. at 85:1-5] Ms. Keys testified that she had been turned away by a nurse at the Perryville Santa Cruz clinic while suffering pain from a gallstone because it was after 12 noon, and she was told that only the people who worked could go to the clinic in the afternoon. [*Id*. at 132:3-4; 134:20-135:12] She also testified that she had seen another woman who was doubled up in pain and had been wheeled to medical being turned away for treatment. [*Id.* at 137:19-138:3]. And Ms. Ashworth testified at length about how she suffered a severe allergic reaction to iodine drops that were put in her eyes for a June 5, 2017 medical procedure. She reported that she and her bunkmate went to the clinic in the afternoon because of her swollen eyes and the rash, swelling, and redness she had on her face, and they were told by the San Pedro clinic nurse that the clinic was not accepting HNRs. The nurse handed back the HNR Ms. Ashworth's bunkmate had filled out without logging it, and told them to go back to their housing unit. [*Id.* at 188:18-189:4; 189:19-191:24; 7/14/17 Hg. Plfs' Ex. 6 (HNR filled out by bunkmate)] Ms. Ashworth's symptoms of her allergic reaction included swollen eyes, redness of her face, a rash, and she was in pain. [*Id*. at 193:12-20] Officer Western confirmed that Ms. Ashworth had gone to the clinic the afternoon of June 5, 2017, and was turned away because "their HNR

hours are from 12:30 until 2" and "it was almost cutoff … to submit an HNR." [8/9/17 Tr. at 12:2-6; 13:13-14; 15:2-4]

Eyman Meadows Assistant Director of Nursing Gualco testified that at her clinic, different buildings are assigned specific time slots, and if a person comes to the clinic when it is not their building's designated timeslot, "we let them know, 'Please fill it out and come back when your building is called.'" [9/13/17 Tr. 152:8-13] She offered an illustrative example that eerily echoed what happened to Ms. Ashworth:

> Q. If somebody shows up at 8:31, what happens to that inmate?
>
> A. It's triaged based off of urgency. If someone has a broken hand, we're going to see -- obviously see them but if it's ["]I'm having allergies,["] then they will have to wait because the next two buildings are already lining up for their HNR time.

[Id. at 139:15-20]

Ms. Gualco also confirmed that the nurses do not have any written guidelines or instructions about what complaints or symptoms would warrant seeing a patient outside his building's assigned timeslot. [Id. at 163:18-22]

C. Defendants' Policy Requiring Patients Seeking Mental Health or Dental Care To Have an Unnecessary and Expensive Nurse's Line Visit Creates a Needless Barrier to Care

In his January 18, 2017 declaration about the open clinics, Defendant Pratt stated that people seeking dental or mental health care would not have their HNRs processed through the open clinic nurse's line prior to seeing staff from the respective disciplines. Rather, these requests would be reviewed, triaged, and referred to the appropriate discipline. He avowed,

> The open clinic was developed by Corizon and ADC in direct response to the Court's November 10, 2016 Order requiring outside transports and was intended to ensure Defendants' compliance with performance measure 37, which requires that inmates be seen within 24 hours of submission of a Health Needs Request (HNR) for routine medical care.
>
> HNRs for routine dental care and mental health care continue to be addressed through referrals to dental and mental health staff and must be seen within the timelines provided in the Stipulation.
>
> [. . .] If the HNR is for routine dental care or mental health care, the inmate is referred to dental or mental health staff and must be seen within the

> timeframes set forth in the Stipulation. If the HNR is for routine medical care, the inmate is seen the same day by an RN or a medical provider as required by PM 37.

[Doc. 1873-1 at ¶¶ 11, 12, 18; *see also* 8/8/17 Hg. Plfs' Ex. 23 at 1 (ADCM967762) (Florence FHA writing on November 23, 2016 that HNR boxes will be kept in place "to keep up with Dental, MH and a back up plan in case…things change down the road") (ellipses in original); 7/14/17 Tr. at 152:5-11 (Ms. Keys testified that when HNR boxes were in place, people were not made to be seen on nurse's line when requesting dental or mental health care)]

Notably, in the same paragraph (¶ 18) where Mr. Pratt refers to HNRs that are "for routine dental care or mental health care," he distinguishes HNRs filed "for routine medical care," where "the inmate is seen the same day by an RN or a medical provider as required by PM 37." [Doc. 1873-1 at ¶ 18] Mr. Pratt was asked, "So [on] January 18th request[s] for dental and mental health were not forced to go to the nurse's line?" and in response he said, "Prior to that, no." [8/8/17 Tr. at 65:9-11] Nurse Gualco testified that when the HNR boxes were in place, the nurses would collect and triage the HNRs, review them, and give the HNRs seeking non-medical care to the appropriate discipline – the patients were not seen on nurse's line. [9/13/17 Tr. at 137:12-20; 140:20-141:4]

However, at some point this changed, (Mr. Pratt testified he could not remember when, *see* 8/8/17 Tr. at 65:12-14), and now people seeking mental health or dental care cannot put the request in a box or drop it off at the clinic, but rather are required to report to nurse's line, wait in line, see a nurse who is untrained in mental health or dentistry, pay $4 for the encounter, and *then* have the HNR referred to the proper discipline. The only explanation Defendant Pratt could offer for the mandate that dental and mental health patients first be seen on nurse's line is that the change was made "for consistency." [*Id*. at 76:1-2] In response to the Court's questions, Mr. Pratt initially testified that a person would not pay an additional $4 charge to see the mental health staff, (*id*. at 63:20-64:5), but then subsequently confirmed that unless a person has a SMI (seriously mentally ill) designation, he or she will be charged an *additional* $4 when seeing mental health staff.

[*Id*. at 63:9-10; 70:4-15]

While Mr. Pratt testified he didn't think that this additional $4 nurse's line charge would create a disincentive for people to seek mental health care, (8/8/17 Tr. at 62:20-63:9), given the reality of the pennies an hour that prisoners are paid (if they even have a job), it is reasonable to conclude that prisoners will be deterred from requesting mental health care or dental care. [7/14/17 Tr. at 66:22-23 (Mr. Oyenik is paid 15 cents an hour to work on a construction crew); 179:8-10 (Ms. Ashworth is paid 30-35 cents an hour to drive a tram); *see also* Doc. 2103 at ¶¶ 30-31 (Dr. Wilcox opining that the $4 copay is a disincentive to request care and that at 15 cents an hour, a nurse's line visit with a $4 copay is the equivalent of 26 hours and 40 minutes of labor)].[4] In light of this spring's rash of suicides of people in ADC custody (four suicides in twenty days), Defendants should not erect any additional barriers to care, especially mental health care. [*See* Doc. 2091 at ¶¶ 5, 7-9 (Decl. of Pablo Stewart, M.D.) (only one out of these four people who died by suicide was classified as SMI)]

D. Since Class Members Cannot Use HNR Boxes to Request Health Care, They Are Forced To Wait for Longer Periods of Time, Often in Harsh Conditions

No citation to authority is necessary to support the proposition that Arizona suffers from extreme and harsh temperatures; that is abundantly apparent to anyone in the state between the months of March and October. Testimony and grievances filed by class members described having to spend long periods of time in the outdoors waiting to be seen by a nurse, as opposed to when they could request health care through an HNR deposited in a box, and then be scheduled for an appointment at a specific time. As class

[4] To illustrate how staggering a $4 copay is for an incarcerated person paid 15 cents an hour pursuant to the 13th Amendment, consider that it is equivalent to a free person paid an annual salary of $50,000 (which works out to $961.54 a week, or $24.04 an hour on a 40-hour work week) being charged a co-pay of $641 for a brief encounter with a registered nurse (26.67 hours' worth of salary). The prisoner's payment of a total of $8 to see nurse's line and then dental (or mental health) staff is comparable to $1,282 for the person making $50,000 a year.

members no longer have that option available to them as a means to request medical, mental health, or dental care, they now must wait longer to be seen.

Mr. Blocksom testified that at Florence East unit, there are normally no more than two or three persons who can wait inside the clinic, and all others wait outside. [7/14/17 Tr. at 18:18-21] There are some shaded areas, but in the summer, "it can be pretty brutal" because "[i]t's all exposed." [*Id.* at 20:12-18; 49:23-50:16] He testified seeing people waiting for open clinic "falling out" due to heat, and that the longest he has had to wait was three and a half hours. [*Id*. 20:25-21:4; 52:6-20] He noted, "I have gone up there for morning meds, come back for afternoon meds, and they are still there waiting." [*Id.* at 34:4-5] He has seen people give up and leave the open clinic after waiting. [*Id*. at 34:11-35:5] He testified that some people choose not to go to open clinic or medication line when the line is particularly long or when it is very hot. [*Id*. at 34:17-35:5]

Mr. Oyenik similarly testified that he has personally seen people waiting for insulin line or open clinic give up and leave, because they were outside and it was too hot to continue to wait. [*Id*. at 83:13-15; 94:20-95:1] He testified that there were seven seats inside the new clinic for people who were waiting for pill line (also known as "med pass"), but the people who were waiting for the open clinic had to wait outside. [*Id.* at 94:4-16] He also testified that approximately in the middle of May, he observed a person have some sort of seizure while waiting in the sun. [*Id*. 83:23-84:4] He testified that there was no shade for the people waiting outside except for an overhang of the building that covers part of a bench, "but it's not far enough out to keep you out of the sun." [*Id*. at 74:18-75:11; 75:20-22] He stated, "we all get up in there as close as we can to the window and that's as far as you can get. But if you are in . . . a wheelchair there's no getting in closer. . .. You are out there in the sun." [*Id*. at 75:14-19]

Ms. Ashworth similarly described how the women waiting to see the nurse at San Pedro unit wait outside, and that she has never seen people waiting inside. [7/14/17 Tr. at 182:22-183:2] They wait on a concrete bench outside the clinic, which only on one side is partially shaded by the overhang of the building's roof, and there are no misters, but there

is an Igloo jug of water. [*Id*. at 183:5-184:5] She testified that people are seen first come, first served, and there is no policy or practice that people with disabilities who use wheelchairs, or pregnant women, can jump to the front of the line to be seen sooner and not have wait as long. [*Id*. at 184:25-185:15] She testified that she has seen people waiting for open clinic leave the line and not be seen, and she also has seen people suffering adverse effects from the heat while waiting outside. [*Id*. at 186:14-187:3][5] Ms. Keys similarly testified that she had observed "a lot of people" leaving the nurse's line because of the heat. [*Id*. at 137:11-14]

Three weeks after class members testified, Defendants called deputy wardens to show pictures and testify about physical plant improvements and accommodations for people with disabilities at Perryville and Florence, many that they admitted had only been recently installed. [*See, e.g.*, 8/8/17 Tr. at 190:22-25 (newly installed misters at Florence-South)] Defendants' witnesses confirmed the descriptions offered by class members. Perryville Deputy Warden Twyford confirmed Ms. Keys' testimony that the caged-in enclosure near the clinic where Santa Cruz prisoners wait for open clinic in the morning is in the sun. [8/8/17 Tr. at 213:16-21 ("And in the morning, the morning sun will shine toward the waiting area that's right here. And within eyeshot across from there the inmates will congregate on the shaded side. But 11:00, 10:00, depending on the summer/winter hours, the shade covers the holding enclosure you see in this picture and they congregate there.")][6] However, as Ms. Keys testified, she cannot get in the holding enclosure cage outside the clinic that offers some shade, due to her wheelchair, and clinic staff do not allow people to wait inside. [7/14/17 Tr. at 136:20-137:8, 162:3-10]

[5] *See also* Doc. 2291-1 at 273-277 (numerous temperature readings between 100 and 110 degrees in "medical holding enclosures" at ASPC-Safford; *id.* at 288-290 (multiple readings exceeding 110 degrees in holding areas and ramadas at ASPC-Yuma).

[6] Mr. Twyford testified that the hours for people to show up for open clinic at Santa Cruz were 7 to 9 am, and they will wait past 9 am until they are seen, (8/8/17 Tr. at 205:2-10), so the arrival of shade in the holding cage at 10 or 11 am is of limited value to women in the cages or outside the cage in a wheelchair when their wait begins at 7 am.

E. Removing the HNR Boxes Erects a Barrier for People With Disabilities to Access Health Care, In Violation of Law

Defendants are obligated by law to provide equal access to health care services for people with disabilities in ADC custody as they do for all other class members. According to the National Council on Disability, "[p]eople with disabilities tend to be in poorer health and to use health care at a significantly higher rate than people who do not have disabilities," and "are affected disproportionately by barriers to care."[7] Counsel for Plaintiff Arizona Center for Disability Law ("ACDL") reported to the Court that ACDL is concerned that the removal of the HNR boxes creates a barrier to care for people with disabilities. Counsel noted:

> It's a principal tenet of serving individuals with disabilities that you provide multiple options to access a program, information, what have you. We are very concerned that removal of these HNR boxes is going to erect another barrier for those prisoners with disabilities to be able to access the healthcare system that operates in the prisons.
>
> It's anecdotal evidence, but I have been on many of these monitoring tours and I have spoken with prisoners that have mobility impairments that make it difficult for them to get around. Some have expressed to me that it's difficult for them to get to the HNR box to drop the HNR and have relied on aids or their cellmates to do that for them so they can have access to medical. If they are going to be required to be waiting in line at a health clinic it could be yet another barrier and perhaps prevent them from accessing the care that they need in disproportionate numbers. . ..

[6/14/17 Tr. at 110:9-25]

Not only is providing multiple options of access a basic tenet of serving people with disabilities, the concept of equal access is a cornerstone of the Americans with Disabilities Act (ADA). [*See* 28 C.F.R. § 35.130(b)(1)(iii) ("A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability— […]Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal

[7] NATIONAL COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 10 (Sept. 30, 2009), *available at* https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf.

opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others. . ."); *see also* 28 C.F.R. § 35.130(b)(1); 42 U.S.C. § 12132 ("[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.")] The ADA applies to state prison systems, (*Penn. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 213 (1998)); Defendants are thus bound by federal disability law.

To that end, ADC has a policy, Department Order 108: Americans with Disabilities Act Compliance, that has the stated purpose of ensuring "that all job applicants, employees, contractors, visitors *and inmates* are provided barrier-free access to facilities, services, programs and activities…consistent with reasonable accommodation and security requirements." [DO 108 at 2, (effective date May 9, 2014) available at https://corrections.az.gov/sites/default/files/policies/100/0108.pdf (emphasis added)] As was demonstrated consistently during the evidentiary hearings on the HNR box removal, Defendants have failed to make the medical care services required by the Stipulation, ADC policy, and federal law, available on an equal basis for class members with disabilities.

Multiple witnesses confirmed that a person seeking medical care, dental care, or mental health care on a yard where the open clinic system is operating must wait in line and be seen on nurse's line prior to obtaining care or a referral to a provider or the appropriate discipline. [*See, e.g.*, 9/13/17 Tr. at 158:10-15; *see also* 8/8/17 Tr. at 62:11-19] This has the effect of increasing the number of trips that people with disabilities must make to the clinic to seek care. [7/14/17 Tr. at 143:11-18] Ms. Keys, who is a full-time wheelchair user with significant medical needs, testified that when there was a HNR box on the Santa Cruz Unit, it was near the chow hall, closer to her building. [*Id*. at 130:22-131:8; 141:5-17; 143:11-21; 151:13-23] She could either put in a HNR when going to chow, or have others put in the HNR for her. [*Id.* at 140:24-141:4] She described the path of travel from her housing unit to the clinic as "paved but it's kind of falling apart." [*Id.* at

138:21-25] She also testified that she currently did not have a wheelchair pusher assigned to her to take her to the clinic, that she had to wait for an officer to call a pusher, or rely upon other prisoners who lived near her to push her up the ramp from her cell. [*Id.* at 138:11-16]

When Perryville Deputy Warden Twyford testified the next month, he testified that Ms. Keys recently was assigned an aide, approximately two weeks after her testimony. [8/8/17 Tr. at 202:5-18] He testified that previously, as Ms. Keys testified, the Santa Cruz unit had an ad hoc system of on-call ADA workers, but had switched two weeks ago to a system in which a specific aide is assigned to a specific mobility impaired person who uses a wheelchair. [*Id.* at 202:25-203:6] According to his notes, there were three women at Santa Cruz who were fulltime wheelchair users (including Ms. Keys), and another 20 who were intermittent wheelchair users, and under the new system, 17 workers employed to assist the people with disabilities. [*Id.* at 200:25-201:19] This change in system was also made at San Pedro Unit, where there are seven people who use wheelchairs. [*Id.* at 203:8-15] He also confirmed that the only medication refill box now on the Santa Cruz unit is outside the medical clinic. [*Id.* at 211:11-212:12] He did not have details about the number of people on Santa Cruz and San Pedro Units who use canes or other non-wheelchair mobility devices, or if these individuals have access to an ADA aide if necessary. [*Id.* at 242:7-19].

Mr. Oyenik testified that with the move of the medical clinic at Florence South in early July from a location adjacent to the dorms designated for people with mobility impairments (Dorms 7 and 8-Baker), to a new location outside the yard near the administrative building, the distance was much longer for the mobility impaired people to navigate, on sidewalks that "are pretty much well chewed up." [7/14/17 Tr. at 67:2-12; 67:25-68:8; 69:9-71:6] He also testified that the HNR box that previously had been very close to ADA dorms 7 and 8 near the chow hall had been removed, and the only way to get a HNR in front of health care staff or to put in a medication refill request was to physically take it to the clinic outside the main fence of the yard (and the clinic is

inaccessible and the fence is locked during lockdowns). [*Id*. at 76:7-9; 76:20-77:24]

Florence Deputy Warden Van Winkle, apparently called to contradict Mr. Oyenik on August 8, 2017, testified and showed pictures ostensibly of the outside and inside of Dorm 1, which he said was closest to the new clinic. [*See, e.g.*, 8/8/17 Tr. at 150:20-151:1; 152:19-154:1] He admitted that pictures taken inside Dorm 1 showed that the clearance space between beds for people in wheelchairs was not comparable to that in the ADA-designated Dorms 7 and 8. [*Id*. at 188:11-189:15; 190:1-5; 8/8/17 Hg. Defs' Ex. 5, pages 5, 12-13] He stated that people with disabilities may not have wanted to move out of Dorm 7 because it is air conditioned. [*Id*. at 189:17-18] Mr. Van Winkle testified he is not familiar with ADA construction guidelines and dimensions needed to accommodate people with disabilities, but that the maintenance supervisor reviews construction plans. [*Id*. at 173:4-19] As a result, Mr. Van Winkle had no actual knowledge that the current "ADA units" or the new unit met the ADA construction requirements; he was not aware of any documentation showing compliance; and his basis for saying units are "ADA compliant" was because bars were installed. [*Id*. at 173:16-23;174:15-17; 182:5-183:10]

However, one month later Deputy Warden Van Winkle returned to the courthouse on September 11, 2017, to inform the Court and others that a cornerstone of his prior testimony had been in error – that on August 8, he had misidentified in the photographs, and misstated in his testimony, that Dorm 1 was the closest building to the clinic (8/8/17 Tr. at 150:20-151:1), when in reality Dorm 1 has two other dormitories in between it and the clinic. [9/11/17 Tr. at 235:20-237:10; 237:22-238:23; 239:4-9] [8]

Mr. Van Winkle testified that he did not have any information about how open clinic hours of operation or similar signage information is provided to people with visual disabilities, or how people with auditory disabilities waiting outside are notified and made

[8] Unlike DWOP Van Winkle, Mr. Oyenik correctly identified Dorm 1 on the aerial photo, which while making a record, Counsel for Plaintiffs described as "the building shaped like an H that is farthest to the right and to the top of three units." [7/14/17 Tr. at 71:19-72:7; *see also* 7/14/17 Hg. Plfs' Ex. 2]

aware that it is their turn to be seen. [8/8/17 Tr. at 175:7-176:4]. Additionally, he had no knowledge about the number of people on East Unit or South Unit who have disabilities and use mobility assistance devices other than wheelchairs, but knew that there were such individuals on the units. [*Id.* at 176:24-177:11]. He also admitted that neither he nor any of his subordinates had ever actually talked to people with disabilities to see if they were having problems getting to the new medical clinic, and that the basis for his statement that there were no problems was that – as far as he knew – no ICSs had been called for a person falling on the sidewalk on the way to the clinic. [*Id*. at 183:11-184:2]

Even setting aside the physical plant barriers at ADC facilities, the removal of HNR boxes from the yards as an option for seeking medical care disproportionately burdens people with disabilities. With the removal of the HNR boxes, a person with disabilities can no longer have someone else place the HNR in the box on his or her behalf, and then be called the next day for an appointment at a specific time. And given the limited – and on some yards nonexistent – indoor waiting area for clinics, those people with sun or heat sensitivity due to psychotropic and other medications face exposure to the sun and significant heat when waiting in the nurse's line. [7/14/17 Tr. at 75:8-11; 75:20-22] The first-come, first-served system does not allow people who use wheelchairs to move to the front of the line to be seen regardless of whether they have a disability-related need to do so: they must wait along with everyone else. [*Id*. at 74:14-17 (Florence East); *id*. at 185:9-12 (Perryville San Pedro); 9/13/17 Tr. at 162:10-17 (Eyman Meadows)]

CONCLUSION

Defendants have failed to carry their burden. For the reasons set forth above, Plaintiffs seek an Order directing Defendants to re-install the HNR boxes so that class members can request medical care either by going to the open clinic and waiting to see the nurse, or by submitting a HNR and being called to the nurse's line the next day. Such a dual system of accessing medical care would ensure patients have multiple avenues by which they can request care, and address recordkeeping and CGAR reliability concerns inherent in only logging the HNRs of people who are actually seen by a nurse. Patients

seeking mental health or dental care should be able to submit HNRs in the boxes so the requests are referred directly to those disciplines for scheduling in accordance with PMs 98, 102, and 103, and they are not charged $4 to see a nurse with no mental health or dental training before being referred to the appropriate discipline.

A proposed order is attached hereto.

Dated: October 4, 2017

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CERTIFICATE OF SERVICE

I hereby certify that on October 4, 2017, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law, Plaintiffs, v. Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities, Defendants.	No. CV 12-00601-PHX-DKD **ORDER**

The Court, having reviewed Plaintiffs' Statement Regarding Defendants' Removal of Health Needs Request (HNR) Boxes, the evidence submitted therein, and the testimony of ten witnesses who testified on July 14, 2017, August 8-9, 2017, and September 11 and 13, 2017, and finding good cause, hereby **FINDS** that Defendants' removal of HNR boxes from minimum, medium, and close custody prison units has created an unnecessary barrier for class members to access health care. The Court also **FINDS** that Defendants' removal of the HNR boxes calls into question the reliability of the monthly monitoring reports for multiple performance measures.

Accordingly, the Court hereby **ORDERS** the following:

1. Within two weeks of this order, Defendants must reinstall HNR boxes on all

minimum, medium, and close custody yards, and permit class members who are requesting health care of any kind, including medical or nursing care, to use the box to submit their requests if they so choose.

2. Within two weeks of this order, Defendants and its contractor Corizon will not require class members who submit HNRs seeking non-medical care (*i.e.*, dental or mental health care; information regarding the status of diagnostic procedures, lab results, or specialty procedures), to report to nurse's line to be seen by a medical nurses and charged $4. Rather, these HNRs should be directed to the appropriate discipline for scheduling and response.

3. Within four weeks of this order, Defendants shall submit written declarations and any other evidence they deem necessary to the Court, to confirm that the HNR boxes have been reinstalled on all yards to which this order is applicable.

4. Within four weeks of this order, Defendants and/or their contractor Corizon shall submit written declarations and any other evidence they deem necessary to the Court, to confirm that the policy changes ordered in Paragraphs 1 and 2 have been implemented, and that class members and staff have been educated about the policy changes.

IT IS SO ORDERED.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

Because of pervasive and intractable failures to comply with the Stipulation, the Court is considering the exercise of its civil contempt authority.

Court's Contempt Authority. The Stipulation, negotiated by the parties, defines the Court's enforcement authority as follows:

> In the event the Court subsequently determines that the Defendants' plan did not remedy the deficiencies, the Court shall retain the power to enforce this Stipulation through all remedies provided by law, except that the Court shall not have the authority to order Defendants to construct a new prison or to hire a specific number or type of staff unless Defendants propose to do so as part of a plan to remedy a failure to comply with any provision of this Stipulation. In determining the subsequent remedies the Court shall consider whether to require Defendants to submit a revised plan.

(Doc. 1185-1 at ¶ 36) Contempt is a statutory remedy afforded to federal courts under 18 U.S.C. § 401. Accordingly, contempt is one of the "remedies provided by law" to the Court under the Stipulation.

Coercive, Civil Contempt. Any exercise of the Court's contempt authority in this matter would be intended to spur Defendants' compliance with the performance measures

that they have contractually agreed to perform. *Shell Offshore Inc. v. Greenpeace, Inc.*, 815 F.3d 623, 629 (9th Cir. 2016) (describing coercive civil contempt). When Defendants provide the health care required by the Stipulation, the contempt will purge. *Int'l Union, UMWA v. Bagwell*, 512 U.S. 821, 829 (1994). The power of economic carrots and sticks is clearly understood by Defendants. (Doc. 2295; Doc. 2330 at 195-197) Accordingly, the Court expects this to be an effective and short-lived tool that creates compliance with the Stipulation.

Scope of Contempt. The Stipulation established increasing benchmarks, now at 85%. These benchmarks are a triggering device to inform the parties and the Court whether remedial measures must be imposed. The Court reiterates that the Stipulation requires Defendants to provide all class members with the health care described therein. (Doc. 2179 at 2) Accordingly, any contempt sanction ultimately imposed by the Court will be for every single violation of the Stipulation, not just those below 85%.

Order of Compliance. Defendants submitted two remediation plans and the Court adopted both of them. (Docs. 1619, 2030) For a subset of performance measures, these remediation plans have failed. The Court has provided Defendants wide latitude to revise their remediation plans over the last two years. As a result, the Court has determined that requiring Defendants to submit a revised plan is not necessary. (Doc. 1185-1 at ¶ 36)

Since at least June 2017, Defendants have been on notice that the Court was considering some form of monetary sanction to achieve compliance with the Stipulation. (Docs. 2124, 2236) The Court is now putting Defendants on notice that certain performance measures/locations are subject to possible civil contempt because (1) they were subject to an existing remedial plan and either (a) have not had three or more consecutive months of compliance in the last 12 months or (b) had three consecutive months of compliance nearly one year ago and consistent non-compliance since then.[1]

[1] This second category applies to PM 51 at Florence and Tucson and PM 66 at Florence, Lewis, and Tucson.

IT IS THEREFORE ORDERED that, effective immediately, Defendants shall comply with the following performance measures at the following prisons for every class member:

- Performance Measure 11 ("Newly prescribed provider-ordered formulary medications will be provided to the inmate within 2 business days after prescribed, or on the same day, if prescribed STAT.") at Eyman and Lewis;
- Performance Measure 35 ("All inmate medications (KOP and DOT) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption.") at Eyman, Florence, Lewis, and Tucson;
- Performance Measure 39 ("Routine provider referrals will be addressed by a Medical Provider and referrals requiring a scheduled provider appointments will be seen within fourteen calendar days of the referral.") at Lewis;
- Performance Measure 44 ("Inmates returning from an inpatient hospital stay or ER transport with discharge recommendations from the hospital shall have the hospital's treatment recommendations reviewed and acted upon by a medical provider within 24 hours.") at Eyman;
- Performance Measure 46 ("A Medical Provider will review the diagnostic report, including pathology reports, and act upon reports with abnormal values within five calendar days of receiving the report at the prison.") at Eyman, Florence, Perryville, and Tucson;
- Performance Measure 47 ("A Medical Provider will communicate the results of the diagnostic study to the inmate upon request and within seven calendar days of the date of the request.") at Eyman, Florence, Lewis, Phoenix, Perryville, and Tucson;
- Performance Measure 50 ("Urgent specialty consultations and urgent specialty diagnostic services will be scheduled and completed within 30 calendar days of the consultation being requested by the provider.") at Florence;
- Performance Measure 51 ("Routine specialty consultations will be scheduled and completed within 60 calendar days of the consultation being requested by the provider.") at Eyman, Florence, and Tucson;
- Performance Measure 52 ("Specialty consultation reports will be reviewed and acted on by a Provider within seven calendar days of receiving the report.") at Florence

- Performance Measure 54 ("Chronic disease inmates will be seen by the provider as specified in the inmate's treatment plan, no less than every 180 days unless the provider documents a reason why a longer time frame can be in place.") at Eyman; and

- Performance Measure 66 ("In an IPC, a Medical Provider encounters will occur at a minimum every 72 hours.") at Florence, Lewis, and Tucson.

IT IS FURTHER ORDERED that, by Friday, January 5, 2018, Defendants shall file a list of every instance of non-compliance with this Order during December 2017. Defendants shall file a redacted list on the public docket and an unredacted list under seal.

IT IS FURTHER ORDERED that, on Tuesday, January 9, 2018, Defendants shall show cause as to why the Court should not impose a civil contempt sanction of $1,000 per incident of non-compliance commencing the month of December 2017. If the Court finds clear and convincing evidence that Defendants have failed to take all reasonable steps to comply with this Order, the Court shall impose civil contempt sanctions on Defendants.

Dated this 10th day of October, 2017.

David K. Duncan
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
CIVIL MINUTES - GENERAL

Phoenix Division

CV-12-0601-PHX-DKD DATE: October 11, 2017

Title: Parsons et al vs. Ryan et al
Plaintiffs Defendants

==========

HON: David K. Duncan Judge # 70BL/DKD

Kenneth Miller/Caryn Smith Laurie Adams
Deputy Clerk Court Reporter

APPEARANCES:
Corene Kendrick, David Fathi and Maya Abela, with Amy Fettig and Kirstin Eidenbach appearing telephonically, for Plaintiffs

Daniel Struck, Timothy Bojanowski, Richard Valenti and Rachel Love, with Lucy Rand appearing telephonically, for Defendants

==========

PROCEEDINGS: X Open Court ____ Chambers ____ Other

9:04 AM – This is the time set for Status Hearing. The Court discusses with the parties how best to enforce compliance with the stipulation. Argument is heard regarding Defendants' Notice re: Lack of Jurisdiction to Rule on Plaintiffs' Motion to Vacate Court Orders (Doc. 2375). Plaintiffs request until October 13, 2017 to provide a brief. SO ORDERED.

Discussion is held regarding upcoming hearing dates. IT IS ORDERED resetting the December 13, 2017 Status Hearing to December 20, 2017 at 9:00 AM. Further discussion is held regarding hearing dates for 2018.

Discussion is held regarding the University of Arizona telemedicine program. Defendants are working on a detailed declaration for the Court which will be filed prior to the next hearing date.

Discussion is held regarding Plaintiffs' October 4, 2017 letter. IT IS ORDERED Defendants shall respond to the letter by no later than October 20, 2017 and then the parties shall meet and confer and report back to the Court by October 24, 2017. If a telephonic conference is required, the parties are to contact the Court to schedule the same.

Further discussion is held regarding the telemedicine issue. Plaintiffs request a deadline be set for production of the detailed declaration Defendants will be filing. IT IS ORDERED the declaration shall be produced by no later than October 25, 2017.

BJ Millar appears telephonically and presents his view of the requests of each party and the staffing vacancies at each of the ten facilities. His suggestion is to work on providers first and see if the nursing situation corrects itself. The Court can expect to see results in five to six months at which time a report will be submitted. Argument is heard. The Court will enter an order for Mr. Millar which addresses the staffing issues. IT IS ORDERED Mr. Millar shall submit a written scope of the work by no later than October 20, 2017.

10:12 AM – Court stands at recess.

10:26 AM – Court reconvenes with respective counsel present. Court Reporter, Laurie Adams, is present.

Performance Measure 6 at Eyman is reviewed. Upon agreement of the parties the Court finds the measure is substantially noncompliant and adopts the proposed remediation measures.

Performance Measure 12 at Eyman and Florence is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures.

Performance Measure 15 at Eyman, Florence and Lewis is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures. Argument is heard. The Court will issue an order regarding the Tucson facility.

Performance Measure 20 at Eyman, Florence, Lewis, Perryville, Phoenix and Tucson is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures.

Performance Measure 24 at Lewis is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures.

Performance Measure 42 at Eyman, Florence and Perryville is reviewed. The Court finds the measure is substantially noncompliant at Eyman and Florence and adopts the proposed remediation measures. For Perryville, the steps taken are adopted as the remediation plan. Argument is heard regarding this performance measure at Lewis. Upon agreement of the parties the Court finds the measure is substantially noncompliant at Lewis and adopts the proposed remediation measures. Further argument is heard. IT IS ORDERED Defendants shall provide the copies of the training information and the new policy to Plaintiffs by no later than November 8, 2017 and inform the Plaintiffs of the start date of implementation of the policy at all facilities.

Performance Measure 49 at Douglas, Eyman, Florence, Perryville, Phoenix and Tucson is reviewed. The Court finds the measure is substantially noncompliant at Eyman, Florence,

Phoenix and Tucson and adopts the proposed remediation measures. Argument is heard regarding Douglas and Perryville. The Court finds Douglas and Perryville in substantial noncompliance but holds the remediation plan in abeyance.

Performance Measure 50 at Perryville is reviewed. The Court finds the measure is substantially noncompliant.

Performance Measure 51 at Douglas, Perryville and Yuma is reviewed. The Court finds the measure is substantially noncompliant and requires a remediation plan for all three facilities be provided by no later than October 25, 2017.

Performance Measure 52 at Eyman is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures. The Court is informed a supplemental plan is being implemented on November 1, 2017. As with Performance Measure 42, the training information and new policy is to be provided to Plaintiffs.

Performance Measure 55 at Eyman is reviewed. The Court finds the measure is substantially noncompliant. IT IS ORDERED Defendants shall provide a remediation plan by no later than October 25, 2017.

Performance Measure 67 at Lewis is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures which are to begin on November 15, 2017.

Performance Measure 72 at Eyman is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures. As with the previous performance measures the plan is to be provided to Plaintiffs by no later than November 8, 2017.

Performance Measure 91 at Phoenix is reviewed. The Court is informed the cause of noncompliance is under review and a remediation plan will be forthcoming by October 25, 2017. Defendants agree the measure is substantially noncompliant.

Performance Measure 94 at Phoenix is reviewed. The Court finds the measure is substantially noncompliant and adopts the proposed remediation measures. Argument is heard regarding the Yuma facility for this performance measure. The Court finds there is no substantial noncompliance at Yuma.

Performance Measure 97 at Phoenix is reviewed. The terms of the stipulation call for a finding of noncompliance; however, the Court will hold the remediation plan in abeyance.

Performance Measure 98 at Douglas is reviewed. The Court finds the measure is substantially noncompliant but will hold the remediation plan in abeyance.

Argument is heard regarding the Motion to Enforce the Stipulation (Maximum Custody Performance Measures 1-3, 5-6 and 8) (Doc. 1944). IT IS ORDERED Defendants shall file their response to the proposed order to which Plaintiffs shall have an opportunity to reply.

The Court is informed the parties have agreed to modify the Stipulation related to Performance Measure 9. IT IS ORDERED accepting the modification to the Stipulation.

Discussion is held regarding Defendants' Notice Relating to Performance Measures for October 11, 2017 Status Hearing (Doc. 2374). Argument is heard regarding Performance Measure 11. IT IS ORDERED at the next status hearing there be someone available to discuss what steps were taken to determine if implementation of the remediation plan was working and explain if no steps were taken.

The benchmark for Performance Measures 13 and 14 have been satisfied.

Performance Measure 15 is reviewed.

11:57 AM – Court stands in recess.

1:17 PM – Court reconvenes with respective counsel present. Court Reporter, Laurie Adams, is present.

Performance Measures 20, 24, 27, 29, 35, 37, 39, 40, 42, 44 and 45 are reviewed.

Performance Measure 46 is reviewed. Argument is heard. The Court will highlight its questions as black box warnings regarding real time information gathering that has been producing continual real time failures to see what type of corrective action is taken.

Performance Measure 47 is reviewed. Argument is heard. In light of the number of facilities not meeting this Performance Measure, the Court inquires as to why the results are not routinely printed out and mailed to the inmates.

Performance Measure 49 is reviewed.

Performance Measures 50 and 51 are reviewed. IT IS ORDERED someone shall be present at the next status hearing to discuss the matter of specialty providers.

Performance Measures 54, 55, 66, 67, 72, 73, 80, 86 and 92 are reviewed.

Performance Measure 93 is reviewed. Defendants place the corrective action on the record.

Performance Measure 94 is reviewed. Defendants will make the identified correction in the next update.

Performance Measure 98 is reviewed. Defendants place the numbers for Yuma on the record. Dr. Taylor addresses the Court. IT IS ORDERED when staffing reports are received by Defendants they are to be produced to Plaintiffs. Further discussion is held. IT IS ORDERED by

no later than October 20, 2017 Defendants are to advise Plaintiffs where they are in the document transition.

The Court is informed that Agenda Item 10A is still in negotiation.

Discussion is held regarding Corizon items B and C. The Court is informed the staff offsets as of August, 2017 is $3,344, 229.09.

Discussion is held regarding the dental subcontractor. Defendants state all providers are grouped together and dentists are included in the offset.

3:00 PM – Hearing concludes.

Time in court: 4 hr 22 min (9:04 AM – 3:00 PM)

Nos. 17-17501 & 17-17502

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

B.K. by her next friend, MARGARET TINSLEY, *et al.*,
Plaintiffs/Appellees,
v.
GREGORY McKAY, *et al.*,
Defendants/Appellants.

On Appeal from the United States District Court
for the District of Arizona
No. 2:15-CV-00185-PHX-ROS
Hon. Roslyn O. Silver

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF ARIZONA, AND PRISON LAW OFFICE IN SUPPORT OF PLAINTIFFS/APPELLEES' OPPOSITION TO APPEAL OF CLASS CERTIFICATION ORDER APPENDIX, VOL. III

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TABLE OF CONTENTS

VOLUME I

(Please see following pages for index to additional volumes.)

VOLUME II

VOLUME III

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al., Plaintiffs, v. Charles L. Ryan, et al., Defendants.	No. CV-12-0601-PHX-DKD **ORDER**

The Court has determined that, pursuant to Federal Rule of Evidence 706, it would benefit from the appointment of an expert to assess and recommend solutions that will inform the Court's goal of meeting the Defendants' established staffing levels. The parties submitted proposed experts and the Court has selected BJ Millar at Advisory Board Consulting ("Advisory Board"). The parties and the Court have discussed the scope of Advisory Board's work with Mr. Millar and Advisory Board has submitted an Engagement Letter, attached hereto, that details the scope of the engagement. Accordingly,

IT IS ORDERED the Advisory Board undertake the analysis in the attached Engagement Letter to provide information to the Court that would allow the Court to make the most informed decisions it could make with respect to the enforcement of the Stipulation. All of the investigation, research, and inquiries made on behalf of the Court as identified in the Advisory Board's Engagement Letter are pursuant to this Order of the

Court to do so. Advisory Board is engaging in this work as an agent of the Court and so it is the Court's view that Advisory Board is acting on behalf of the Court.

IT IS FURTHER ORDERED that if, at any time, Advisory Board believes that it is encountering an area of concern with respect to whether or not it is acting at the order of the Court, and there is action that it believes that is necessary for the achievement of the purposes of the engagement, then Advisory Board may bring that information to the Court and the Court will specifically identify that area of concern and make an appropriate order which may include the direction that that activity go forward as a specific direction of the Court.

IT IS FURTHER ORDERED that Defendants shall pay Advisory Board according to the terms of the attached Engagement Letter. The first payment shall be due within 10 days of the date of this Order.

IT IS FURTHER ORDERED that the confidentiality provisions governing this case shall extend to the Court's appointment of Advisory Board as its expert.

Dated this 4th day of December, 2017.

David K. Duncan
United States Magistrate Judge

Scope of Engagement

Provider Staffing & Retention Assessment

This scope of work describes Advisory Board Consulting's ("Advisory Board's") approach to providing United States District Court, District of Arizona ("the Court") with an assessment of and recommendation for provider staffing and retention within the Arizona Department of Corrections ("ADC"), as stipulated by Case 12CV601: Victor Parsons, et al. v. Charles Ryan, et al. The scope of work is based on the information provided during recent conversations with the Court and with the respective counsels for both the plaintiffs and defendants of this case. (Note: the scope of this work will not include recommendations for health care delivery or clinical practices between caregivers and patients)

Advisory Board understands there is an ongoing case in which the prisoners in the custody of the ADC and the Arizona Center for Disability Law ("ACDL") are pursuing action against the ADC Director and Interim Director of the Division of Health Services, both in their official capacities. This class action case seeks to provide better, more consistent and timely care to the prisoners of the ADC, as well as set monthly reports on staffing and performance against a set of identified benchmarks in order to monitor that level of care.

In response to this, Advisory Board has been appointed by the Court to provide an assessment and recommendation for health care provider staffing and retention at the ADC facilities in order to identify challenges and recommend solutions for meeting the budgeted staffing levels established to meet the above-stated goals. As Advisory Board is a Court appointed agent, the Court acknowledges and agrees that since the Court is judicially immune, as an agent of the Court, Advisory Board shall have the same level of protection for claims which arise out of the performance of the services set forth herein.

The below scope of services includes the following 10 facilities, which are spread across eight markets in the state of Arizona:

- Douglas;
- Eyman;
- Florence;
- Lewis;
- Perryville;
- Phoenix;
- Safford;
- Tucson;
- Winslow;
- Yuma.

Please note that the engagement below will include the following classes of clinical resources and/or staff, representing all physician and non-physician providers (collectively referred to hereafter as "providers"):

- Physicians;
- Advanced Practice Registered Nurses ("APRNs");
- Nurse Practitioners ("NPs");
- Physician Assistants ("PAs");
- Psychiatrists;
- Psychologists;
- Psychiatry and Psychology Associates;
- Mental Health Nurse Practitioners.

Note: During the provider staffing assessment, Advisory Board will also gather input regarding operational issues or challenges within nursing and other care delivery staff, with the intent that if issues are identified that Advisory Board can inform the Court of the value or need to extend the assessment as described herein to these classes of caregivers. (Should the assessment need to be extended following this process, Advisory Board will prepare and submit a supplemental Addendum outlining the mutually agreed upon scope of services and additional fees for signature.)

Market Profiles and Compensation Benchmarks

A market provider profile will be conducted to provide a report of all active practicing providers in the eight-market service areas. The market profile's specific objective is to identify provider supply and distribution by provider type for the eight specified markets, as well as benchmark compensation for each provider type. To accomplish this objectives, Advisory Board will develop a market provider database of the eight-market service area through completion of the following tasks:

- Conduct market analyses to understand the current market environment and provider numbers by type in each of the eight markets;
- Facilitate market interviews via teleconference to understand and culminate recruitment capabilities, obstacles, opportunities and threats within each of the markets;
- Conduct benchmarking of compensation against an agreed upon dataset for each provider type in each of the eight markets, including the following metrics:
  - Productivity (visits and panel sizes);
  - Compensation;
  - Benefits;
  - Other metrics as mutually agreed upon;
- Coalesce findings to identify potential surpluses and/or shortages within each market by provider type.

Facilities Profile and Baselines

Advisory Board will conduct a focused assessment to gather information on the current state working environment of the facilities, the compensation packages for relevant providers, and the conditions driving opportunities or obstacles for recruitment and retention of providers. This work stream will be completed through the following tasks:

- Conduct interviews via teleconference with past and current ADC health care providers on topics such as job descriptions and expectations, culture, working environment, compensation and benefits, infrastructure, organization and management;
- Prepare and submit a data request for current compensation packages and relevant arrangements for the four provider types, as well as employment/contractor agreements, job descriptions, turnover rates and other pertinent data;
- Analyze and assess all compensation packages and employment/contractor agreements as compared to market benchmarks described above;
- Review data related to recruitment, retention and turnover rates to gain a thorough understanding of standard employment timing and factors;
- Analyze job descriptions for each of the provider types across the eight markets to assess expectations, opportunities, obstacles to success and other position requirements.

Interim Project Updates

Throughout this engagement, Advisory Board will schedule and conduct project status reviews and interim update meetings on at least a monthly basis. It is anticipated that these will be virtual meetings, defined as teleconferences or virtual meetings; however if the need for face-to-face interaction is required, this will be accommodated on an as-needed basis. Updates are anticipated to include the following:

- Current project status;
- Discussion and resolution of obstacles or hurdles;
- Vetting and validation of data and analysis;
- Review of initial findings;
- Review of draft materials.

Final Deliverable

Our results will be synthesized into the final report identifying the market profile as compared to the profile of the facilities across the eight identified markets. This report will include the following:

- Data amalgamating the market analyses to demonstrate the overall market profile as broken down by provider type across each of the eight identified markets;
- Comparison of market profile as mapped to facility need to identify surplus and/or shortages, where found applicable through the assessment;
- Benchmarked compensation arrangements for each provider type as compared to those arrangements for ADC facilities;
- A blinded inventory of findings related to overall job satisfaction within the facilities across provider types;
- Opportunities or obstacles toward achieving desired recruitment and retention rates within the facilities based on the market profile and as compared to job satisfaction and compensation arrangements within the facilities;
- Specific recommendations by facility for achieving budgeted staffing levels;
- Insights and recommendations to identify and discuss other opportunities or challenges that have come to light through the provider assessment process.

Management Team

A small team of Advisory Board subject-matter experts will support this engagement under the leadership of BJ Millar, MBA, Vice President, who will be responsible for the quality and timeliness of Advisory Board's deliverables. Mr. Millar will be supported by a consultant. Representative biographies for these consultant roles are included as an attachment. Should the need arise to substitute a resource, Advisory Board will provide a consultant of equal or greater experience and will provide the Court with biographical information.

Professional Fees, Expenses & Other Terms

Professional Fees

Advisory Board's professional fees for this engagement will be a fixed fee of $124,100.

The professional fee quoted for this engagement encompasses only the scope of services described herein. Any additional services requested, including additional travel to or site visits, an expanded number of stakeholder interviews, or analysis or advice regarding issues not identified herein will result in additional professional fees. Advisory Board will notify the Court in the event that scope has been expanded and that additional fees apply. The Court will approve additional services and fees in advance.

Expense Reimbursement

In addition to our professional fees, Advisory Board invoices clients an administrative and travel fee in the amount of 20 percent (20%) of all professional fees hereunder. This amount covers all expenses related to this engagement.

Invoicing

Advisory Board will invoice the Court six monthly retainers each in the amount of $24,820[1]. The retainers will be invoiced upon the execution of this Engagement Letter and prior to the first day of the month for the following five months. Payment of invoices is due within 30 days of invoice receipt. The services and associated professional fees described herein are valid for 30 days from the date of this Engagement Letter.

All invoices will be delivered via email. Please provide a specific contact and email address for all invoices:

Estimated Project Timeline

Advisory Board can begin work within 10 business days of the execution of this Engagement Letter and receipt of the first retainer. We expect to complete the project within approximately six months, dependent upon the timely provision of information and scheduling of key meetings.

Confidentiality

As an agent of the Court, the Advisory Board's standard terms and conditions have been waived, however the Court hereby agrees as follows:

Ownership/Confidentiality.

The Court acknowledges that the Advisory Board will retain all copyright, patent and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by the Advisory Board before the commencement of, or developed or acquired by the Advisory Board during or after, the performance of the services set forth herein (the "Services"), including without limitation, all systems, software, specifications, documentation and other materials created, owned or licensed and used by the Advisory Board, or its affiliates or subcontractors in the course of providing the Services (the "Intellectual Property"), and the Advisory Board shall not be restricted in any way with respect thereto. To the extent any of the Services incorporates any Intellectual Property, the Advisory Board hereby grants the Court a non-exclusive, non-transferable right to use such Intellectual Property solely for purposes of using the services internally in accordance with the terms of the Order. The Intellectual Property is confidential to Advisory Board and its suppliers, if any. Thus, neither the Court nor the ADC shall disseminate to, or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, the Intellectual Property by any of its personnel to any third party. The Court shall not remove from the Intellectual Property any confidential markings, copyright notices and other similar indicia therein.

Advisory Board may use the Court's name on a list of clients and members in its programs.

1) Advisory Board will not commence work on the engagement until the initial retainer in the amount of $24,820 is received.

Acceptance

Client hereby agrees to the Advisory Board Terms and Conditions attached hereto and incorporated herein by this reference. In addition, if we do not have a Business Associate Agreement in place that would cover this engagement, Client will also enter into a Business Associate Agreement with us that will contain additional terms to set forth obligations of the parties with respect to protected health information.

If the above terms are acceptable, please indicate your acceptance by returning one signed original Engagement Letter via email or mail to:

ADVISORY BOARD CONSULTING

Attn: Development Team

3102 West End Avenue, Suite 800

Nashville, TN 37203

We look forward to the opportunity to work with you on this important initiative.

Sincerely yours,

Advisory Board Consulting

ADVISORY BOARD CONSULTING

ACCEPTED:

12-4-17

Signature Date

DAVID K. DUNCAN

U.S. MAGISTRATE JUDGE

Print Name Title

UNITED STATES DISTRICT COURT, DISTRICT OF ARIZONA

Attachments: Management Team Biographies

Management Team Biographies

Braxton Millar, MBA

Vice President
25+ Years of Experience
Salt Lake City, UT

Braxton "B.J." Millar, MBA, brings more than 25 years of health care experience to his role as an Advisory Board Vice President specializing in value-based care. Mr. Millar serves Advisory Board clients with Accountable Care Organization and Clinical Integration program formation, program evaluation, care transformation strategy, population health management, payer strategy development, provider alignment and readiness assessments. Mr. Millar's versatile skillset combines analytics, communications, process design and strategy to provide exceptional project management and delivery to Advisory Board's clients.

In his role with Advisory Board, Mr. Miller has led many CIN development engagements, served as an Interim CIN Director for a multisite regional system, and managed value-based care teams in assessing and deploying value-based strategies on local, regional and multistate initiatives. He provides executive oversight, subject-matter expertise and thought leadership across the entire value-based care spectrum, leading a large consulting team to deliver exceptional results for our clients.

Prior to joining Advisory Board, Mr. Millar served as Health Care Director of Navigant Consulting in Chicago. His responsibilities included managing project teams on physician enterprise assessment and implementation projects to effectively identify real value opportunities and produce sustainable results without creating artificial dependencies.

Before joining Navigant Consulting, Mr. Millar served Quorum Health Resources Consulting, located in Brentwood, Tennessee, as Director of Physician Services. In this role, Mr. Millar led the development and delivery of physician-focused consulting solutions to address the economic, operational and strategic needs of hospitals and their physician partners.

In addition to the above roles, Mr. Millar's consulting career has included work in hospital and health system projects, correctional health care, and data and information technology solutions. He has worked in several regional consulting firms, including Equation Consulting and Phase 2 Consulting in Salt Lake City, as well as managing his own firms at Vertex Healthcare Consulting in Salt Lake City and Logix Consulting in Dallas. He began his career in health care as a surgical practice administrator at Salt Lake Cardiovascular and Thoracic Surgery P.C.

Mr. Millar earned a Master of Business Administration, a Bachelor of Arts in philosophy and an associate degree in Spanish and Portuguese from Brigham Young University in Provo, Utah.

David Long, J.D., MBA

Consultant
9+ Years of Experience
Nashville, TN

David Long, J.D., MBA, brings more than nine years of professional and health care experience to his role as an Advisory Board Consultant. In this role, Mr. Long supports project leaders by gathering data, facilitating stakeholder discussions, performing due diligence, and preparing key documentation and presentations. Mr. Long serves Advisory Board clients with Clinical Integration program formation, medical home implementation, Accountable Care Organization formation, Center for Medicare and Medicaid Services application and grant writing, bundled payment design and implementation and program effectiveness, among others.

Prior to joining Advisory Board, Mr. Long served as a Summer Associate for Vanderbilt University Medical Center in Nashville, Tennessee. In this position, Mr. Long observed and mapped clinical processes and workflows and recommended strategies based on these observations for the creation of a standard clinical operations model in accordance to Meaningful Use standards. In addition, Mr. Long created and implemented strategic plans for HITECH Phase II and ICD-10 transitions. He was also responsible for financial returns for the potential implementation of voice recognition software for physician dictation services.

Previously, Mr. Long served the Risk and Patient Safety Clinical Services Group at Hospital Corporation of America Inc. in Nashville, Tennessee. During this time, he analyzed data from patient safety initiatives and conducted a correlation study comparing the safety data with hospital lawsuit claims data. Mr. Long was responsible for delivering the study results with strategic recommendations for future initiatives to a cross-department management team.

Previously, Mr. Long served as an Intern at the Mississippi Attorney General's Office in Jackson, Mississippi, in the Consumer Protection and Civil Litigation Division. During this time, he drafted memoranda, motions and other legal documents for federal and state-level cases. He researched and drafted memoranda on state and federal level constitutional law with regards to health care reform in Mississippi with a primary focus on Medicare and Medicaid financials in the state system.

Mr. Long began his professional career at Google Inc., in Mountain View, California, as a Legal Assistant for the Commercial Legal Team. In this role, Mr. Long drafted and negotiated standard agreements with Google's business executives, conducted due diligence for mergers and acquisitions, and created process improvements for team functions and performance.

Mr. Long earned a Juris Doctorate in business and health care law from the University of Mississippi School of Law in Oxford, Mississippi, a Master of Business Administration in health care, operations and strategy from Vanderbilt University Owen Graduate School of Management in Nashville, Tennessee, and a Bachelor of Arts in political science from Stanford University in Palo Alto, California.

Rene Sobolewski

Consultant
3+ Years of Experience
Nashville, TN

As an Advisory Board Consultant, Rene Sobolewski specializes in strategic planning, design and implementation of accountable care solutions. She has been deeply involved in the formation of Clinically Integrated Networks ("CINs"), providing hands-on support for organizational and legal structure development, marketing/communications and independent physician recruitment activities. Furthermore, Ms. Sobolewski supports project leaders in assessing population health strategies by gathering data, facilitating stakeholder discussions and performing due diligence, with a critical focus on infrastructure and operational effectiveness.

Prior to and in addition to her work with value-based care engagements, Ms. Sobolewski conducted deep dive assessment work in fair market value and medical staff planning engagements. Working directly with hospitals and health systems across the country, she developed significant expertise in physician needs assessments, medical staff development and understanding the competitive landscape for health care organizations seeking to redefine their strategic direction.

Ms. Sobolewski plays a pivotal role in conducting operational assessments for organizations seeking to create or improve value-based care and population health management programs. In her work developing and implementing CINs and Population Health Services Organizations ("PHSOs"), Ms. Sobolewski focuses on facilitating and collaborating with physician councils to form organizational structures and governance models, including meeting participation, template creation and finalization, physician training and education, network outreach and participation, and physician recruitment and retention.

Ms. Sobolewski has worked with academic medical centers, nonprofit health systems, and multi-system CINs across the country to design, operationalize and optimize physician alignment strategies. In addition, she has provided best practice support with a state-sponsored innovation model grant, serving on a team of experts that collaborated with the state, as well as government and commercial payers, to support reduced care variation and improved coordination across the state.

Prior to joining the Advisory Board, Ms. Sobolewski served as an Administrative Intern with the Upper Allegheny Health System with time spent at both Olean General Hospital in Olean, New York, and Bradford Regional Medical Center in Bradford, Pennsylvania. Ms. Sobolewski worked with senior management in key functional areas of each hospital including finance, quality and information technology.

Ms. Sobolewski received her Bachelor of Arts in medicine, health and society from Vanderbilt University in Nashville, Tennessee, where she also competed on the Division One Women's Golf Team.

Kathleen E. Brody (Bar No. 026331)
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Attorneys for Plaintiffs Shawn Jensen, Stephen Swartz, Sonia Rodriguez, Christina Verduzco, Jackie Thomas, Jeremy Smith, Robert Gamez, Maryanne Chisholm, Desiree Licci, Joseph Hefner, Joshua Polson, and Charlotte Wells, on behalf of themselves and all others similarly situated

[ADDITIONAL COUNSEL LISTED BELOW]

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Attorneys for Plaintiff Arizona Center for Disability Law

[ADDITIONAL COUNSEL LISTED BELOW]

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-DKD

DECLARATION OF DR. TODD R. WILCOX, M.D., M.B.A.

I, Todd Randall Wilcox, declare:

1. I have personal knowledge of the matters set forth herein. If called as a witness, I could and would testify competently to the facts stated herein, all of which are within my personal knowledge.

2. I have worked as a physician in jail and prison environments for more than 20 years. I am currently the Medical Director of the Salt Lake County Jail System. I am licensed to practice medicine in the States of Arizona and Utah, and am Board Certified in Urgent Care Medicine. I submitted my updated curriculum vitae on September 2, 2016. [Doc. 1670-1]

3. I was asked by Plaintiffs' counsel to review documents from the medical file of Walter Jordan, 078789, to offer my professional opinion regarding his medical care prior to his death on September 7, 2017 at the age of 67, while in the custody of the Arizona Department of Corrections (ADC). Prior to his death, Mr. Jordan was housed at ASPC-Florence, East Unit.

4. In addition to Mr. Jordan's medical record, which I reviewed electronically, I reviewed the Notice of Impending Death that Mr. Jordan sent to the Court and that was filed on the docket on August 29, 2017. [Doc. 2262] Mr. Jordan stated, "ADOC and Corizon delayed treating my cancer. Now because of there [sic] delay, I may be luckey [sic] to be alive for 30 days. The delayed treatment they gave me is causing memory loss, pain."

5. Sadly, Mr. Jordan's prediction was prescient, as he died on September 7, 2017 from invasive squamous cell cancer that had resulted in a very large (6 by 7 cm) open lesion on his head that invaded the underlying skull bone and caused the bone to die and ultimately become infected. Once the tumor breached the bone, it was inevitable that it would directly invade his brain. Mr. Jordan's case was unfortunate and horrific, and he suffered excruciating needless pain from cancer that was not appropriately managed in the months prior to his death.

6. The failures in treatment and care he experienced prior to his death are

illustrative of several systemic problems with the medical care provided by ADC and its contractor Corizon that I have observed in my reviews of hundreds of medical files of people in ADC's custody: (1) the limited pool of quality specialists willing to treat ADC prisoners; (2) a broken system of providing pain management, which may or may not be due to Corizon's limited formulary; and (3) a failure by nursing and provider staff to take basic preventive measures to reduce the likelihood of medical problems from developing into a catastrophic condition.

Deficiencies in Mr. Jordan's Specialty Care

7. The first systemic issue I identified in Mr. Jordan's care is a failure in specialty care and treatment. As I have noted in prior reports to the Court, ADC (and Corizon) are restricted by state law as to how much they can pay specialist contractors, and as a result this greatly limits the number of doctors that they can find in the community willing to accept ADC patients. [*See* Doc. 2103 at ¶¶ 51-53] I learned that Mr. Pratt recently testified about at least three separate incidents of Corizon not paying hospitals or specialists (for example, more than $1.2 million in a year's worth of unpaid bills in the case of the Gilbert/Florence Anthem Hospital). [8/8/17 Hearing Transcript at 93:19-103:5] Obviously, Corizon's failure to pay its bills does not do anything to increase the pool of quality community specialists willing to accept ADC patients. Therefore, it was sadly not surprising to discover that Mr. Jordan was sent for treatment at a dermatology clinic that did not practice its specialty within the standard of care.

8. Mr. Jordan had a history of skin cancer prior to 2017, and at the time of his death he had multiple skin cancers. Squamous cell carcinoma is generally easily managed when it is identified early and it has a greater than 90% cure rate. While the initial standard of care for uncomplicated skin cancers is to have the lesions or growths managed by a dermatologist, a serious case requires calling in oncologists and experienced surgeons who specialize in the area of anatomy that has to be treated. Mr. Jordan may well have survived had he been treated by a competent dermatologist and referred to an oncologist sooner when it was abundantly clear his cancer had progressed beyond the

scope of a dermatologist. Unfortunately, the dermatologist he saw was not competent, and by the time he saw an oncologist, his cancer had advanced and it was too late.

9. The records from the dermatology clinic did not document a comprehensive workup or treatment plan for him. The specialist's clinical notes are sparse and there is little detail. Also, one of the physicians who treated him at the dermatology clinic is not a Board-certified dermatologist.

10. When the dermatology clinic did decide to intervene, the notes indicate that they did office-based electrodesiccation—they electrically fried the tissue. While this is a treatment for squamous cell carcinoma, it is indicated for only small, superficial, well-defined lesions located in noncritical sites of the body. Mr. Jordan's largest cancer on his scalp was more than 2 inches by 2 inches, and did not qualify for electrodesiccation on any of these criteria. The scalp skin and the skull bone are absolutely precious anatomical structures that must be preserved at all costs. As such, the treatment he received from the dermatology clinic was not what he needed.

11. Given the number, size, and aggressiveness of Mr. Jordan's growths, the specialist should have called in an oncologist. Unfortunately, valuable time was wasted by the dermatology clinic attempting to perform procedures inadequate to address the skin cancer, repeatedly (and painfully) attempting to excise large growths from Mr. Jordan's body. The attempted electrodesiccation procedure when it was contraindicated made him much worse, and burning a hole in his skull bone could cause the surrounding bone to die and become at risk of infection.

12. After several trips to the dermatology clinic failed to address the cancerous growths on his head, on June 6, 2017, Mr. Jordan was seen by a Corizon provider who documented a 6 cm by 7 cm ulcerated lesion on his scalp (among others), and indicated that she was requesting an "urgent oncology consult for radiation of frontal SCC lesion" be approved by Corizon Utilization Management. On July 8, 2017, the prison provider submitted an urgent request to Utilization Management that radiation therapy be approved and started. She wrote (all capital letters are in the original):

> PT [Patient] NEEDS URGENT BRACHYTHERAPY FOR VERY LARGE OPEN INVASIVE SQUAMOUS CELL CARCINOMA OF THE R FRONTAL TEMPORAL SCALP. BIOPSY POSITIVE FOR INVASIVE, MODERATELY TO WELL DIFFERENTIATED SCC. PAIN IS SEVERE. WOUND IS ENLARGING RAPIDLY IN DEPTH.
>
> PT HAS SEEN NO IMPROVEMENT OR HEALING FROM THE EXCISION DONE BY DERMATOLOGY. EXCISION SITE IS DRAINING CLEAR FLUID, YELLOW AND BROWN ADHERENT SLOUGH; EXQUISITELY PAINFUL. WILL NEED TREATMENT AND F/U WITH RAD ONCOLOGY WEEKLY.
>
> THIS NEEDS EMERGENT TREATMENT. HE IS NOT SAFE AND IS AT VERY HIGH RISK FOR OSTEOMYELITIS OF THE SKULL OR MRSA CELLULITIS. THE WOUND IS HORRIFIC. PT IS EXPOSED TO THE ENVIRONMENT (DUST, DIRT, HEAT, FLIES), DIRTY HOUSING AND SHOWER FACILITIES (OLD EVAP COOLERS, DORM STYLE HOUSING AND BATHING).
>
> I CANNOT STRESS HOW IMPORTANT IT IS THAT WE TAKE SOME TYPE OF IMMEDIATE ACTION.

13. Mr. Jordan finally started radiation therapy on July 21, 2017. However, by the time Mr. Jordan began radiation, the squamous cell cancer had penetrated his skull, and reached the parenchyma of his brain. The most common way for squamous cell carcinoma to spread is via the lymph nodes. It almost never invades bone unless there is damage to the tissue and bone from incomplete attempts of managing the tumor. It is difficult to fathom how a squamous cell carcinoma could grow so large and deep that it breached the skull and reached the brain, if the treating provider and the specialist dermatologist is vigilant and practicing within the standard of care.

14. Mr. Jordan was ultimately hospitalized on August 28, 2017, a day before his Notice of Impending Death arrived at the courthouse. According to his hospital records, he suffered a seizure while being transported from the radiation oncologist's office to the prison, and he was taken to the Emergency Department. The combination of the invasive tumor touching his brain lobe, and the radiation of his head that was necessary to treat the cancer, resulted in seizure activity. Review of his hospital records demonstrates the

extensive bony destruction of his skull as a result of the invasive nature of the cancer and the inappropriate treatment he received from the dermatologist office.

15. Mr. Jordan died on September 7, 2017 after his daughter agreed to no heroic measures.

Inadequate Pain Management by Corizon

16. The second systemic problem I identified with Mr. Jordan's treatment was inadequate pain control. While the limited selection and quality of specialists is most likely a reflection of policy choices made by the State of Arizona, and Corizon's historic failure to pay its bills, and thus out of the control of the providers treating Mr. Jordan at the prison, the providers profoundly failed at appropriately managing the excruciating pain Mr. Jordan experienced as a result of the cancer and these painful electrodessiccation and curettage procedures, and the resultant very painful dressing changes.

17. The medical record clearly documents the patient's extreme pain throughout the last few months of his life. The medical record also documents Corizon provided him only Tylenol with Codeine dosed twice per day. Tylenol with Codeine is simply not an appropriate pain medication for cancer pain for multiple reasons. First of all, the Tylenol in the combination drug limits the amount of codeine you can give the patient because of associated Tylenol toxicity. In addition, it is well known that the metabolism and efficacy of codeine is highly variable in patients due to genetic issues that impact its metabolism. Many healthcare systems have removed codeine from their formulary for lack of efficacy. In addition, the appropriate dosing schedule of Tylenol with codeine is every 4 to 6 hours. The prison dosed it twice per day which, even if the medication were slightly effective, provided only intermittent pain relief for this patient. This pain management style with intermittent pain relief from a short-half-life medication is just wrong. It is actually the opposite of how cancer pain should be managed. Appropriate management of chronic severe cancer pain should be accomplished using long-half-life opiates of adequate strength to ameliorate the pain. All of the prescribers in the AZ DOC system should know this since it is one of the core teachings of basic pain management. Their choice to use

Tylenol with codeine is willful ignorance of the lack of efficacy for their patients in favor of adhering to an unreasonable formulary and institutional pressures.

18. Most patients with end stage cancer experience severe pain and it is one of the fundamental duties of physicians to address this pain at the end of life. There are many other medications that are low-cost generic medications that would be appropriate and presumably on formulary. Given the many options for adequate pain management, there is no excuse for therapeutic nihilism (undertreatment) of cancer pain that appears to be the norm in the Arizona prison health care system.

Failure to Take Appropriate Preventive Measures

19. The third systemic problem I identified in Mr. Jordan's care is that prison health care staff failed to take appropriate and basic preventive measures to reduce his likelihood of developing skin cancers in the first place. On April 1, 2016, the provider issued Mr. Jordan a special needs order ("SNO") valid for one year for sunscreen. However, on June 6, 2016, Mr. Jordan filed a HNR stating "I received some SPF-50 sunscreen lotion that the doctor had ordered for me on 4-1-16. I would like to know if I can get a refill on it? And if so, how soon?" The response by the registered nurse, dated the next day stated "SPF 50 Non-Formulary – (Denied). Store have SPF-30 available for purchase." This denial is medically inappropriate. The SNO for SPF-50 is a medically necessary treatment for Mr. Jordan as part of his cancer management. For a nurse to deny the sunscreen, is overruling and countermanding a provider's order for care, and exceeds the scope of that nurse's decisionmaking capability and licensure.

20. On April 27, 2016, Mr. Jordan also was issued SNO good for one year, issuing him a wide-brimmed straw hat. Based on my experience with ADC and other prison systems, a patient is issued a paper SNO when he or she is issued any sort of durable medical equipment (i.e. a cane, wheelchair), or for special dispensation (i.e. a lay-in, sunglasses, extra toilet paper, extra ice). Prisoners must have a copy of the valid SNO with them at all times, so custody staff can confirm they are authorized to have the item in their possession. This SNO expired on April 27, 2017 and I could find no indication in

his medical file that it was re-authorized. Assuming the straw hat was still in decent condition after a years' worth of use, and still provided sun protection, he technically was not authorized to possess it after April 27, 2017 without a valid SNO, and was subject to confiscation at any time as a result.

21. I was surprised that these April 2016 SNOs did not also authorize long-sleeved clothing, as this is of critical importance for reducing the likelihood of additional cancers. Mr. Jordan finally was issued a SNO for a long sleeved shirt on September 15, 2016, but in my review of his file I could find no record of a subsequent order for long-sleeved clothing in 2017.

Mr. Jordan's Care is Emblematic of Systemic Dysfunction in Medical Care Delivery

22. Mr. Jordan's experience in medical care was sadly predictable because ADC's specialty care, pain management, and preventive care systems continue to be dysfunctional.

23. The amount that specialists are paid to provide care to prisoners is capped by state law, and Defendant Pratt admits that on multiple occasions, Corizon failed to pay specialists and subcontractors. The completely foreseeable result of not paying specialists, or paying them very little, is that there is an ever-shrinking pool of specialists willing to see prisoners, and the quality of those willing specialists can be lower, as was the case here.

24. One of my recommendations to the Court in June of this year to address Defendants' chronic substantial noncompliance with performance measures related to specialty care was "to enlist the State's publicly-funded medical schools and their affiliated practice groups to provide their expertise and assistance, including delivery of specialty care, to persons who are wards of the State." [Doc. 2103 at ¶ 52] I am disappointed to learn Defendants reported that Corizon is struggling to engage the University of Arizona in a telemedicine program to provide specialty care. [9/12/17 Hearing Transcript at 187:3-192:14; Doc. 2398-1 at ¶ 5] I cannot fathom that the University of Arizona – which offers high-quality specialty medical care – would not be

interested in a telemedicine program if the money for the clinical visits and the technology in use were up to community standards.

25. With regard to pain management, in addition to Mr. Jordan's case, I reviewed the record of a young man with testicular cancer that had metastasized to many of his other internal organs, leaving him at Stage IV cancer. At the time of his orchiectomy, in early May he was prescribed only ibuprofen and Tylenol with Codeine for his pain. According to his medical records, he was not prescribed morphine until late July 2017.

26. I also reviewed the medical record of a patient paralyzed from the chest down housed in the Tucson infirmary, who is suffering from severe pain, in part as a result a poorly managed decubitus pressure sore. The infirmary provider appropriately made a nonformulary request for Gabapentin, but Corizon's Utilization Management rejected the request, stating that, "Corizon's preferred medication for neuropathic pain is venlafaxine XR 37.5 mg daily." Venlaxafine is also known by its brand name, Effexor, and is a psychotropic medication used to treat depression.

27. I have also been informed by Plaintiffs' counsel that over the course of 2017 they have been notified by numerous class members who state that certain pain medications, including Tramadol and the non-opioid Gabapentin, were abruptly cut off by Corizon with no step-down weaning, and on occasion, without the provider first meeting with and evaluating the patient. I cannot emphasize enough how irresponsible it is for a prescribing provider to abruptly discontinue pain medications without a tapering-down schedule. These class members report that they are having effective pain management medications replaced with less effective medication including psychotropic medications such as Effexor, or over-the-counter treatment such as ibuprofen or alpha lypoic acid.

28. There have been some studies that have found that Effexor has some benefit for treating pain, but it is far less effective than standard mainline therapy for neuropathic pain. Effexor also does not have an indication from the U.S. Food and Drug

Administration for the treatment of neuropathic pain, which means Corizon is using it off-label to treat pain. Additionally, some patients are unable to tolerate the side effects of the psychotropic medication. Attached as Exhibit 1 is a summary of a recent study of the use of Effexor for neuropathic pain, in which the authors concluded

> We found little compelling evidence to support the use of venlafaxine in neuropathic pain. While there was some third tier evidence of benefit, this arose from studies that had methodological limitations and considerable risk of bias. Placebo effects were notably strong in several studies. Given that effective drug treatments for neuropathic pain are in current use, there is no evidence to revise prescribing guidelines to promote the use of venlafaxine in neuropathic pain.

29. Finally, the failure to provide basic and simple preventive measures is a problem that I have described in past reports. I also have documented the tendency of nursing staff to act outside of their scope of practice, such as the nurse did here in overriding the provider's special needs order for SPF 50 sunblock to prevent skin cancer.

Executed December 15, 2017, in Salt Lake City, Utah.

Todd Randall Wilcox, M.D., M.B.A

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CERTIFICATE OF SERVICE

I hereby certify that on December 18, 2017, I electronically transmitted the above document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
CIVIL MINUTES - GENERAL

Phoenix Division

CV-12-0601-PHX-DKD DATE: April 11, 2018

Title: Parsons et al vs. Ryan et al
Plaintiffs Defendants

==========

HON: David K. Duncan Judge # 70BL/DKD

Caryn Smith Laurie Adams
Deputy Clerk Court Reporter

APPEARANCES:
David Fathi, Corene Kendrick, Kirstin Eidenbach and Maya Abela for Plaintiffs
Daniel Struck, Timothy Bojanowski, Rachel Love and Richard Valenti for Defendants

==========

PROCEEDINGS: X Open Court ____ Chambers ____ Other

This is the time set for Status Hearing. Discussion is held regarding scheduling of evidentiary hearings. IT IS ORDERED setting Evidentiary Hearing for May 31, 2018 at 9:00 AM and June 1, 2018 at 9:00 AM before this Court. Discussion is held regarding Angela Fischer. A subpoena will be issued once the date of her appearance is determined.

Discussion is held regarding the final reports of Mr. Millar and additional hearings that will be required. The Court proposes adding a day before and a day after the regularly scheduled status hearings in June, July, and August. Plaintiffs request a streamlining as to the expert testimony of Dr. Khan and request an order from the Court that the expert produces a report pursuant to Rule 26. The Court will not require that Defendants produce an expert report but will limit Dr. Khan to two hours of direct examination. If efficient use of time is made the Court will consider any extension that may be requested.

The Court addresses and refutes any suggestion that the Stipulation envisioned a four-year time frame to satisfy the Performance Measure requirements of the Stipulation.

Further discussion is held regarding the additional dates proposed from June through August, 2018.

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April 11, 2018

Further discussion is held regarding Ms. Fischer. The Court will subpoena the documents as well. Defendants request the documents already received by Plaintiffs. Plaintiffs agree and IT IS SO ORDERED.

The February CGAR report is reviewed.

Performance Measures 19, 44, 48, 50, 52, 67, 73, 95, 96 and 98 are reviewed as set forth on the record as they relate to Plaintiffs' Motion to Enforce the Stipulation (Doc. 2520). The Court will hold in abeyance a ruling on the motion.

Performance Measures 12, 15, 24, 40, 42, 44, 46 and 47 are reviewed as set forth on the record.

10:24 AM – Court stands in recess.

10:43 AM – Court reconvenes.

Further discussion is held regarding scheduling status hearings. Defendants request to move the hearings to the third week of the month instead of the second to which Plaintiffs have no objection. The Court will review its calendar and advise.

Discussion is held regarding Ms. Fischer. IT IS ORDERED Plaintiffs email her phone number to chambers.

The Court is informed Mr. Pratt has not sent the denominator reports yet but intends to by the close of business today.

Further discussion is held regarding the phone call with Ms. Fischer.

Performance Measures 52, 66, 67 and 49 are reviewed as set forth on the record. IT IS ORDERED the parties shall meet and confer after Plaintiffs send Defendants an email detailing their questions.

Performance Measure 50 is discussed. Plaintiffs will include this question in their email to Defendants.

Performance Measure 94 is reviewed.

Discussion is held regarding telemedicine.

Privilege log issues are discussed.

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Discussion is held regarding the Corizon contract negotiations, penalties and incentives. Plaintiffs request to seal the hearing to allow for discussion regarding negotiations. For the reasons set forth on the record, IT IS ORDERED denying the request to seal the hearing.

Discussion is held regarding flu shots. The Court will not make a determination as to Plaintiffs' discovery request until after the Plaintiffs' counsel have an opportunity to meet with their clients at their upcoming prison visits to see if there is problem with the provision of flu shots, Counsel will then report if there is a need for the Court to follow up on this issue. As to Agenda item 8A, Plaintiffs received the current version of the Monitoring Guide and will notify the Court if issues arise.

The monitoring methodology for Performance Measure 86 is discussed. Defendants have rejected the Court's suggestion. The Court will issue an Order.

Discussion is held regarding the re-audited CGAR items listed in Agenda item 8D. Plaintiffs request a response deadline. Argument is heard. IT IS ORDERED Defendants shall produce the items requested in 8C and 8D within 14 days. Further argument is heard. IT IS ORDERED Plaintiffs shall provide a copy of the transcript from the out-of-court April 9, 2018 discovery meeting to the Court.

11:57 AM – Court stands in recess.

1:33 PM – Court reconvenes.

BJ Millar and The Advisory Board present their report.

Discussion is held regarding the reporting process.

Argument is heard regarding auditors. IT IS ORDERED the parties shall meet and confer regarding a timetable.

Agenda item 8E is discussed. Defendants shall produce the items requested within 14 days.

Argument is heard regarding the staffing reports. IT IS ORDERED Defendants shall produce them by no later than the 15th of each month.

Argument is heard regarding Agenda item 9. Defendants state the information at issue has been produced but Plaintiffs' counsel report that they have not received this information. Defendants' counsel will resend.

Argument is heard regarding Defendants' Motion to Terminate Monitoring (Doc. 2251) and Plaintiffs' Response (Doc. 2344). IT IS ORDERED within seven days Plaintiffs shall provide

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April 11, 2018

Notice to Defendants and the Court as to whether or not they agree to the removal of the Performance Measures Defendants' counsel identified on the record.

Further discussion is held regarding the best way to contact Ms. Fischer. IT IS ORDERED the counsel shall provide her email address to the Court instead of her phone number.

3:01 PM – Court is adjourned.

Time in court: 4 hr 1 min (9:05 AM – 3:01 PM)

Exhibit 6

Advisory Board | Consulting

United States District Court, District of Arizona

Court Update: Market / Facility Comparative Analysis
May 9, 2018

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Agenda Topics and Meeting Objectives

	Agenda	Time
1	**Project Status Update** *Update on accelerated timeline*	*5 minutes*
2	**Staffing Budget Compliance, Turnover, Compensation Analysis by Site** *Review assumptions and data*	*45 minutes*
3	**Update on Interview Process** *Phone interview and Survey Monkey status update*	*5 minutes*
4	**Next Steps & Discussion** *Review of next steps and discussion*	*5 minutes*

Meeting Objectives

- ❑ Deliver findings from analyses by site
- ❑ Provide update on interviews
- ❑ Discuss any questions or concerns moving forward

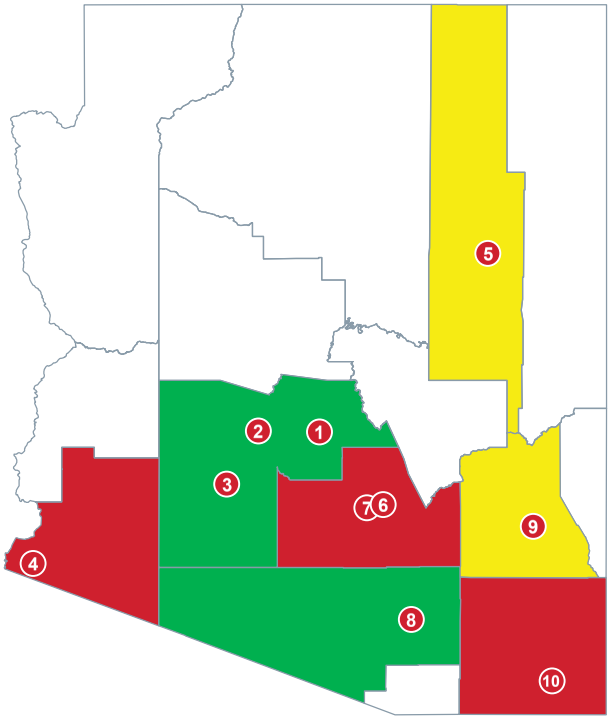
Framework for Evaluation

	Definition	Assumptions	Legend
Compliance	Percent of weeks of the year that the site reached budgeted levels	Discounted budgeted time by 10% to account for non-working time – PTO, Paid Sick Leave, Admin, etc.)	>75% weeks of the year 50-75% weeks of the year <50% weeks of the year
Turnover	Three year average of percent of providers who have terminated their contracts each year	Based on all employees from 2015 through 2017 Rates developed by role, by facility (primary facility determined based on swipe data)	<25% turnover 25-50% turnover >50% turnover
Compensation	Comparison of compensation to 2016 MGMA[1] benchmarks (Primary Care, Nurse Practitioner, Psychiatry, Psychology, NP Psychiatry)	Based on 2017 W2 data and Kronos hours Primary facility determined based on swipe data Psychology Associates excluded due to lack of MGMA benchmarks	>75th percentile 50th to 75th percentile <50th percentile

1) Medical Group Management Association

Physician Supply by County and Facility

Analysis completed in context of supply gap groupings



Market	#	Facility	Supply Gap
Maricopa	1	Phoenix	
	2	Perryville	
	3	Lewis	
Yuma	4	Yuma	
Navajo	5	Winslow	
Pinal	6	Eyman	
	7	Florence	
Pima	8	Tucson	
Graham	9	Safford	
Cochise	10	Douglas	

Legend		
< 25% Gap	25-75% Gap	> 75% Gap

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Supply Gap <25%
Lewis, Perryville, Phoenix, Tucson
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< 25% Supply Gap

Relatively high turnover, despite competitive compensation

	Medical Providers[1]			Behavioral Health Providers[2]		
	Compliance	Turnover	Compensation	Compliance	Turnover	Compensation
Lewis	47%	38%	~ 50th	45%	39%	> 75th
Perryville	62%	19%	50th – 75th	0%	44%	> 75th
Phoenix	64%	39%	50th – 75th	4%	48%	> 75th
Tucson	79%	52%	75th	2%	43%	> 75th

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

1) Medical Director, Physician, Non-Physician Practitioner (NPP; Nurse Practitioner, Physicians Assistant)
2) Psych Director, Psychiatrist, Psychologist, BH Nurse Practitioner, Psych Associate;
Psych Associates not included in compensation analysis due to unavailable MGMA benchmarks

● < 25% Supply Gap

Lewis Complex

	Medical Providers	Behavioral Health Providers
Compliance	**47%** *of the year medical staffing met budgeted levels (25 weeks)* • **Fully staffed NPPs** for all but one week of the year, yet **fell short on Physician staffing** • Did not have any Medical Director coverage for 33 weeks of the year	**45%** *of the year behavioral health staffing met budgeted levels (24 weeks)* • Consistent staffing of a 1.0 FTE Psychiatrist • Very **inconsistent staffing of Psychologists and MH Nurse Practitioners** – five different NPs across short portions of the year • Psych Associates met budget levels 70% of the year
Turnover	**38%** Medical provider turnover (3 year average) • **Significant increase in both hiring and turnover in 2017** • Significant increase in hiring of NPPs in 2017 despite limited terminations	**39%** BH provider turnover (3 year average) • **Turnover has steadily decreased** each year since 2015 • Steady retention of Psychologists across all three years including an additional hire in 2017 • Increase in Psych Associate staffing in 2016-2017 with very little turnover
Compensation	**~ 50th percentile overall** • **Physicians and Medical Director paid below the median** • NPPs paid just above the median	**> 75th percentile overall** • Psychologists paid at the median • **Psychiatrists and BH NPs paid well above the 75th percentile**

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Perryville Complex

	Medical Providers	Behavioral Health Providers
Compliance	**62%** of the year medical staffing met budgeted levels (33 weeks) • **Physicians never reached budgeted staffing levels** • Directors and NPPs were fully staffed 47 and 45 weeks respectively • Impact of Physician deficit softened with **additional Medical Director staffing beyond budgeted hours**	**0%** of the year behavioral health staffing met budgeted levels (0 weeks) • **Consistent understaffing of all provider types for majority of the year** • Consistent 1.0 FTE Psychiatrist became staffed in mid-June
Turnover	**19%** Medical provider turnover (3 year average) • **Good retention of medical providers**, especially Physicians over the past three years • Steady hiring of NPPs each year, with fewer terminations year after year	**44%** BH provider turnover (3 year average) • Behavioral health staff **turnover was significant in 2017** with 7 providers leaving across all provider types (2 of whom worked for less than one year)
Compensation	**50th - 75th percentiles overall** • Paying NPPs just above the MGMA 75th percentile • Physicians are paid **below the median** • Directors are paid **at or below the median**	**> 75th percentile overall** • Paying Psychiatrists and BH NPs above the 75th percentile • **Inconsistent Psychologist pay** across individual providers

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Phoenix Complex

	Medical Providers	Behavioral Health Providers
Compliance	**64%** *of the year medical staffing met budgeted levels (34 weeks)* • Challenged to meet Physician staffing at the beginning of 2017 with **no coverage from June to September 2017** • **Consistent NPP staffing** between 4-5 providers; approached budgeted NPP Staffing levels for ¾ of the year	**4%** *of the year behavioral health staffing met budgeted levels (2 weeks)* • Significant understaffing of Psychologists in first three quarters of the year • Consistent staffing of a 1.0 FTE Psychiatrist for most of the year yet never reached 1.5 FTE budget • **Met Psych Associate budget nearly 75% of the year**
Turnover	**39%** Medical provider turnover (3 year average) • Number of medical provider **hires decreased each year**, yet termination rates remained relatively consistent	**48%** BH provider turnover (3 year average) • **No Psychologists on staff until 2017** • Consistent Psych Associate hiring/turnover rates per year • Appears to **be difficult to maintain a BH NP** at this site • Only retained one of four Psychiatrists in time period
Compensation	**50th - 75th percentile overall** • Paying NPPs and Directors slightly above the MGMA 75th percentile • **Physicians paid slightly below median**	**> 75th percentile overall** • Psychologists paid at the 75th percentile • Psychiatrists paid well above the 75th • BH NPs paid above the 75th

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Tucson Complex

	Medical Providers	Behavioral Health Providers
Compliance	**79%** *of the year medical staffing met budgeted levels (42 weeks)* • Fully met or exceeded budget staffing levels for NPPs every week of the year • Physician staffing **rarely met even 1/3** of budgeted levels • Medical Directors reached staffing levels 77% of the year	**2%** *of the year behavioral health staffing met budgeted levels (1 week)* • BH NPs met staffing levels 48 weeks of the year and often overstaffed which may have closed coverage gaps • Although Psychiatrists and Psychologists were consistently staffed, **there weren't enough FTEs present to meet budgeted levels**
Turnover	**52%** Medical provider turnover (3 year average) • **Significant turnover in NPPs in 2017 (6 departures)** • Relatively consistent retention of Physicians over the three-year period	**43%** BH provider turnover (3 year average) • **Turnover has steadily decreased each year since 2015** • Steady hiring as well as retention of Psychologists across all three years • Consistent turnover of Psych Associates with 2-4 departures each year; yet 2-4 new hires each year
Compensation	**~ 75th percentile overall** • Overall average impacted by NPP compensation, as they make up the majority of medical providers and are paid above the 75th percentile • Directors and Physicians were paid just below the median	**> 75th percentile overall** • Psychologists paid between the median and 75th percentile • Psychiatrists and BH NPs paid well above the 75th percentile

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile


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• Supply Gap 25% to 75%
Safford, Winslow
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25% to 75% Supply Gap

Strong compensation may contribute to low turnover, yet compliance still low

	Medical Providers[1]			Behavioral Health Providers[2]		
	Compliance	Turnover	Compensation	Compliance	Turnover	Compensation
Safford	25%	17%	> 75th	26%	0%	N/A
Winslow	40%	14%	> 75th	0%	50%	N/A

	Compliance		Turnover		Compensation
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

1) Medical Director, Physician, Non-Physician Practitioner (NPP; Nurse Practitioner, Physicians Assistant)
2) Psych Director, Psychiatrist, Psychologist, BH Nurse Practitioner, Psych Associate
Psych Associates not included in compensation analysis due to unavailable MGMA benchmarks

• 25% - 75% Supply Gap

Safford Complex

	Medical Providers	Behavioral Health Providers
Compliance	**25%** *of the year medical staffing met budgeted levels (13 weeks)* • Didn't meet budget 75% of the year because the 1.0 FTE **Medical Director stopped providing coverage** in mid-April, although was not termed until December 1st • NPPs were fully staffed for over two-thirds of the year, and approached budgeted levels nearly 90% of year	**26%** *of the year behavioral health staffing met budgeted levels (14 weeks)* • Psych Associates comprise the behavioral health staff, yet **only met staffing levels 14 weeks of the year** (averaged 0.8 FTE vs. 1.0 FTE budgeted)
Turnover	**17%** Medical provider turnover (3 year average) • One consistent NPP since 2015 with one more added in 2017 • Medical Director departed in December 2017	**0%** BH provider turnover (3 year average) • One Psych Associate has been staffed since 2013 and remains active (only BH staff at Safford)
Compensation	**> 75th percentile overall** • Paid Medical Director above 75th percentile during the 13 weeks of coverage • **NPPs were paid well above the median** in 2017	*No access to compensation benchmarks for Psych Associates and no other BH providers staffed*

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Winslow Complex

	Medical Providers	Behavioral Health Providers
Compliance	**40%** *of the year medical staffing met budgeted levels (21 weeks)* • **NPPs were fully staffed for 70% (38 weeks) of the year**, yet exceeded budgeted staffing levels 36 of those 38 weeks. • 1.0 Medical Director was budgeted but only staffed part-time for 9 non-consecutive weeks (main facility was Yuma)	**0%** *of the year behavioral health staffing met budgeted levels (0 weeks)* • Budgeted 1.0 FTE Psych Associate but **position was never filled throughout the year**
Turnover	**14%** Medical provider turnover (3 year average) • **NPPs comprised nearly the entire medical staff**. Consistent staffing throughout three year period, with one term and two hires in 2017	**50%** BH provider turnover (3 year average) • Staffed one Psych Associate who termed in June 2016 and had not logged any hours; **position was not refilled**, despite the 1.0 FTE budget
Compensation	**> 75th percentile overall** • 4 of 5 NPPs paid above the 75th percentile	*No BH providers staffed*

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

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Supply Gap >75%
Douglas, Eyman, Florence, Yuma
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> 75% Supply Gap

High turnover rates may contribute to staffing compliance challenges

	Medical Providers[1]			Behavioral Health Providers[2]		
	Compliance	Turnover	Compensation	Compliance	Turnover	Compensation
Douglas	36%	75%	~ 75th	32%	100%	N/A
Eyman	43%	35%	50th – 75th	21%	30%	> 75th
Florence	58%	38%	50th – 75th	36%	33%	> 75th
Yuma	30%	20%	50th – 75th	85%	38%	> 75th

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

1) Medical Director, Physician, Non-Physician Practitioner (NPP; Nurse Practitioner, Physicians Assistant)
2) Psych Director, Psychiatrist, Psychologist, BH Nurse Practitioner, Psych Associate
Psych Associates not included in compensation analysis due to unavailable MGMA benchmarks

Douglas Complex

	Medical Providers	Behavioral Health Providers
Compliance	**36%** *of the year medical staffing met budgeted levels (19 weeks)* • **NPPs met budget 98% of the year (52 weeks)** • 1.0 FTE Medical Director was budgeted, yet never staffed, thereby bringing down the overall compliance percentage	**32%** *of the year behavioral health staffing met budgeted levels (17 weeks)* • Only one Psych Associate was staffed and worked less than a 1.0 FTE throughout the year
Turnover	**75%** Medical provider turnover (3 year average) • Medical staff is comprised of NPPs; **three termed in 2017 while two new hires were made**	**100%** BH provider turnover (3 year average) • **Difficulty retaining Psych Associate 1.0 FTE**
Compensation	**~ 75th percentile overall** • NPPs paid at or above the 75th percentile	*No access to compensation benchmarks for Psych Associates and no other BH providers staffed*

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Eyman Complex

	Medical Providers	Behavioral Health Providers
Compliance	**43%** *of the year medical staffing met budgeted levels (23 weeks)* • Physicians met budgeted levels 74% of the year • Medical Director staffing was inconsistent • **NPPs began to meet budgeted levels in the second half of 2017**	**21%** *of the year behavioral health staffing met budgeted levels (11 weeks)* • **Most fully staffed Psychiatrists of all sites** (met budget 92% of weeks, and often exceeded it) • BH NPs and Psych Associates each met budget less than half of the year
Turnover	**35%** Medical provider turnover (3 year average) • **Significant physician turnover,** with all existing and hired physicians departing within the three year period • **NPP staffing was relatively consistent** throughout three year period, with one term and two hires in 2017	**30%** BH provider turnover (3 year average) • **No turnover in Psychiatrists or Psychologists in the past three years** • Relatively consistent hiring and turnover of Psych Associates
Compensation	**50th - 75th percentile overall** • Majority of NPPs paid above the 75th percentile • Both Physicians were paid below the 75th percentile, one below the median	**> 75th percentile overall** • Psychologists paid under the median • BH NPs were paid well over the 75th percentile

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

Florence Complex

	Medical Providers	Behavioral Health Providers
Compliance	**58%** *of the year medical staffing met budgeted levels (31 weeks)* • Medical Director and Physician staffing was inconsistent, with many weeks without coverage • **NPPs were fully staffed throughout the year** (98% / 52 weeks), and even exceeded budgeted levels the majority of the year	**36%** *of the year behavioral health staffing met budgeted levels (19 weeks)* • Relatively consistent staffing across all BH provider types, yet falling short of budgeted levels
Turnover	**38%** Medical provider turnover (3 year average) • **Have not hired new Physicians since 2015 but have lost 1-2 each year** • Added 4 NPPs in 2017, yet one termed before year end • Difficulty retaining Medical Director in 2017	**33%** BH provider turnover (3 year average) • **Turnover/retention rates have been consistent each year** between 2015 to 2017 • Psych Associates have demonstrated a high turnover rate considering there were 15 individuals staffed in this period • Psychologists and BH NPs had no turnover in this period
Compensation	**50th – 75th percentile overall** • Majority of NPPs are paid above the 75th percentile • **Physicians paid below the median**	**> 75th percentile overall** • Psychiatrists and BH NPs are paid well above the 75th percentile for their respective specialties • **Psychologists are paid below the median**

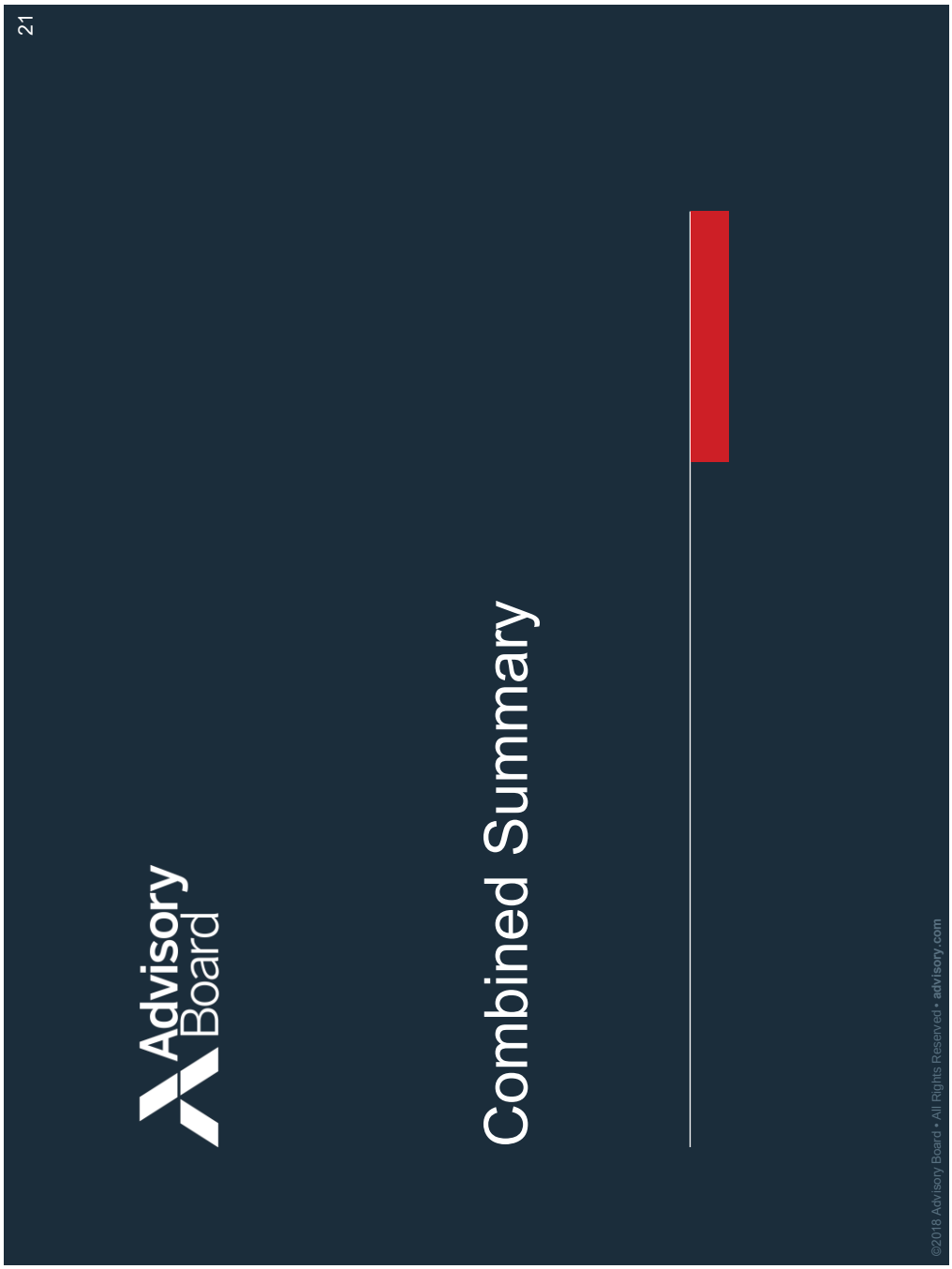
Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile

● > 75% Supply Gap

Yuma Complex

	Medical Providers	Behavioral Health Providers
Compliance	**30%** *of the year medical staffing met budgeted levels (16 weeks)* • Medical Director position was the most fully staffed at this facility (72% of weeks) • **NPPs were the lowest staffed provider** type, only meeting budget 30% of weeks	**85%** *of the year behavioral health staffing met budgeted levels (45 weeks)* • **Yuma has the highest compliance to budget for behavioral health of all facilities** • A Psychiatrist was not budgeted yet was staffed 42 weeks of the year, causing overall BH staffing to far exceed the budgeted levels
Turnover	**20%** Medical provider turnover (3 year average) • **Low turnover across the board** • Medical Director has been present since before 2015 • Termination of two NPPs in 2016 increases turnover percentage	**38%** BH provider turnover (3 year average) • Only have retained one BH NP; two others started and termed in less than three months • **Relatively consistent hiring and turnover of Psych Associates**
Compensation	**50th – 75th percentile overall** • Only one NPP being paid above the 75th percentile • **Physician paid below the median** • Director paid at the median	**> 75th percentile overall** • All providers (2 Psychiatrists and 1 BH NP) are paid consistently above the 75th percentile

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile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Combined Summary
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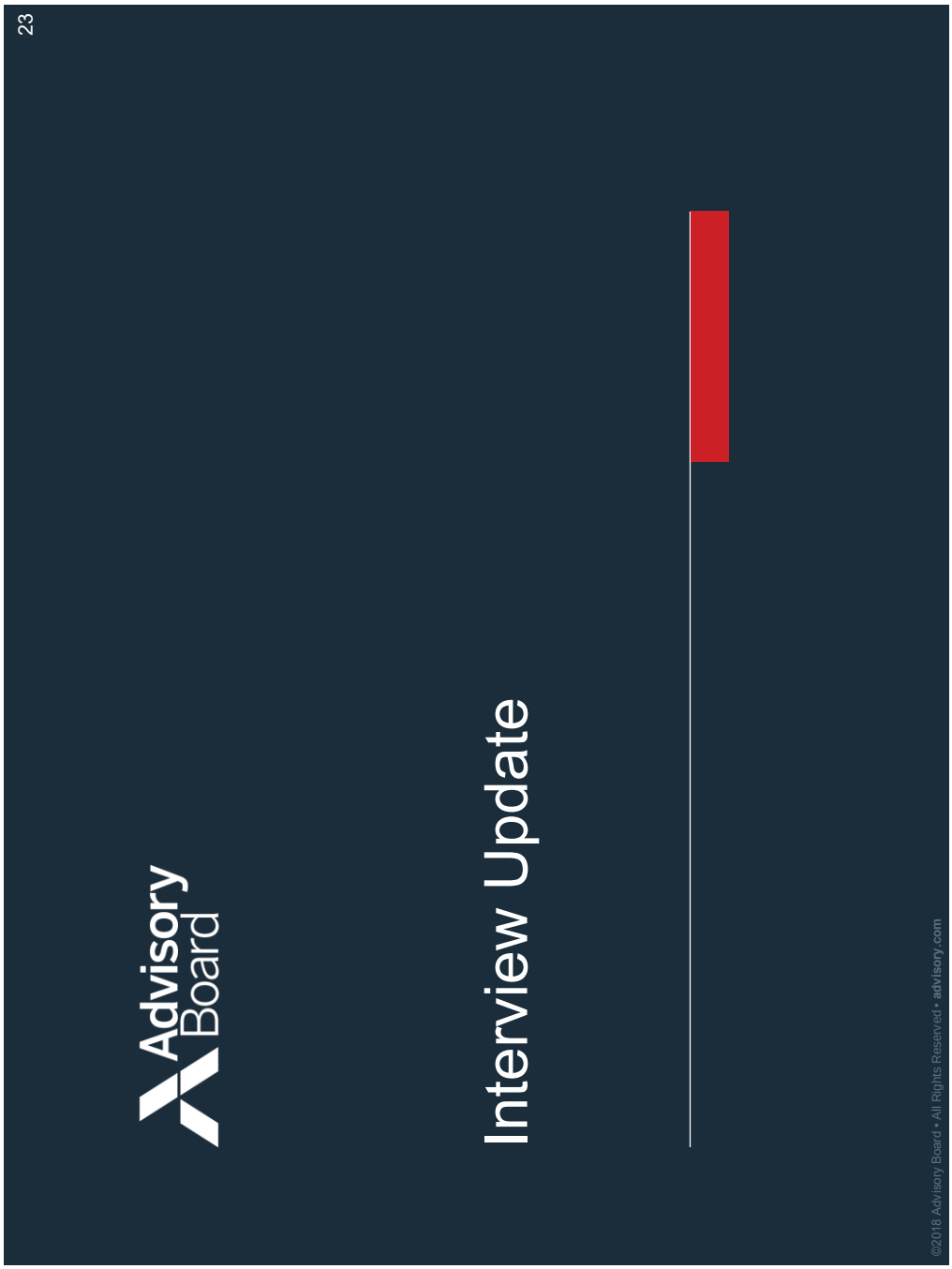
Overview of Compliance, Turnover and Compensation by All ADC Sites

	Medical Providers			Behavioral Health Providers		
	Compliance	Turnover	Compensation	Compliance	Turnover	Compensation
● *< 25% Gap*						
Lewis	47%	38%	~ 50th	45%	39%	> 75th
Perryville	62%	19%	50th – 75th	0%	44%	> 75th
Phoenix	64%	39%	50th – 75th	4%	48%	> 75th
Tucson	79%	52%	~ 75th	2%	43%	> 75th
● *25% - 75% Gap*						
Safford	25%	17%	> 75th	26%	0%	N/A
Winslow	40%	14%	> 75th	0%	50%	N/A
● *> 75% Gap*						
Douglas	36%	75%	~ 75th	32%	100%	N/A
Eyman	43%	35%	50th – 75th	21%	30%	> 75th
Florence	58%	38%	50th – 75th	36%	33%	> 75th
Yuma	30%	20%	50th – 75th	85%	38%	> 75th

Compliance		Turnover		Compensation	
Green	> 75% of weeks	Green	< 25%	Blue	> 75th percentile
Yellow	50% - 75% of weeks	Yellow	25% - 50%	Green	50th – 75th percentile
Red	< 50% of weeks	Red	> 50%	Red	< 50th percentile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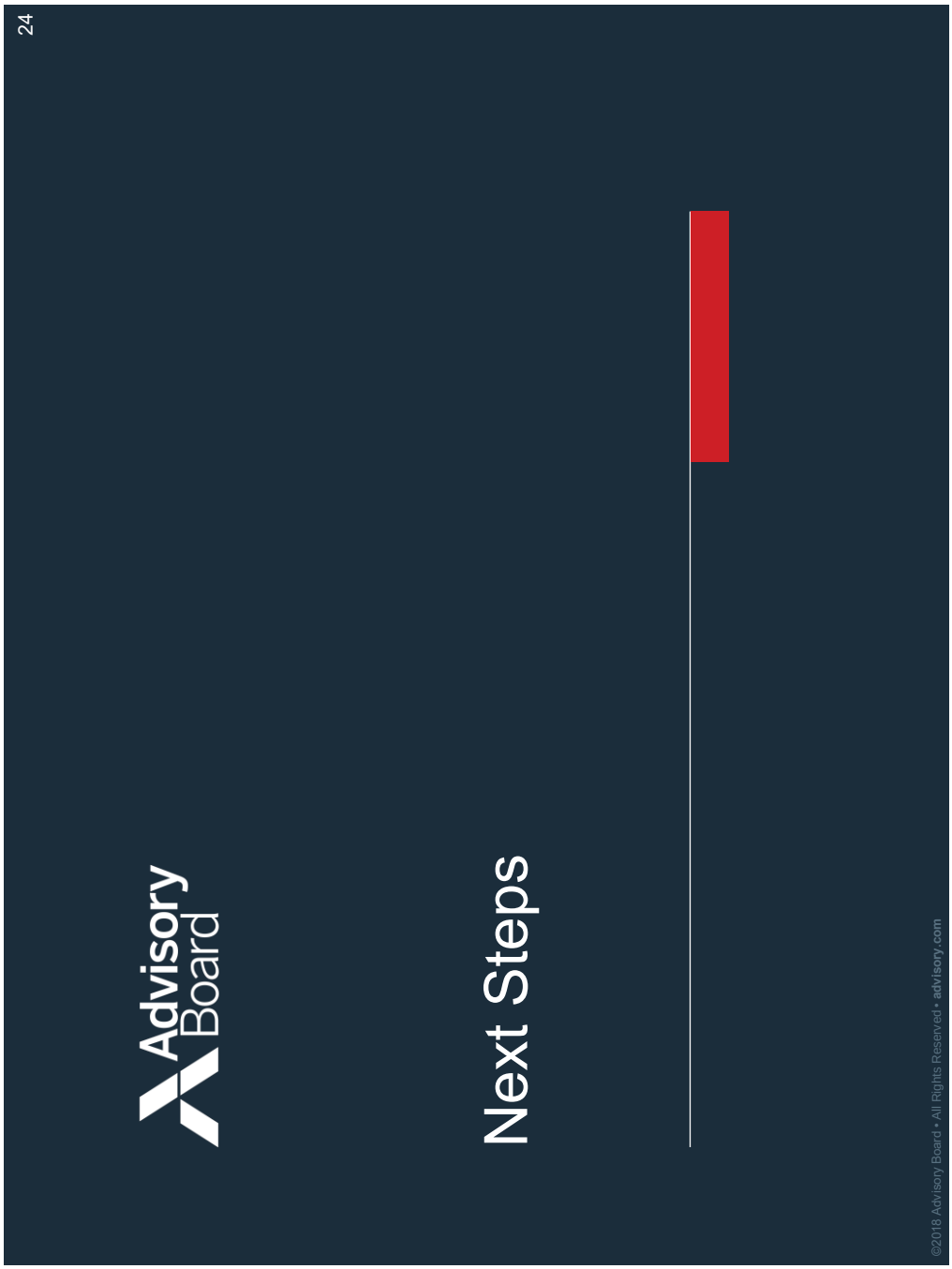
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Next Steps
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Next Steps

1. Finalize analysis based on feedback from the Court
2. Finalize phone interviews and Survey Monkey and aggregate results
3. Establish final recommendations based on combination of quantitative and qualitative data
4. Next/ final court report out: June 13th

WO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER AND JUDGMENT OF CIVIL CONTEMPT

In October 2014, the parties settled this case and signed a Stipulation to end the litigation. The Court approved the settlement and Stipulation after a fairness hearing in February 2015. (Doc. 1185 at 16; Doc. 1455) Under the Stipulation, Defendants agreed to provide health care to the Class Members as measured by 103 Performance Measures. (Doc. 1185)

In April 2016, after Defendants failed to meet many Performance Measures, Plaintiffs filed their first Motion to Enforce the Stipulation. (Doc. 1555) At the May 2016 Status Conference, the Court ordered Defendants to submit a responsive remediation plan ("First Remediation Plan"). (Docs. 1582, 1583, 1754) The Court thereafter informed Defendants of its concerns about the efficacy of the First Remediation Plan but, in deference to the Stipulation's framework, adopted it nonetheless. (Doc. 1619)

In November 2016, after three months under the First Remediation Plan, the Court "'determine[d] that the Defendants' [First Remediation] plan did not remedy the deficiencies' for the First Non-Compliant PMs. (Stipulation at ¶ 36)." (Doc. 1754) Citing to the Stipulation's acknowledgment that "[t]he Court has 'the power to enforce this Stipulation through all remedies provided by law,'" the Court ordered Defendants "to use the health care services in the community to ensure compliance with the" Performance Measures covered by the First Remediation Plan." ("Outside Provider Order") (Doc. 1754) The Court noted that "the current data show that Defendants have not been able to meet the Performance Measures by using their current procedures or by adopting the First Remediation Plan." (Doc. 1754) The Court further explained that it had "considered and rejected requiring the Defendants to submit a revised plan because of its concerns, expressed earlier on the record, about Defendants' grasp of the problem at hand, the failure, abject in some cases, of its first remediation plan to deliver compliance, and the health and safety danger posed by continued failures to meet the Performance Measures."

In May 2017, Defendant Pratt testified that he did not know of any instances of compliance with the Outside Provider Order. (Doc. 2071 at 742:1-4)

The Court continued to conduct monthly status conferences with the parties. These monthly status conferences were often lengthy and constituted the Court's efforts to understand the impediments to compliance and to prompt Defendants to meet their obligations under the Stipulation. The centerpiece of the status conferences, as with the Stipulation, was (and is) Defendants' compliance with the Stipulation as measured by the CGAR (Code Green Amber Red) results. The CGARs are the monthly report card on Defendants' performance under the Stipulation. For many of the PM/locations, particularly PMs addressing critical components of inmates' healthcare, compliance remained unattainable.

On June 14, 2017, the Court informed Defendants that, effective immediately, every single failure to comply with certain performance measures at certain prisons

("OSC PMs") would result in an order to show cause as to why a $1,000 fine should not be imposed. (Doc. 2124) Based on Plaintiffs' suggestion that Defendants should have time to cure their ongoing failure to comply with the Stipulation, the Court held off until October 2017 to enter its Order "that, effective immediately, Defendants shall comply" with specific performance measures at specified prisons "for every class member" ("OSC Order"). (Doc. 2373 at 3) The October 2017 Order required Defendants to "file a list of every instance of non-compliance with this Order during December 2017" by Friday, January 5, 2018. At the November 2017 Status Hearing, the Court added Performance Measure 52 at Eyman. (Doc. 2456) An order to show cause hearing was set for Tuesday, January 9, 2018. (Doc. 2373 at 4)

Defendants requested and received several extensions for submitting the list of every instance of non-compliance (the "OSC List") and for holding the show cause hearing. (Doc. 2456, 2526, 2605, 2620, 2640) As part of these extension requests, Defendants informed the Court—for the first time—that there was no system for collecting real time data on compliance with any performance measure covered by the Stipulation. Defendants submitted a partial OSC List but, without explanation or warning, did not timely comply with the Court's OSC Order for PM 54 at Eyman. (Doc. 2583) Subsequently, Defendants filed multiple revised OSC Lists. (Doc. 2595, 2648, 2662, 2786, 2812)

The Court heard testimony on March 26, March 27, and April 10, 2018, from the following witnesses: Arizona Department of Corrections Director Charles Ryan, Deputy Director Richard Pratt, Division Director Carson McWilliams, Dr. David Robertson, and William Upton. (Docs. 2689-1 at 5, 2769, 2770, 2724) Mr. Pratt has primary responsibility to ensure compliance with the Stipulation's performance measures. (Doc. 2769 at 48) Mr. McWilliams is in charge of prison operations. (Doc. 2724 at 167) Dr. Robertson works as a physician monitor in ADC's Monitoring Bureau. (Doc. 2671 at 87) Mr. Upton is a member of the Plaintiff class. (Doc. 2671 at 60)

At the conclusion of testimony, Defendants informed the Court that they were re-reviewing the OSC Lists. (Doc. 2782 at 136-139) The parties agreed that Defendants would provide the persons most knowledgeable about the procedure used to compile the OSC Lists. (Doc. 2782 at 148-149) Because counsel did not timely inform the Court about witness availability, Defendants filed declarations instead. (Docs. 2807 at 92-93; 2808; 2809)

LEGAL STANDARD FOR CIVIL CONTEMPT

The Parties' Stipulation empowered the Court to enforce it "through all remedies provided by law" with two exceptions not relevant here. (Doc. 1185 ¶ 36) Thus the Court's remedial power necessarily includes civil contempt proceedings. *See* 18 U.S.C. § 401(3) ("A court of the United States shall have power to punish by fine or imprisonment, or both, at its discretion, such contempt of its authority, and none other, as [. . .] [d]isobedience or resistance to its lawful writ, process, order, rule, decree, or command."); *Spallone v. United States*, 493 U.S. 265, 276 (1990) ("[C]ourts have inherent power to enforce compliance with their lawful orders through civil contempt") (quotation marks and citation omitted).

Before finding civil contempt, a court must determine by clear and convincing evidence that: (1) a valid court order exists that is "specific and definite" (*Balla v. Idaho State Bd. of Corr.*, 869 F.2d 461, 465 (9th Cir. 1989)); (2) the party had knowledge of the order, and notice of and an opportunity to be heard about the alleged noncompliance (*Int'l Union, United Mine Workers of Am. v. Bagwell*, 512 U.S. 821, 827 (1994); *United States v. Ayres*, 166 F.3d 991, 995 (9th Cir. 1999)); and (3) the party failed to take "*all* reasonable steps to comply with the order." *Kelly v. Wengler*, 822 F.3d 1085, 1096 (9th Cir. 2016) (emphasis in original).

Civil contempt "need not be willful, and there is no good faith exception to the requirement of obedience to a court order." *In Re Dual-Deck Video Cassette Recorder Antitrust Litig. v. Motion Picture Ass'n of Am.*, 10 F.3d 693, 695 (9th Cir. 1993) (internal quotation marks and citation omitted). Should a party seek to defend against a contempt

finding by arguing inability to comply, it must show "categorically and in detail" why it is unable to comply. *N.L.R.B. v. Trans Ocean Export Packing, Inc.*, 473 F.2d 612, 616 (9th Cir. 1973).

FINDINGS OF FACT

To show that they had taken all reasonable measures, Defendants presented testimony about their engagement with the State's prisoner health care provider Corizon and their efforts with Performance Measure 35, the only Performance Measure on the OSC List that ADC has not delegated to Corizon.

ADC's Oversight of Corizon

Written Demands

(1) Defendants have chosen to contract with a third-party to provide Plaintiffs with heath care and awarded that contract to Corizon in 2013. (Doc. 2770 at 61-62, Ex. 99, 103)

(2) Since the OSC Order was issued, ADC sent at least six letters to Corizon about its lack of compliance. (Doc. 2770 at 181-182, 199-201; Exs. 18, 30, 35, 36, 87, 193)

(3) As a result of the OSC Order, ADC's Monitoring Bureau reclassified one staff position from clerical duties to a liaison position. (Doc. 2770 at 155) In addition, ADC sent several letters to Corizon demanding performance. (Doc. 2770 at 108, 114; Exs. 20, 30, 31, 33, 97)

(4) In February or March 2018, ADC began requiring Corizon to provide additional details about staffing efforts because "additional staff were required to fill a current gap." (Doc. 2770 at 112, 208:12-13) Director Ryan testified that he thought Corizon might have flown in additional health care staff but he did not know how many people, what positions, what prison complexes were impacted, when they arrived, how long they stayed, or if they were still here. (Doc. 2769 at 72-73)

(5) Deputy Director Pratt testified that he believed Corizon did bring in staff to assist in Arizona but he did not know how many people came. (Doc. 2770 at 208-209)

Corizon did not provide him with any specifics about flying in additional staff. (Doc. 2769 at 158) Mr. Pratt believes that up to a dozen nurses may have come but he does not know when they arrived and there was no testimony about how long they stayed and no written communication about any staffing increases. (Doc. 2770 at 209-210) Corizon may add five additional monitors but have not yet done so. (Doc. 2770 at 153-154)

Meetings with Defendant Ryan and Defendant Pratt

(6) In November 2017, Defendants Ryan and Pratt began to meet every other week with Corizon leadership to discuss performance measures, staffing, and compliance with the OSC Order. (Doc. 2770 at 112, 130, 179; Doc. 2769 at 22, 35, 39) In these meetings, ADC had asked Corizon to increase the use of telemedicine because Corizon did not regularly use telemedicine; however, ADC has not made a written demand to Corizon to do so. (Doc. 2671 at 208; Doc. 2769 at 95, 160-163; Doc. 2770 at 49-51, 23-26; Ex. 160) In these meetings, ADC had also asked Corizon to fill the staff positions that were required by the then-current contract but had not asked Corizon to add more staff. (Doc. 2769 at 95)

(7) In November 2017, Corizon informed ADC that it was "prepared with detailed analyses of the root causes of non compliance." (Doc. 33) This analysis consists of flow charts that identify potential fail points for different performance measures. (Doc. 2770 at 113-114, 133, 147-148; 152-153, 223-224; Doc. 2781 at 72-73; Exs. 52-74) There is no evidence that these flow charts address or analyze facility-specific fail points. Further, there is no evidence that these flow charts were based on past performance at Arizona prisons.

(8) Defendant Ryan had conversations with Corizon's CEO "almost on a weekly basis." (Doc. 2769 at 35) But not until January 31, 2018, did Defendants Ryan and Pratt have an ad hoc meeting with Corizon leadership and ADC operations staff about the OSC Order issued in October.

. . .

. . .

Meetings with Regional and Site Staff

(9) In November or December 2017, ADC began to conduct daily meetings at each facility to discuss facility-level issues such as inter-facility transportations, missed medical appointments, staffing issues, and nursing lines. (Doc. 2781 at 9-10, 36) These meetings are attended by the warden, facility health administrator, ADC monitor, transportation sergeant, and deputy warden of operations. (Doc. 2781 at 9)

(10) ADC Wardens are expected to have daily meetings with their prison's health administrator to solve problems. (Doc. 2769 at 44) Corizon conducts monthly meetings at each prison to discuss corrective actions plans. These meetings have been expanded to include ADC Monitoring Bureau staff and ADC's outside counsel. (Doc. 2770 at 84, 113, 133-134) Corizon posted training materials for its field staff but there were no classes for staff. (Doc. 2770 at 138-147; Exs. 41-51)

(11) ADC regional operations staff meets every other week with the Corizon team to discuss the performance measures in the OSC Order and staffing levels. (Doc. 2770 at 112; Doc. 2769 at 35-36) Specific performance measures are discussed at this meeting. (Doc. 2770 at 129) As a result of the OSC Order, ADC expanded its weekly meeting with Corizon to include more people. (Doc. 2770 at 112, 128, 129)

Mortality Reviews

(12) ADC conducts mortality reviews for each inmate who dies in custody. (Doc. 2671 at 95-100) Starting in February or March 2018, an individual from Corizon's Continuous Quality Improvement ("CQI") team started to call into ADC's mortality reviews. (Doc. 2671 at 131:15-16; Doc. 2770 at 7, 28-29) The ADC Mortality Review team has made recommendations to Corizon's CQI representative and those recommendations have received "a mixed response" and have not generated a solution for expediting specialty consults. (Doc. 2770 at 8:25, 9)

(13) These mortality reviews consistently show a failure to properly document the medical care provided to inmates and a failure in written and verbal communication among the health care staff. (Doc. 2671 at 137-138) Of the 18 mortality reviews

submitted into evidence during the OSC hearing, ADC checked "yes" 6 times to the question: "Could the patient's death have been prevented or delayed by more timely intervention." (Exs. 30, 35, 36, 37, 40, 47) ADC checked "yes" 8 times to the question: "Is it likely that the patient's death was caused by or affected in a negative manner by health care personnel." (Exs. 30, 33, 35, 36, 37, 40, 46, 47)

Escalation List

(14) In the summer of 2017, Dr. Robertson was speaking to Dr. FallHowe, Corizon's Western Regional Director, almost daily about obtaining specialty care for specific patients because their consults were languishing and prisoners were not being seen on a timely basis. (Doc. 2671 at 146-147) Dr. Robertson felt "that Utilization Management was being arbitrary." (Doc. 2671 at 147:15-16) Subsequently, Dr. FallHowe "and her team decided to have meetings on every one of the[] cancer patients in the Tucson complex." (Doc. 2671 at 147:16-18)

(15) By August 2017, Tucson's Assistant Facility Health Administrator had started circulating a weekly email update to ADC and Corizon staff about high acuity inmates at Tucson with cancer. (Doc. 2671 at 143-144, 148; Ex. 84) These emails were "to make sure the patients that were high acuity that needed care got the care." (Doc. 2671 at 143:21-22) There was a regular meeting about the patients on this email list. (Doc. 2671 at 143-144) There is no evidence in the record whether a similar system was employed to track high acuity patients in other facilities. (Doc. 2671 at 143, 144)

(16) Around December 2017, the meeting about high acuity Tucson cancer patients evolved into a weekly, system-wide meeting between ADC and Corizon staff to discuss high acuity patients who did not seem to be obtaining care ("Escalation Meeting"). (Doc. 2671 at 144, 148-150; Doc. 2770 at 31)

(17) The agenda for the weekly Escalation Meeting is a spreadsheet listing individual patients who have come to the attention of Dr. Robertson ("Escalation List"). (Doc. 2671 at 144, 150-153, 156; Ex. 95 at 2) There are no formal criteria to include someone on the Escalation List. (Doc. 2770 at 13-15, 38) Sometimes an individual in

ADC will advocate for an individual. (Doc. 2671 at 206-207; Ex. 158) Sometimes family members write a letter to Dr. Robertson and he will contact Corizon to bring attention to that individual's case. (Doc. 2770 at 11) The University of Arizona's Cancer Center has contacted Dr. Robertson about an individual who needs expedited care. (Doc. 2770 at 38) Corizon line staff have also contacted Dr. Robertson to complain about delays in specialty care. (Doc. 2770 at 42)

(18) Dr. Robertson testified that when Class Counsel writes to ADC's counsel about individuals, those individuals are added to the Escalation List. (Doc. 2671 at 151) However, it appears that as late as July 2017, Dr. Robertson had not been informed of these letters. (Doc. 2671 at 171)

(19) Dr. Robertson asks the ADC field monitors to track the care provided to the inmates on the Escalation List. (Doc. 2770 at 11-12) Defendants Pratt and Ryan also get involved in individual patient care. (Doc. 2770 at 135-138)

(20) Corizon's Utilization Management ("UM") Team manages the Escalation List and circulates it ahead of the weekly calls. (Doc. 2770 at 35) Dr. Robertson believes that the UM team participates in the weekly meeting but it could be "their clerks or somebody." (Doc. 2671 at 157:5)

(21) Dr. Robertson testified that the system of weekly meetings about the Escalation List is "working" to obtain care for individual inmates but acknowledged that if the system worked as it should then high acuity patients would receive appropriate care as a matter of course and there would be no need for the Escalation List. (Doc. 2671 at 154:19; Doc. 2770 at 40-41)

(22) Dr. Robertson believes Corizon's site and regional medical directors have become more responsive to his calls about individuals. (Doc. 2770 at 32) As of August 2017, Dr. Robertson has noticed an improvement in that "morphine is given on the yards if it's needed. And nursing notes are much more thorough." (Doc. 2671 at 115:2-3)

. . .

. . .

(23) There is no version of the Escalation List for chronic care patients or patients of a slightly lower acuity to ensure that they receive care before they become high acuity patients. (Doc. 2770 at 39)

Carrots and Sticks: Fines, Sanctions, and Incentives

(24) Originally, the ADC contract with Corizon was for three years. This Contract included an offset for failing to meet staffing requirements. (Doc. 2770 at 75-77, 121) ADC has assessed this staffing offset penalty every month of the Corizon contract which, at the time of the hearing, had totaled $3,800,000. (Doc. 2770 at 77; Exs. 7, 9, 13, 14, 15, 103, 205)

(25) In May 2015, ADC amended its contract with Corizon to extend the contract to a fourth year, or from March 2016 to March 2017 ("Amendment 10"). (Ex. 201) Amendment 10 increased the amount paid to Corizon to $11.60 per inmate per day. (Ex. 201.3 at ¶ 8)

(26) Amendment 10 included a sanctions provision whereby ADC would sanction Corizon $5,000 for each performance measure at each prison that did not satisfy the Stipulation's requirements but the total for this sanction was capped at $90,000 per month. (Doc. 2770 at 93, 98, 183-184; Doc. 2769 at 55-56; Ex. 201.3 at ¶ 6) Director Ryan testified that it was "a smart business decision." (Doc. 2769 at 70) Deputy Director Pratt also testified that this cap "was an appropriate business decision" and that he thought it was "reasonable" but acknowledged that the $90,000 per month was only "a small percentage" for Corizon. (Doc. 2770 at 197-198) Director Ryan testified that the cap was "part of the negotiation process" and thought that the sanction was likely to have a significant effect on Corizon's behavior. (Doc. 2769 at 57-58)

(27) In Amendment 10, Corizon agreed to extend the contract to a fifth year "if ADC requests 4.0% CPI increases in its annual budget request for contract Years 4 and 5." (Ex. 201.1 at ¶ 2) While negotiating Amendment 10, Corizon indicated that it would cancel the contract if it did not receive the 4.0% increase. (Doc. 2769 at 18) Mr. Pratt testified that this increase was a business decision and reflected increased health care

costs. (Doc. 2781 at 52-53) At the time of Amendment 10, Director Ryan was not satisfied with Corizon's performance. (Doc. 2769 at 50, 60)

(28) Amendment 10 includes a revised indemnity provision. (Doc. 2769 at 114; Ex. 201.1-201.2 at ¶ 4) Deputy Director Pratt and Director Ryan understand this indemnity language to mean that the State would look to Corizon for any monies assessed for contempt from the Court. (Doc. 2770 at 205; Doc. 2769 at 74-75) Director Ryan believes that this was appropriate because Corizon is "the entity or organization [responsible] for the delivery of health care to the inmate population" while ADC "was overseeing Corizon in terms of its accountability in the delivery of health care to the inmate population." (Doc. 2769 at 21)

(29) In September 2015, ADC sent Corizon a letter detailing sanctions for failure to perform between April 1 and June 30, 2015. (Ex. 12)

(30) In June 2016, Director Ryan was not satisfied with Corizon's performance but nevertheless extended Corizon's contract to a fifth year, March 2017 to March 2018, because ADC had received approval for the retroactive application of the 4% increase described in Amendment 10 ("Amendment 11"). (Doc. 2769 at 59-60; Exs. 18, 20, 202) Amendment 11 increased the inmate health care per diem from $11.60 to $12.06. (Doc. 2770 at 183, 185; Ex. 202)

(31) In June 2016, ADC sent Corizon a letter detailing sanctions for failure to perform in April 2016. (Ex. 18) In July 2016, ADC sent Corizon a letter detailing sanctions for failure to perform in May 2016. (Doc. 2769 at 64-65; Ex. 20)

(32) In June 2017, ADC again amended its contract with Corizon to extend the contract from March 2018 through June 2018 and increased Corizon's payment to $12.54 per prisoner per day ("Amendment 13"). (Doc. 2770 at 185-186; Ex. 202) Between March 2016 and June 2017, Corizon paid ADC a total of $1,440,000 in sanctions but would have paid $7,350,000 without the cap. (Doc. 2770 at 199; Ex. 206) Between July and October 2017, the cap on sanctions meant that Corizon paid $1,260,000 less than it would have paid without the cap. (Doc. 2770 at 202) From March 2016 to October

2017, ADC could have offset $6.8 million against Corizon's payment but for the negotiated cap. (Doc. 2770 at 203)

(33) In September 2017, ADC made a business decision to amend its contract with Corizon to remove the previous cap on performance-based sanctions and to add performance-based incentives ("Amendment 14"). (Doc. 2770 at 73-74, 122-123, 125, 126; Doc. 2769 at 23-24; Ex. 205) Amendment 14 does not specify that Corizon has to spend the incentive payments on anything specific. (Doc. 2770 at 196; Doc. 2769 at 70) This amendment was made in anticipation of the Court's OSC Order. (Doc. 2770 at 124-125; Doc. 2769 at 24, 27)

(34) During the first four months of Amendment 14, ADC has paid Corizon $2,550,000 in incentive payments. (Doc. 2770 at 189-90; Doc. 2769 at 92). The incentive payments are capped at $3,500,000. (Doc. 2770 at 127) The incentive payments will be paid in the first part of FY 2018 and then there will be no further funds available to Corizon. (Doc. 2770 at 194-195; Doc. 2769 at 106) Corizon's CEO asked Director Ryan to consider providing Corizon with additional incentive funds and Director Ryan told him that there would not be any. (Doc. 2769 at 108-109)

(35) Director Ryan testified that Amendment 14's incentive money came either from a contingency fund or from vacancy savings accrued from vacant Correctional Officer positions. (Doc. 2769 at 27, 92-93) After his testimony, Defendants submitted a declaration correcting this testimony and stating that the incentive funds came only from funds appropriated for health care. (Doc. 2716)

(36) The disparity between the sanctions and the incentive payments in Amendment 14 was "the negotiated business decision that [ADC] made to try and compel and encourage Corizon to achieve much better performance." (Doc. 2769 at 104:22-24) Director Ryan thinks this decision "was, and still is, a good idea." (Doc. 2769 at 106:9-10)

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(37) Director Ryan believes that Amendment 14 worked to increase compliance because the CGAR numbers increased shortly after ADC and Corizon executed Amendment 14. (Doc. 2769 at 24)

(38) For FY2014 to FY2017, ADC assessed $2,071,000 in sanctions against Corizon for Corizon's failure to comply with its contract with the State for the delivery of health care. (Doc. 2770 at 189) Through January 2018 of FY2018, ADC had assessed $945,000 in sanctions against Corizon. (Doc. 2770 at 189)

(39) Director Ryan testified that Corizon paid ADC's outside counsel's fees and the annual fee to Plaintiffs' counsel that is required by the Stipulation. (Doc. 2769 at 51-53) On re-direct, he testified that he did not know. (Doc. 2769 at 112)

(40) Mr. Pratt assumes that the Amendments' various increases in the inmate health care per diem are used by Corizon to compensate for the increased cost of doing business. (Doc. 2770 at 188-189) But there is no contractual requirement that Corizon use money to increase salaries for health care staff or to hire more staff. (Doc. 2769 at 160) Mr. Pratt understands that Corizon operated at a loss in Arizona during the previous two quarters. (Doc. 2781 at 55)

(41) Mr. Pratt has not been satisfied with Corizon's performance. (Doc. 2770 at 181-185) Mr. Pratt has thought that if ADC pushes Corizon too hard, Corizon will terminate its contract. (Doc. 2781 at 78)

Performance Measure 35

(42) PM 35 states "All inmate medications (KOP [keep on person] and DOT [direct observation therapy]) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption." (Doc. 1185-1 at 10)

(43) Compliance with PM 35 is "a true partnership" between ADC and Corizon and requires ADC to follow its own rules. (Doc. 2770 at 162:9-11; Doc. 2769 at 42) ADC transfers 30,000 inmates every year between complexes. (Doc. 2769 at 174)

(44) ADC began collaborating with Corizon on PM 35 in June 2017 because compliance with PM 35 was "a failed process." (Doc. 2769 at 172; Doc. 2770 at 161,

163:18) As a result of that collaboration, during the summer of 2017, ADC conducted a series of meetings and developed an outline of a process to transfer medication with an inmate. (Doc. 2769 at 178; Ex. 1) As part of this process, ADC and Corizon developed a flowchart with possible fail points. (Doc. 2770 at 163-164; Ex. 78)

(45) There was no evidence presented to the Court indicating that ADC understood the fail points at specific prisons.

(46) ADC began to develop DI-361 in August 2017 and adopted it on October 31, 2017. (Doc. 2781 at 28; Ex. 78, 98) DI-361 was submitted to the Court shortly thereafter. (Ex. 2) DI-361 was distributed to ADC employees with an email address. (Doc. 2769 at 191) For ADC employees without an email address, ADC generally distributes new Director's Instructions through electronic briefing boards and through discussions at briefings. (Doc. 2769 at 191-192) There is no evidence that this process was, in fact, completed for DI-326.

(47) If an inmate arrives at the new complex and his medications are not available, DI-361 dictates that Corizon will "obtain the medications from the back-up pharmacy." (Ex. 2 at ¶3.5) There have been instances when a local pharmacy was used to obtain medications for a transferring inmate. (Doc. 2769 at 186)

(48) In March 2018, Mr. Pratt wrote to Roland Maldonado, Corizon's Vice President of Operations for Arizona, about Corizon's controlled substance audits and stated that the quarterly controlled substance findings "have been a great concern for years as related to non-adherence to the stated policies." (Ex. 96; Doc. 2769 at 154) ADC has not asked Corizon to stop relying on an out-of-state pharmacy to provide medications to prisoners but it has asked Corizon to increase the stock of pharmaceuticals maintained on site. (Doc. 2769 at 96) Mr. Ryan does not know if this request was made in writing. (Doc. 2769 at 96) Mr. Ryan understands that Corizon is not willing to relocate a pharmacy into Arizona. (Doc. 2769 at 127)

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Real Time Monitoring

(49) ADC cannot monitor health care in real time. (Doc. 2781 at 60) Two weeks after the Court issued its October 2017 OSC Order, ADC leadership asked Corizon leadership to institute real-time data tracking for the performance measures covered by the OSC Order. (Doc. 2769 at 28; Ex. 31) Deputy Director Pratt understood that Corizon would implement such a program in part to find fail points. (Doc. 2770 at 211)

(50) In early November 2017, Mr. Pratt exchanged emails with Corizon's EVP/CAO about real-time reporting on the performance measures covered by the OSC Order. (Doc. 2781 at 58-60; Exs. 105, 106)

(51) In response, Corizon's interim CEO and chair of their Board wrote a letter to Director Ryan that stated Corizon would "not implement any daily real-time monitoring data program." (Doc. 2770 at 211:2-3; Doc. 2769 at 31-32; Ex. 33) Ryan and Pratt co-signed a response letter demanding that Corizon hire additional staff to monitor the OSC Order performance measures. (Doc. 2769 at 34-35; Doc. 2769 at 150; Ex. 34) Mr. Pratt thinks that, as part of complying with the OSC Order, Corizon brought in three or four people to assist with real time data collection. (Doc. 2769 at 150; Doc. 2781 at 81)

(52) In January 2018, Ryan and Pratt co-signed a letter to Mr. Maldonado that concluded there had been 2,481 incidents covered by the OSC Order in December 2017. (Doc. 2769 at 37-38; Ex. 37) In February 2018, they sent a clarification letter stating that they had recalculated the number of incidents to be 668. (Doc. 2769 at 38-39; Ex. 39)

(53) In March 2018, the week before the hearing in this matter, Ryan and Pratt co-signed a letter to Mr. Maldonado about real time reporting. (Doc. 2769 at 82; Ex. 97) This letter noted that, for January 2018, Corizon had compiled the number of incidents and concluded that there were 891 incidents of non-compliance for the PMs covered by the OSC Order. (Ex. 97.002)

(54) In March 2018, Corizon informed ADC that it had implemented real-time reports for some performance measures. Neither Mr. Ryan nor Mr. Pratt know or could

remember which performance measures have real-time reports. (Doc. 2770 at 211; Doc. 2769 at 82-83)

(55) There is still no real-time monitoring program for all performance measures. (Doc 2704 at 3:25-26; Doc. 2770 at 108, 210; Ex. 31.002)

(56) In March 2018, ADC made its first written demand to Corizon for a written description of its "efforts taken over the last five months to document Corizon's commitment to comply with the [OSC Order's] performance measures and to fill vacant positions on your rosters." (Doc. 2769 at 85)

(57) Pentaho, a Corizon-owned program, can run reports from eOMIS, Corizon's electronic medical records program. (Doc. 2769 at 147-148) ADC does not have access to Pentaho and has to ask Corizon for any specific Pentaho reports. (Doc. 2769 at 148-149)

(58) ADC had, and has, "serious concerns" with using Pentaho to generate lists of incidents for the OSC Order. (Doc. 2769 at 156; Ex. 38, 97) ADC worked with Corizon to run different Pentaho reports for the OSC Order in an attempt to increase the accuracy of the reports. (Doc. 2769 at 155-156) ADC demanded "significant improvement" in Corizon's next report. (Doc. 2769 at 157:21; Ex. 97) ADC did not disclose its concerns to the Court or to Plaintiffs about the December 2017 real time data until Mr. Pratt's cross-examination as a part of the OSC hearing. (Doc. 2769 at 156-157; Doc. 2781 at 81-82; Ex. 97)

(59) Plaintiffs alleged that ADC had missed 420 instances of non-compliance in the December 2017 OSC List. ADC reviewed Plaintiffs allegations and added 238 names to the December 2017 OSC List. (Doc. 2690 at 21; Doc. 2781 at 62, 68; Docs. 2745, 2755) Plaintiffs made no similar allegation about the January 2018 or February 2018 OSC List.

CONCLUSIONS OF LAW

(a) Defendants' contract with Corizon does not obviate their non-delegable duty to provide Plaintiffs with health care under state law. Ariz. Rev. Stat. §§ 31-

201.01(D); 41-1604(B)(1)(d) (the director may delegate functions or duties "that the director believes can be competently, efficiently and properly performed"); *Starr v. Baca*, 652 F.3d 1202, 1208 (9th Cir. 2011) (relying on fact that the defendant sheriff was required by state statute to take charge of county jails and was answerable for prisoner's safekeeping). (Doc. 2781 at 89:11) Similarly, Defendants' contract with Corizon does not modify their position as obligors on the Stipulation.

(b) Defendants' management of Corizon does not indicate that they have any real ability to spur Corizon's compliance with the Stipulation. The Demand Letters evince ADC's frustrations with Corizon, frustrations that are similar to the frustration that the Court has expressed to Defendants. Specifically, ADC's communication with Corizon demonstrates a concern about the quality of internal audits, about staffing levels, and about performance.

(c) Obtaining care for high acuity patients depends on committed individuals advocating for the care that the State has already paid Corizon to provide. Notwithstanding Defendants' use of the Escalation List, Defendants are not entitled to congratulations for developing an extraordinary method, which identifies a subset of high acuity patients, in order to ensure that they receive the care that all high acuity inmates are entitled to receive under the Stipulation. To be clear, these high acuity patients made it to the Escalation List because they had not received the health care to which all inmates are entitled. If the system worked as it should, there would be no need for this Escalation List.

(d) Instead, Defendants' "good business decision" was to provide incentive payments to a contractor who had already committed to the State to provide that very service and had repeatedly and consistently failed to meet that obligation. The wisdom of a business decision that so rewards a failing contractor escapes the Court but is, for these purposes, irrelevant.

(e) Of the performance measures covered by the OSC Order, only PM 35 involves ADC operations. When undertaking a remediation plan for PM 35, ADC did

not review operations at each prison to determine why PM 35 was, or was not, working. ADC did not begin working on a procedure to address PM 35, DI-361, until after the Court first announced it was contemplating the OSC. This is no evidence before the Court to show that ADC understands why DI-361 did not create compliance in Eyman or Lewis in December 2017, why DI-361 did not create compliance in Florence or Lewis in January 2018, or why Tucson attained compliance in August 2017 without DI-361.

(f) The OSC Order has not resulted in ADC's compliance with the Stipulation, which requires that every single inmate receive the benefit of each Performance Measure. The Stipulation requires 100% compliance with each of its Performance Measures. As this Court has repeatedly stated, the Stipulation's 85% threshold is simply a triggering point for the Court's intervention. And since the OSC Order, the following PM/Locations have remained below the Stipulation's 85% threshold:

- Performance Measure 35 at Eyman in December 2017;
- Performance Measure 35 at Florence in January 2018;
- Performance Measure 35 at Lewis in December 2017 and January 2018;
- Performance Measure 39 at Lewis in January 2018 and March 2018;
- Performance Measure 44 at Eyman in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 46 at Eyman in December 2017 and February 2018;
- Performance Measure 47 at Eyman in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 47 Florence in January 2018 and March 2018;
- Performance Measure 47 Lewis in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 47 Phoenix in December 2017, January 2018, and February 2018;
- Performance Measure 47 Tucson in January 2018 and February 2018;
- Performance Measure 50 at Florence in December 2017 and January 2018;

- Performance Measure 51 at Eyman in January 2017;
- Performance Measure 51 at Florence in December 2018;
- Performance Measure 52 at Florence in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 54 at Eyman in December 2017;
- Performance Measure 66 at Florence in February 2018 and March 2018; and
- Performance Measure 66 at Tucson in March 2018.

(Docs. 2373, 2801-1)

(g) Defendants did not introduce any evidence to the Court about specific efforts to bring PMs 39, 44, 47, 50, 51, 52, 54, or 66 into compliance. With respect to PM 35, the testimony Defendants presented was generic in nature and not geared toward the specific issues precluding compliance at each facility. This failure alone supports the conclusion that Defendants have not taken "all reasonable steps to comply with the [OSC] order." *Kelly v. Wengler*, 822 F.3d 1085, 1096 (9th Cir. 2016).

(h) Because ADC remains noncompliant with these portions of the Stipulation, the Court concludes that civil contempt sanctions against Defendants are warranted here to address Plaintiffs' "injuries resulting from [ADC's] noncompliance." *Shuffler v. Heritage Bank*, 720 F.2d 1141, 1147 (9th Cir. 1983) (citing *Gompers v. Bucks Stove & Range Co.*, 221 U.S. 418, 448-49 (1911)).

(i) The evidence shows that the mere threat of monetary sanctions was not sufficient to generate ADC's compliance with the Stipulation. More importantly, the evidence presented to the Court indicates that wide-spread and systemic failures remain. In one recent example, Defendants had no information about what could be done to improve compliance for PM 50 at Tucson and failed to even attempt to provide a corrective action plan at the May 2018 Status Conference. (Doc. 2810). In another example, instead of presenting a corrective action plan aimed at trying something new, Defendants informed the Court at the June status hearing that they will continue to use their previous plan even though the CGARs reflect that the previous plan has not

obtained consistent compliance for PM 39 at Lewis. (Doc. 2874-1 at 81) That Defendants should exhibit such nonchalance about addressing on-going failures to comply with the Stipulation—even as the sword of sanctions loomed above them—is considerable evidence that a contempt order and monetary sanctions are necessary.

(j) The inescapable conclusion is that Defendants are missing the mark after four years of trying to get it right. Their repeated failed attempts, and too-late efforts, to take their obligation seriously demonstrate a half-hearted commitment that must be braced. The evidence suggests that the States' recalcitrance flows from its fear of losing its contracted healthcare. But even if true, such fear is not a factor that can properly be considered in determining what steps the State must take to meet the health care needs of its inmates. If a private contractor is pushed to the door because it cannot meet the State's obligations, then so be it. Such a result would flow directly from the state's decision to privatize health care to save money. That goal of privatization cannot be achieved at the expense of the health and safety of the sick and acutely ill inmates. Indeed, Arizona for most of its history, and many states, do not privatize their healthcare services. The Court must place a clear and focused light on what is happening here: the State turned to a private contractor which has been unable to meet the prisoner's health care needs. Rather than push its contractor to meet those needs, the State has instead paid them more and rewarded them with financial incentives while limiting the financial penalties for non-compliance. Accordingly, it appears the Court must do what Defendants will not: compel compliance with the Stipulation.

CIVIL SANCTIONS

The OSC Order was valid, specific, and definite. Defendants had knowledge of the OSC Order and an extended opportunity to be heard about their non-compliance. As detailed herein, the Court has concluded that Defendants did not take all reasonable steps to comply with the Court's order. As a result, and as previewed in the OSC Order, Defendants shall pay a financial penalty of $1,000 per failed instance for the

PM/Locations in the OSC Order that fell below the Stipulation's threshold of 85%. The information provided to the Court by Defendants showed 1,445 such violations:

December 2017 (Docs. 2600, 2747, 2815)		
PM/Location	*CGAR %*	*# of Instances*
PM 35 at Eyman	74	26
PM 35 at Lewis	84	26
PM 44 at Eyman	11	9
PM 46 at Eyman	84	161
PM 47 at Eyman	54	17
PM 47 at Lewis	53	11
PM 47 at Phoenix	50	1
PM 50 at Florence	60	34
PM 51 at Florence	80	21
PM 52 at Florence	65	26
PM 52 at Eyman	57	23
PM 54 at Eyman	60	542
	Subtotal	**897**

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January 2018 (Doc. 2650, 2664, 2675, 2815)		
PM/Location	*CGAR %*	*# of Instances*
PM 35 at Florence	82	13
PM 35 at Lewis	70	44
PM 39 at Lewis	81	5
PM 44 at Eyman	56	4
PM 47 at Eyman	75	9
PM 47 at Florence	82	8
PM 47 at Lewis	36	7
PM 47 at Phoenix	83	1
PM 47 at Tucson	62	9
PM 50 at Florence	77	35
PM 51 at Eyman	68	17
PM 52 at Florence	69	21
PM 52 at Eyman	60	34
	Subtotal	**207**

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February 2018 (Doc. 2786-2)		
PM/Location	*CGAR %*	*# of Instances*
PM 44 at Eyman	43	4
PM 46 at Eyman	82	157
PM 47 at Eyman	61	20
PM 47 at Lewis	61	11
PM 47 at Phoenix	67	1
PM 47 at Perryville	83	3
PM 47 at Tucson	64	5
PM 52 at Eyman	58	60
PM 52 at Florence	67	60
PM 66 at Florence	70	20
	Subtotal	**341**

The Court will impose these sanctions and collect these funds with the understanding that they will be used to further compliance with the healthcare requirements of the Stipulation. To that end, the parties will submit proposals for use of the funds and the Court will distribute the monies after considering their proposals.

IT IS THEREFORE ORDERED that Defendants are held in civil contempt for failure to comply with the Stipulation as detailed in the Court's Order to Show Cause.

IT IS FURTHER ORDERED that Defendants shall pay $1,445,000 for their December 2017, January 2018, and February 2018 violations of the Court's Order to Show Cause. Within 14 days, Defendants must remit payment to the Clerk of Court in the amount of $1,445,000.

IT IS FURTHER ORDERED that the Clerk of Court must enter judgment against Defendants reflecting contempt fines for December 2017, January 2018, and

February 2018 totaling $1,445,000. This total is due and payable into the Registry of the Court, to be kept in the Registry until further order of the Court. This judgment shall bear interest at the federal statutory rate until satisfied.

IT IS FURTHER ORDERED that Defendants shall continue to file monthly reports reflecting every instance of noncompliance for PMs at facilities under the October 10, 2017 Order to Show Cause that are at less than 85% compliance.

IT IS FURTHER ORDERED that, within 30 days of the date of this Order, the parties shall submit their respective proposals regarding the best use of these funds.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

Defendants have moved to terminate their monitoring of most of the performance measures covered by the Stipulation. (Doc. 2251) Plaintiffs raise several categories of objections and also concede that termination is appropriate in some instances. (Doc. 2344, 2819)

Defendants' motion to terminate is the first of its kind in this case and raises several questions about how to interpret the Stipulation's termination provision contained in paragraph 10(b):

> The measurement and reporting process for performance measures, as described in Paragraph 9, will determine (1) whether ADC has complied with particular performance measures at particular complexes, (2) whether the health care provisions of this Stipulation may terminate as to particular performance measures at particular complexes, as set forth in the following sub-paragraphs.
>
> b. **Termination of the duty to measure and report on a particular performance measure:** ADC's duty to measure and report on a particular performance measure, as described in Paragraph 9, terminates if:

> i. The particular performance measure that applies to a specific complex is in compliance, as defined in sub-paragraph A of this Paragraph, for eighteen months out of a twenty-four month period; and
>
> ii. The particular performance measure has not been out of compliance, as defined in sub-paragraph A of this Paragraph, for three or more consecutive months within the past 18-month period.

(Doc. 1185 at 4-5) Several predicate questions remain unanswered by this text and so the Court must answer these questions before determining which performance measures at which locations can exit the Stipulation.

Burden of Proof

Defendants argue that paragraph 10(b) of the Stipulation provides for an automatic exit and that Plaintiffs have the burden of proving that a performance measure/location should remain covered by the Stipulation. (Docs. 2251, 2407) The Court disagrees; the relevant text is silent as to the termination's mechanism and any burden of proof. Reading the Stipulation as a whole, the Court concludes that Defendants may move to terminate if they contend they have the qualifying months, but the Court's oversight function requires the Court to rule on termination based on all of the information before the Court at the time of the ruling.

The Court notes that this interpretation of the Stipulation is consistent with the Court's statutory obligation under the Prison Litigation Reform Act which states that "prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation." 18 U.S.C. § 3626(b)(3). To satisfy this requirement, the Court must know the current conditions of health care and must know that the CGAR data is accurate and reliable.

Which 24 months

Paragraph 10(b)(i) requires compliance for 18 months out of a 24 month period. By definition, after 25 months of monitoring, there is a choice about which 24 month period applies to this sub-paragraph. The Stipulation does not specify which 24 months

period applies and so this requirement could cover the first 24 months, the most recent 24 months, or something in between.

Paragraph 10(b)(ii) requires a look-back to "the past 18-month period." Reading these two sub-paragraphs together, and in conjunction with 18 U.S.C. § 3626(b)(3), the Court concludes that the proper way to evaluate this requirement is—generally[1]—to look back 24 months from the month the motion is filed.

Final Procedures

Several times, the parties have agreed to modify how the CGAR data is collected and, when agreement could not be reached, the Court has had to order specific reporting procedures ("Final Procedure"). Nearly 18 months ago, and consistent with binding precedent, the Court informed Defendants that they did not have to recalculate CGAR data but could not rely on CGAR data calculated under discredited methods. (Doc. 1951) *Pauma Band of Luiseno Mission Indians of Pauma & Yuima Reservation v. California*, 813 F.3d 1155, 1165 (9th Cir. 2015) ("Once a court has interpreted an ambiguous contract provision that is and has always been the correct interpretation from its formation.") Put another way, the 24-month period required by Paragraph 10(b) begins from the first month of data collected under a Final Procedure and so a performance measure is only eligible for termination under the Stipulation if there are 24 months of accurate and reliable data as measured by a Final Procedure.

Defendant Pratt testified that, with one possible exception, CGARs have not been recalculated under Court-ordered methodologies. (Doc. 2770 at 192-193) The more recent implementation of Final Procedures means that none of the performance measures subject to a remediation plan are eligible to exit the Stipulation and so the Court need not address the currently-hypothetical relationship between a remediation plan and termination.

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[1] As detailed herein, this lookback period may be longer in a specific instance depending on, for example, N/A results or changes in data collection.

"N/A" and Termination of Inapplicable Performance Measures

At a status conference with the parties, the Court stated that "common sense arguments" about N/A results would be accepted. This statement was in the context of counsel's discussion about measuring Pap smears at prisons that only house men. (Doc. 1956 at 67-70)

The Court informed the parties that months with "N/A" results would not count either for or against termination. This means that the lookback period would be extended to capture 24 months of data. For example, PM 14 at Winslow had five N/A results in January 2016, May 2016, October 2016, December 2016, and January 2017. (Doc. 2251-1 at 42) This means that a look back period that begins in June 2017 must extend back another five months to February 2015.[2]

The Court notes that there are several performance measures where the CGARs are inexplicably littered with N/A results. Instead of providing an affidavit or another form of competent and admissible evidence, counsel for Defendants has stated various hypothetical possibilities to explain away the N/A results. (Doc. 2407 at 10-13, 18:7) This is insufficient and is an argument that the Court will not entertain. (Doc. 1956 at 70:9-10)

Defendants have not explicitly moved to terminate monitoring of "common sense" categories but simply informed the Court that they have "no duty" to monitor these performance measures. *See*, *generally*, Doc. 2251-1. Defendants' posture aside, the Court will terminate monitoring for PM/locations that it understands are inapplicable.[3]

First, the performance measures that apply to infirmaries do not need to be monitored at prisons without an infirmary. The Court understands that the only complexes with infirmaries are Florence, Lewis, Perryville, and Tucson. (Doc. 2251-1 at

[2] This also means that, monitoring methodology aside, PM 14 at Winslow cannot exit the Stipulation because the 18 month lookback extends to August 2015 and includes four consecutive months of non-compliance from August 2015 to November 2015.

[3] If Defendants change their operations in a way that impacts this ruling such that, for example, women are at other facilities or the location of intake units is changed, the Court may proceed accordingly.

¶¶ 225, 231, 235, 243, 251) Accordingly, the Court will terminate monitoring of infirmary-related performance measures—PM 63, 64, 65, 68, and 70—at prisons without infirmaries, namely Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma.[4]

Second, performance measures that apply only to women—PM 57, 58, 60, 61, and 74—do not need to be monitored at prisons that only house men. However, Defendant Pratt avowed that one performance measure involving post-natal care (PM74) applies in Perryville and Phoenix. (Doc. 2251-1 at ¶ 261) However, he also avowed that performance measures involving pre-natal care (PM 57 and PM 58) and Pap smears (PM 60) only apply in Perryville. (Doc. 2251-1 at ¶¶ 204, 208, 217) This inconsistency about the women prisoners in Phoenix may have a straightforward explanation but Phoenix cannot exit these women-only performance measures based on the information currently before the Court. Accordingly, the Court will deny without prejudice Defendants' motion to terminate monitoring PM 57, 58, 60, 61, and 74 at Phoenix.

Finally, the Court agrees that performance measures that apply to intake procedures do not need to be monitored at prisons where no intake occurs. Accordingly, the Court will terminate monitoring PM 33, 34, 62, 75, and 76 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma.

Specific Issues. Plaintiffs argue that Defendants' motion should be denied for PM 40 at Tucson. (Doc. 2344 at 41:8) Because Defendants did not move for termination of PM 40 at Tucson, this issue is moot. (Doc. 2251 at 6:5-6; Doc. 2251-1 at 18)

Defendants argue that they are entitled to terminate PM 42 at Lewis. (Doc. 2251 at 6:9, Doc. 2407 at 18:16-20) However, Defendant Pratt's declaration did not include any reference to PM 42 at Lewis. (Doc. 2251 at 19:1-14) Thus, separate from any data collection or monitoring methodology issues, PM 42 at Lewis is not eligible for termination.

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[4] The Court notes that Defendants' Motion does not address PM 66. *Compare* Doc. 2251 at 7:11-12 *with* Doc. 2251-1 at ¶¶238-39.

Plaintiffs' Stipulations. Plaintiffs have agreed to terminate monitoring of PM 7, 38, 56, and 71. (Doc. 2819) The Court will do so.

The Validity, Reliability, and Accuracy of the CGAR Data[5]

Defendants collect and report the CGAR data that determines whether they are in compliance with the Stipulation's performance measures. Thus, the CGAR data that is the foundation for the operation of the Stipulation is entirely within Defendants' control. For the past several years, Plaintiffs have raised various challenges to the collection and verification of that data. In response, and as detailed on the record, the Court has invested a significant amount of time understanding the data collection process and the implications of Defendants' different data reporting methods. The Court had addressed various minutiae of this process in an on-going attempt to obtain valid, reliable, and accurate CGAR data. At this point, the inescapable conclusion is there are profound and systemic concerns with the monitoring process at every stage of the process.

eOMIS. eOMIS is the electronic medical record system that Corizon providers use to document their care to inmates. ADC's Monitoring Bureau, in turn, relies on eOMIS records to calculate the CGARs. Therefore, the integrity of eOMIS is crucial.

The evidence before the Court is that eOMIS is not an accurate reflection of the care provided because providers can back-date entries in eOMIS and do not have to document that a late entry is late. In other words, "the health care staff at Corizon are able to go into eOMIS and change and manipulate the dates of requests to an earlier date." (Doc. 2671 at 166; Ex. 190)

The Court heard testimony from Cecilia Edwards, a credible witness and a Corizon employee, that she was instructed to cancel consults because Corizon had not yet obtained additional information, such as charts from outside providers or testing, or

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[5] This Order will only discuss the problems with the CGAR data and will not detail the related and concerning information presented to the Court such as exhibits where the date and day did not match (Doc. 2329 at 38, 104-105,166, 241-242, 277), testimony that Corizon does not pay its outside providers (Doc. 2244 at 93-97; Doc. 2876 at 40-42, 58), and Defendants apparently incorrect allegations that one of the oncology providers had filed for bankruptcy without any prior notification (Doc. 2635).

because there was no specialist available to see the patient. (Doc. 2876 at 18-19) Utilization Management instructed Edwards to cancel and then resubmit the consult request when the additional information was available. (Doc. 2876 at 18, 113, 126) This was done to avoid violating the Stipulation's timelines. (Doc 2876 at 128) She understood that she could wait but also that waiting would create non-compliance: this is a decision made by providers. (Doc. 2876 at 18) She was instructed to cancel a pending consult for these reasons an average of five times a month. (Doc. 2876 at 19) For ENT care, she has not cancelled consults and instead left them in place. (Doc. 2876 at 43-44)

Other examples of potential systemic weaknesses exist. Corizon does not provide all new providers with their own username/password immediately and so providers share. (Doc. 2670 at 29-31; Ex. 4) This means that an entry in eOMIS may be attributed to the wrong provider.

The Court recently heard from multiple witnesses about changes and limitations in eOMIS. Approximately four times last year, eOMIS "[went] down" and was sometimes inoperable all day. When that happens, providers had to "write the full note on a piece of paper and hang on to it until eOMIS is back up and running and then [providers] have to spend time inputting that information." (Doc. 2690 at 74-75) When eOMIS is down, there is no backup for the "extremely important" information in eOMIS such as progress notes or written orders. (Tr. 6-12-18 at 68) There is no evidence that Corizon has implemented any kind of eOMIS back-up or that busy providers do, in fact, input the paper information when eOMIS is working again.

Plaintiffs have raised other concerns about eOMIS documentation. For example, Plaintiffs noted nearly two dozen instances where IPC encounters started at precisely the start of the hour. (Doc. 2426-1 at 20-21) Also, during recent testimony, the Court heard that a new drop-down menu was going to be added to eOMIS. (Doc. 2895 at 215) Lisa McNeal, an ADC employee, testified that she had learned at a meeting that "a non-formulary button had kind of disappeared within eOMIS." (Doc. 2895 at 184:1) Finally, the Court learned that Corizon does not want providers to schedule consults 6 months

ahead of time but there is no tickler system for reminding providers to schedule consults, and there is no system to ensure that consults are scheduled even if there is provider turnover. (Doc. 2895 at 80-84)

Simply put, the credible evidence before the Court indicates that eOMIS allows providers to create dishonest and untraceable entries in an inmate's medical record, that Corizon has manipulated categories of records to comply with the Stipulation's time frames, and that Corizon has not ensured the integrity of its electronic medical records system.

Number of Records Reviewed. The Monitoring Bureau picks a seemingly arbitrary number of records to review for each Performance Measure. Although the Court understands that using more than 10 records could lead to more accurate information—the larger the pool reviewed, the more information gleaned—there is no apparent rhyme or reason to the number of records ADC reviews. These decisions can be dispositive to a finding of non-compliance.

For example: in January 2018's CGAR report, PM 51 at Florence listed 49 of 56 records as compliant. (Doc. 2711 at 112-113) Thus, according to the CGAR report, there were at least 7 instances of non-compliance. The first list submitted for the Order to Show Cause hearing ("OSC List") had 5 instances of non-compliance for PM 51/Florence in January 2018 and the amended list had 12 instances where each instance was a different inmate. (Doc. 2815-2 at 15) Adding the 12 instances of non-compliance from the final OSC list and the 49 instances of compliance from the CGAR report, it appears that there was a pool of 61 instances that the Monitoring Bureau could have included in the CGAR.[6] If all 61 instances had been included, this performance measure would not have met the Stipulation's threshold of 85%: 49/61=80%. But because only 56 records were included, the performance measure was documented on the CGAR report as compliant: 49/56=88%.

[6] There could be many more than 61 records for PM 51 at Florence in January 2018.

Escalation Cases vs CGAR Report. The Court expected that recent testimony would buttress the integrity of the CGAR reports. The opposite occurred.

For example, on Friday, July 28, 2017, Karen Padron, a Program Evaluation Specialist in the ADC Monitoring Bureau, emailed Dr. Robertson about Inmate 40 at Phoenix:

> I am working on PM 50-52 and ran across this consult that was cancelled by the regional medical director and wondered if you were aware and that nothing has been pursued since 4/20. . . . Thought you might want to be aware that this IM appears to not be getting an evaluation he needs in order to be appropriately treated.

(Ex. 85) Ms. Padron's email indicates that Inmate 40's care was not compliant with the Stipulation and that his records were part of her review for that months' CGAR. On Monday, July 31, 2017, Ms. Padron entered the June 2017 CGARs for PM 50, PM 51, and PM 52 in Phoenix. She reviewed 5 records for PM 50, 9 records for PM 51, and 11 records for PM 52. Inmate 40 is not included in the CGARs for PM 50, PM 51, or PM 52. (Doc. 2247 at 264-265) Because of the Stipulation's monitoring requirements of reviewing at least 10 records, and the fact that Ms. Padron reviewed fewer for PM 50 and 51, the Court concludes that Ms. Padron should have reviewed the entire universe of possible records for PM 50 and PM 51 in Phoenix for the June 2017 CGARs.[7] (Doc. 1185-1 at 26) Thus, it is inexplicable that Ms. Padron reviewed Inmate 40's records on a Friday and then did not include him on Monday's report. The system is not working when an individual Monitor flags someone for not receiving timely care and then doesn't include that person in the CGAR analysis.

A different email indicates different concerns. On Monday, August 7, 2017, Marlena Bedoya, a Monitor for ASP-Tucson, emailed Dr. Robertson and several others about Inmate 23:

> I think I found another Cancer. I came across this chart while auditing and saw his Cancer diagnosis, went into the latest consult – and found these

[7] Inmate 40 does not appear in the July 2018 CGARs for PM 50, 51, or 52. (Doc. 2333)

> comments. I just don't understand why they continue to state "need more info" if he has ongoing cancer. . . .

Ms. Bedoya then detailed portions of Inmate 23's July 2017 medical record. As part of the response emails, Vanessa Headstream told Ms. Bedoya, "When you find oddities or areas of concern in any i/m [inmate] record, please alert both Dr. Robertson and myself to them. Each case is added to my tracking and f/u caseload." (Ex. 154)

For the July 2017 CGARs, Ms. Bedoya documented Inmate 23 as compliant in several CGARs, including performance measures for access to care (PM 40, 41, 43, 44) and specialty care (PM 50, 51, 52). (Doc. 2333 at 332-333, 337-339) In other words, a conscientiousness individual was so concerned that she escalated his records to a supervisor but the established system did not catch any concerns with his care. Again, something is not working when an individual Monitor flags someone for receiving insufficient care and then still marks that inmate as compliant with the CGARs.

This lacuna indicates that the Monitoring Guide was written, or is being used, in a way that documents compliance even when appropriate care is not being provided to inmates.

Monitoring Guide. The Monitoring Bureau uses a document called the "Monitoring Guide" to determine whether the eOMIS records are compliant with the Stipulation. The Court has repeatedly attempted to understand the monitoring process and specific issues therein. (Doc. 1915 at 3) These investments have had limited returns. For example, the Court attempted to understand the CGARs for PM 85 and 86 and Defendants' explanation did not clarify the matter. (Doc. 2587)

Defendants' Filings. Other submissions by Defendants are inexplicably inconsistent. For example, when Defendants first submitted their March 2018 charts, PM 35 at Florence was listed at 82% and, in an amended filing, it was listed at 88%. (Doc. 2801-1 at 61; 2803-1 at 2) Subsequently, Defendants filed their monthly CGAR report for March 2018 which listed PM 35 at Florence at 86.27%. (Doc. 2836 at 107-108) This means that this PM/location was modified at least twice—first up to 88% and then down

to 86%—with no explanation and no paper trail. This lack of audit integrity causes the Court to question the audit process overall.

Evidentiary Hearing. The Court recently concluded an extensive evidentiary hearing into allegations that Corizon had instructed a provider on ways to "beat the monitor." The evidence presented to the Court was also enough to raise questions about the integrity of the state's CGAR system.

In one example, Ms. Edwards testified that Defendants—in an apparently unilateral decision—changed optometry from the "appointments" category to the "consults" category. (Doc. 2876 at 11-12) By making this change, Defendants moved optometry care from a shorter timeframe under the Stipulation to a longer one and gave themselves additional time to provide the same care. (Doc. 2876 at 11-12)

As part of this change from appointments to consults, Corizon cancelled all pending appointments and initiated consult requests. (Doc. 2876 at 12-13) The consult requests did not accurately capture the previous appointment request date. In other words, Corizon re-categorized a category of care in a way that allowed them to take additional time to provide the care and that did not permit an accurate assessment of whether or not there had been compliance with the relevant performance measure. (Doc. 2867 at 15)

Examples like this indicate that Defendants and their contractor are at times more interested in obtaining compliance with the Stipulation by playing a shell game than by providing care to the Plaintiff Class.

Expert Review. Although the Stipulation is focused on aggregate numbers, compliance can be a life-or-death matter for inmates. (Doc. 2876 at 59-66) In one example, in November 2017, Matilde Smith, the Eyman Assistant Facility Health Administrator, told her supervisor that "[i]n the last month and a half we have sent out 3 Inmates who were on the [chronic care] Backlog at Cook unit to local ER with life threatening issues which correlate with their chronic conditions, 1 of which expired at hospital." (Ex. 213)

Because the stakes could not be higher, the Court cannot release Performance Measures from the Stipulation without confirmation that a compliant CGAR is a valid, reliable, and accurate indicator that Defendants have provided Class Members the care required by the Stipulation. Each of the examples above, when taken together, demonstrates that the Court cannot be confident that the CGARs demonstrate compliance with the Stipulation. To provide confidence, the Court will retain a Rule 706 expert, paid for by Defendants, who will review the entire monitoring process. This review shall include the issues noted above and shall include, but is not limited to, a review of eOMIS, the Monitoring Guide as written and as applied including the sampling process and the number of records reviewed, the ADC/Corizon challenge process, and the metadata/trail of any subsequent modifications. If the expert concludes that any of the CGARs are not, in fact, valid, reliable, or accurate, the expert shall develop remedial measures that will permit the collection and submission of valid, reliable, and accurate CGARs.

Although the Court has determined that an expert is necessary to evaluate the efficacy and reliability of the Monitoring Guide and its procedures, the Court also recognizes that committed and conscientious overseers exist within the system. Nevertheless, sufficient questions have been raised about the audit system's integrity to warrant this expert review. As the Court has explained previously, the state and its contractor have incentives to under report noncompliance. This fact does not mean such conduct is ineluctable—indeed the many months or reported failures to meet the Performance Measures suggest otherwise —however the potential bias of not wanting to report one's errors and the evidence of structural weaknesses in the monitoring program demand a high level of audit integrity.

IT IS THEREFORE ORDERED granting in part and denying in part Defendants Motion to Terminate Monitoring (Doc. 2251). The following performance measures at the following locations will be terminated for the reasons described above:

- PM 7 at all 10 facilities;
- PM 33 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;

- PM 34 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;
- PM 38 at all 10 facilities;
- PM 56 at all 10 facilities;
- PM 57 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 58 at at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 60 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 61 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 62 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;
- PM 63 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 64 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 65 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 68 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 70 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 71 at all 10 facilities;
- PM 74 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 75 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma; and
- PM 76 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma.

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IT IS FURTHER ORDERED that, within 30 days of the date of this Order, the parties shall each submit the names of two proposed experts who can conduct a review of the monitoring process, along with their CVs and confirmation of their availability. Thereafter, the Court will pursue a selection process that may include interviewing a finalist.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

A Health Needs Request (HNR) form is the mechanism by which Arizona Department of Corrections (ADOC) inmates request medical treatment, dental care, mental health treatment, prescription refills, or report symptoms to the health care providers. ADOC's longstanding practice required housing units to have a repository for inmates to submit HNRs—HNR Boxes—from which health care staff would collect, review, log, triage, and act upon accordingly. At least a dozen of the Stipulation's performance measures require Defendants to act within certain time frames and it is the submission of an HNR which starts the clock for assessing compliance with them.[1] For example, PM 37 requires an RN to see a sick call inmate within 24 hours after receiving an HNR (or earlier if a more urgent need is present).

In a significant shift, the parties informed the Court in May 2017 that HNR Boxes would be removed from multiple units because those units had adopted the "open clinic

[1] Specifically, Performance Measures 5, 7, 36, 37, 39, 40, 41, 42, 47, 98, 102, and 103. (Doc. 1185-1)

process." As explained by the Defendants, the open clinic process is similar to the urgent care model in the community and requires inmates to go to the health unit at designated hours to see a nurse. As implemented by the Defendants, the open clinic procedures only allow the inmate to submit the HNR when visiting with the nurse in person (Doc. 2365 at 5).

Because the way HNRs are submitted and evaluated is critical to assuring meaningful compliance with multiple areas of the Stipulation, the Court held a four-day hearing to assess whether the new HNR submission process frustrated the ability to assess compliance with the Stipulation's Performance Measures. The Court heard testimony from multiple inmate witnesses, ADOC staff, and Corizon staff (Docs. 2124, 2186, 2233, 2318).

Witness testimony at the hearing confirmed that HNRs are now only tracked when an inmate sees a health care provider (Doc. 2148, June 14, 2017 Hr'g Tr. at 94:15-95:21; Doc. 2328, September 13, 2017 Hr'g Tr. at 143:13-25). The testimony indicated that ADOC does not have any mechanism to track inmates who attempted to attend an open clinic and does not log HNRs when inmates arrived at the open clinic (Doc. 2148, June 14, 2017 Hr'g Tr. at 94:15-95:21).

The testimony presented in Court indicated that not all inmates are able to attend an open clinic, wait to be seen, and submit an HNR without difficulty. Specifically, witnesses testified that some inmates were unable to attend the open clinic during the designated hours (Doc. 2208, July 14, 2017 Hr'g Tr. at 85:1-5, 132:3-4, 134:20-135:12, 137:19-138:3; Doc. 2243, August 9, 2017 Hr'g Tr. at 12:2-6, 13:13-14, 15-2:4). Other inmates were too ill or disabled to get to and wait at the open clinic (Doc. 2208, July 14, 2017 Hr'g Tr. at 67:2-12, 67:25-68, 69:9-71:6). Finally, some inmates were required to wait outside in temperatures exceeding 100 degrees while waiting to see nursing staff (Doc. 2208, July 14, 2017 Hr'g Tr. at 18:18-21, 20:25-21:4, 34:4-5, 34:11-35:5, 52:6-20, 83:13-15, 94:20-95:1).[2]

[2] This ruling does not pass judgment on the open clinic process itself which, as

This shift flatly contradicts Defendants' avowal to the Court on January 18, 2017, wherein they maintained that multiple HNR submission methods "ensure that inmates are able to submit HNRs in multiple ways to request and receive routine medical care" (Doc. 1873 at 3). And indeed, certain health care monitor staff testified that only accepting HNRs upon seeing a nurse at the open clinic erects a barrier for inmates to access care (Doc. 2244, August 8, 2017 Hr'g Ex. 27 at 2) ("I said this was in direct contradiction to what I was told today, which is that [HNR Boxes] are never going away because it is an access to care issue."). Finally, Mr. Pratt acknowledged that he did not believe it was necessary to completely remove the HNR boxes (Doc. 2244, August 8, 2017 Hr'g Tr. at 54:19-24).

Based on the evidence presented during the four-day hearing and the parties' briefing, it is clear that the open clinic process means that the only HNRs logged for measuring compliance with the Stipulation are the HNRs submitted by inmates who were able to see a nurse in person. In other words, there is no trace of an inmate's HNR until s/he is seen by a nurse, at which point the HNR is submitted. The Court concludes that the modified open clinic HNR process may impermissibly constrict the numbers of HNRs submitted for measurement and so it cannot replace the HNR Boxes for purposes of measuring compliance with the Stipulation. Because the parties identified the HNR boxes as the triggering event with some of the performance measures, this practice cannot be abandoned without proof that it would have no effect on the measurement of Defendants' compliance with the Stipulation. Not only have Defendants failed to meet this burden of proof but the Court is satisfied that it is likely that some class members would not be able to brave the gauntlet of making it to a nurse at the open clinic.

Defendants raise several arguments in defense of the open clinic process. None of them are well taken. First, Defendants maintain that the Court is powerless to address their decision because the Stipulation does not mandate a particular method for inmates

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the witnesses noted, has positive attributes. This ruling also does not address how ADOC collects and logs HNRs during the open clinic process.

to submit HNRs (Doc. 2416 at 3-4). But, as Plaintiffs point out, when the parties negotiated the Stipulation, there was no indication that the HNR Box system—where inmates could submit HNRs in a collection box at any time of the day or to have another inmate submit it on their behalf if they were unable—would change (Doc. 2458 at 3).[3]

Moreover, Defendants' contention that the Court cannot evaluate their fundamental change in health care delivery to determine whether it complies with the letter and spirit of the Stipulation is meritless. As with innumerable disputes regarding monitoring compliance with the Performance Measures, the Court is well within its discretion to address Defendants' removal of the HNR boxes in order to ensure that compliance is assessed meaningfully.

Similarly unavailing is Defendants' contention that this issue is not yet ripe for resolution—it has been over one year since this decision was reported to the Court and the parties have litigated the issue to conclusion.

Based upon the testimony and evidence before it, the Court finds that the removal of the HNR boxes is inconsistent with the Stipulation's requirements.

IT IS THEREFORE ORDERED that within 30 days of this Order, Defendants shall:

(1) Defendants shall reinstall HNR boxes in all housing units where they were removed. The Court will not require the HNR boxes to be replaced in the same locations but will require the same number in each unit as before and expects that any change in location will not create a barrier for any particular group of inmates (i.e., if an HNR box was previously accessible to wheelchair-bound inmates then a comparably accessible box must be placed in the same unit);

(2) Defendants shall resume the previous process for collecting and logging the submitted HNRs. Defendants may also continue the open clinic procedures for accepting HNRs;

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[3] The parties negotiated the Stipulation understanding that other procedural changes, such as the adoption of electronic medical records, were imminent.

(3) Defendants shall notify the affected inmates in writing announcing the reversion to the prior HNR submission process; and

(4) Defendants shall provide competent and admissible evidence to the Court that this return to the *status quo ante* has occurred.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

Pending before the Court is Plaintiffs' motion for attorneys' fees and their motion for reconsideration. Because this is the first time Plaintiffs have sought fees stemming from enforcing the Stipulation, the Court will provide more detail to explain the reasoning for its decision.

The Stipulation

Background. In October 2014, the Parties entered into a Stipulation resolving this matter and empowering the Court to enforce it. (Doc. 1185) In April 2016, Plaintiffs filed their first "Motion to Enforce." (Docs. 1534-1548) Defendants moved to stay briefing on the Motion to Enforce and requested a status conference. (Doc. 1549) The Court conducted such a status conference on April 26, 2016. (Doc. 1554) Since then, the Court has moved to monthly status conferences that have grown from 30 minutes to an entire day. During the last two years, Plaintiffs have filed several other Motions to Enforce and have used the monthly status conferences to prosecute enforcement claims

for other aspects of the Stipulation, such as the Stipulation's requirement to offer Class Members a mammogram or colorectal screening. Prosecution of these claims has resulted in findings of substantial non-compliance, evidentiary hearings, Court tours of prison units, and some have resulted in Court imposed remedial measures. As it became clear that Defendants could not readily comply with the Stipulation, the Court has heard testimony on different aspects of compliance that are inextricably intertwined with enforcement such as how the CGAR data is collected and the Court has resolved a long string of disputes about how to interpret various terms in the Stipulation such as "90 days" and "being seen." (Doc. 1907)

Stipulation. Paragraphs 43 and 44 of the Stipulation discuss different avenues for Plaintiffs' counsel to receive fees. Paragraph 43 states in full:

> In the event that Plaintiffs move to enforce any aspect of this Stipulation and the Plaintiffs are the prevailing party with respect to the dispute, the Defendants agree that they will pay reasonable attorneys' fees and costs, including expert costs, to be determined by the Court. The parties agree that the hourly rate of attorneys' fees is governed by 42 U.S.C. § 1997e(d).

(Doc. 1185 at 16) Paragraph 44 details an annual payment to Plaintiffs' counsel for "work reasonably performed or costs incurred to monitor or enforce the relief set forth in this Stipulation" and "shall not apply . . . to any work performed before the District Court to enforce or defend this Stipulation." (*Id.*)

This is Plaintiffs' first fee application and so the Court has not yet delved into this corner of the Stipulation and the parties disagree about what work is covered by Paragraph 43's statement awarding reasonable attorneys' fees and costs "[i]n the event that Plaintiffs move to enforce any aspect of the Stipulation and Plaintiffs are the prevailing party with respect to the dispute." Defendants' central argument against Plaintiffs' fee application is that Plaintiffs are only entitled to fees if they prevailed "with respect to a specific dispute to enforce the Stipulation." (Doc. 2402 at 25) The Court concludes that this is an inappropriately narrow interpretation of the Stipulation. All of these various activities described above are driven by Plaintiffs' attempts to enforce the Stipulation. All of these matters are before the Court because Defendants have not

satisfied their obligations under the Stipulation thereby requiring Plaintiffs to move to enforce it. Hence, all are covered by Paragraph 43.

Hourly Rate

Paragraph 43 states that Plaintiffs' hourly rate "is governed by 42 U.S.C. § 1997e(d)." The parties disagree about what dollar amount this translates into. Plaintiffs argue that they are entitled to the Judicial Conference rate, a dollar amount proposed by the Judiciary's budget. Defendants argue that this statutory cite is tied to the hourly rate set by the Administrative Office of the Court to compensate CJA-appointed lawyers. (Doc. 2402, 2433)

Under Ninth Circuit precedent, even when the "approved rate had not been implemented," hourly rates under Section 1997e(d) are not related "to the amount actually paid to CJA counsel." *Webb v. Ada County*, 285 F.3d 829, 839 (9th Cir. 2002).[1] Thus, the Circuit concluded that "Section 1997e(d)(3) makes no distinction between the amount authorized by the Judicial Conference and the amount actually appropriated by Congress to compensate court-appointed counsel in criminal proceedings." *Id*.

As relevant here, Section 1997e(d)(3) states that "No award of attorney's fees in an action described in paragraph (1) shall be based on an hourly rate greater than 150 percent of the hourly rate established under section 3006A of Title 18 for payment of court-appointed counsel." The Judicial Conference sets this rate and it is currently $146/hour. (Doc. 2044-1 at 45). Accordingly, the Court concludes that the Stipulation provides Plaintiffs an hourly rate of $219/hour for fiscal year 2017.

Fiscal year 2017 covered the time period from October 1, 2016 to September 30, 2017. Plaintiffs argue that they are entitled to the FY17 rate for all of their work because Defendants did not engage with their attempts to negotiate a fee payment. As support for this argument, Plaintiffs' counsel avowed that he attempted to negotiate with Defendants for fees incurred from October 2015 to December 2016 to no avail. (Doc. 2278 at ¶10)

[1] Put another way, the Ninth Circuit explicitly disagreed with Defendants' position over 15 years ago.

However, there is no explanation for why Plaintiffs waited until they had incurred 15 months of fees or what happened between January 2017 (when the fees through December 2016 were, presumably, known) and September 2017 (when the fee application was filed).

It appears that the delay in filing the fee application was the Plaintiffs own doing and so they are not entitled to retrospective application of the higher rate. At the Court's direction, Plaintiffs have submitted their hours based on fiscal years and the Judicial Conference Rate for Fiscal year 2016. (Doc. 2721)

Application of Enhancement

The Stipulation contains no mention of an enhancement or multiplier and the Court understands that silence to mean that it is free to evaluate the propriety of such an enhancement. *See, e.g.*, *Kelly v. Wengler*, 822 F.3d 1085, 1100 (9th Cir. 2016) (noting absence of limitation means multiplier is acceptable).[2]

The parties do not dispute that analysis of an enhancement is governed by *Kerr v. Screen Guild Extras, Inc.*, 526 F.2d 67, 70 (9th Cir. 1975), as modified by *City of Burlington v. Dague*, 505 U.S. 557 (1992). *See Jordan v. Gardner*, 986 F.2d 1521, 1531, n.10 (9th Cir. 1993). When the Court calculates a lodestar amount and then evaluates an enhancement, these factors are evaluated in either the lodestar analysis or the enhancement analysis. Because the Stipulation set the hourly rate, there is no true lodestar analysis here. Accordingly, the Court will evaluate the applicability of all the *Kerr* factors to determine whether an enhancement is appropriate.

Unsurprisingly, Plaintiffs argue they meet all of them and Defendants argue Plaintiffs meet none of them. As detailed below, the Court concludes Plaintiffs satisfy the *Kerr* factors.

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[2] Defendants argue that the recent opinion in *Murphy v. Smith*, 138 S.Ct. 784 (2018), governs this case and overturned *Kelly v. Wengler*, 822 F.3d 1085 (9th Cir. 2016). (Doc. 2676) Plaintiffs disagree. (Doc. 2678) *Murphy* "is a case about how much prevailing prisoners must pay their lawyers" as a percentage of an award. 138 S.Ct. at 786. Before the Court is the enforcement of a contractual term, not allocation of fees after a monetary award for damages. Accordingly, the Court concludes that *Murphy* is inapposite to this attorneys fee application.

The Time And Labor Required

Defendants argue that Plaintiffs should not be compensated for "litigating claims that have nothing to do with the enforcement of the Stipulation." (Doc. 2403 at 19) The Court did not disagree and ordered Plaintiffs to refile their fee request without the time spent litigating several enumerated and unrelated topics.

Defendants further argue that claims of retaliation and expert review of records should not be compensable. The Court concludes that this is an overly narrow understanding of what constitutes enforcement of the Stipulation. As the Court has repeatedly stated, claims of retaliation strike at the heart of the Court's ability to enforce the Stipulation. (Doc. 2223 at 5) Moreover, the CGAR data—which forms the foundation of enforcement—is generated and reviewed by people with medical training who review individual records. Thus, Plaintiffs' use of medical experts to review individual records is sufficiently related to enforcement of the Stipulation.[3]

The Novelty And Difficulty Of The Questions Involved

Defendants argue that "the post litigation phase is quite simple." (Doc. 2402 at 20) As stated to the parties, the Court initiated the enforcement of the Stipulation with the expectation that enforcement would be simple. And it could have been simple if Defendants had been able to comply with the Stipulation's requirements, had timely responded to document requests, had promptly developed a final version of the Monitoring Guide, and had not raised spurious legal arguments.[4] However, the last two years have not been simple and so the Court concludes that this prong has been met.

The Skill Requisite To Perform The Legal Service Properly

The Court notes that the attorneys on both sides of this case have extensive experience in prison litigation and assumes that Plaintiffs would have billed significantly

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[3] The Court understands that some of the medical experts who appear on the fee application did not submit any reports to the Court because they were, in essence, associates and the expert was the partner. (Doc. 2545 at 2-3) This use of lower-cost medical experts is appropriate.

[4] *See, supra,* at fn 1.

more hours on this matter if more of the work had been done by co-counsel with less subject matter expertise.

Defendants argue that "little skill is required to monitor enforcement with the Stipulation." (Doc. 2402 at 20) In a different case, this could have been true. But here, Defendants have been unable to comply with multiple performance measures and so the post-Stipulation enforcement work has required a deep dive into the minutiae of prison health care operations, from refilling prescriptions to informing patients of test results. Any suggestion that skill is not required to solve the problem of compliance is belied by the fact that, notwithstanding their various proposed remediation plans, the problem remains. Based on their experience, Plaintiffs' counsel has brought ideas from other jurisdictions to this matter and this has assisted the Court (and Defendants) with solutions.

The Preclusion Of Other Employment By Attorney Due To Acceptance Of The Case

There are only so many hours in a day and working on one case necessarily precludes work on another. As with any piece of complex litigation, a division of labor is required but also certain leaders must emerge to corral the various complexities. From the time sheets and court appearances, it is clear that Corene Kendrick, Kirstin Eidenbach, and David Fathi are those leaders. Their time on this matter necessarily precluded work on other matters.

The Customary Fee

The customary fee analysis addresses market rates. The evidence before the Court is that the Stipulation's current rate of $219/hour is comparable to private practice rates for a first year lawyer; comparable to what Defendants' RFP authorized to outside counsel; and less than half the hourly rate for an experienced private sector attorney. (Doc. 2279, 2280)

Time Limitations Imposed By The Client Or The Circumstances

The Stipulation is structured around monthly reports and the parties and the Court long ago concluded that the most efficient way to manage enforcement was to conduct

monthly status conferences. In other words, the pace of this matter is on-going and does not allow counsel to pause this case and work on other matters.

The Results Obtained

As earlier, Defendants argue that Plaintiffs' fee application should be limited to discreet "successes." (Doc. 2402 at 22) Again, this is too narrow an understanding of the enforcement phase of this Stipulation and does not reflect the reality of monthly status conferences where many, related enforcement issues are reviewed, developed, and discussed such as access to electronic medical records, useable temperature logs, or how to offer every female inmate a mammogram.

The Experience, Reputation, And Ability Of The Attorneys

Like the requisite skill analysis, the Court notes that counsel (on both sides) have deep experience in prison litigation and have used that experience to accelerate the Court's focus on issues. The Court further notes that Plaintiffs are seeking fees only for a subset of the attorneys who are counsel of record.

The "Undesirability" Of The Case

The nature of institutional reform litigation means that the most experienced counsel will have a national practice and the Court understands that is true for Plaintiffs' (and Defendants') counsel in this matter.

Defendants argue that "Arizona attorneys take on inmate cases regularly" and so it would be easy to find local counsel.[5] (Doc. 2402 at 22) Defendants do not explain how a lawyer who handles individual personal injury matters would be qualified, or interested in, a class action case and on-going enforcement of a comprehensive settlement. Thus, this argument is not well-taken.

Separately, Defendants also argue that an enhancement cannot be justified as an "incentive to other attorneys" and argue that "this factor flies in the face of Congress's

[5] Defendants, not for the first time, argue that Plaintiffs' counsel use these cases as "cash cows" and are "incentivized by prolongation of the settlement agreement." (Doc. 2402 at 22) These sorts of ad hominem attacks are beneath the dignity of counsel and the Court. Moreover, the Court notes that these arguments could be applied equally to Defendants.

intent in passing the PLRA" because the "purpose was to discourage prisoner lawsuits."[6] (Doc. 2402 at 24, 25) Even if the PLRA governed this fee application, the Ninth Circuit is clear that "the PLRA was an effort to 'eliminate *frivolous* lawsuits,' it was not an effort to 'eliminate the ameliorative effect achieved by valid constitutionally-based challenges.'" *Kelly v. Wengler*, 822 F.3d 1085, 1104 (9th Cir. 2016) (quoting *Cano v. Taylor*, 739 F.3d 1214, 1219 (9th Cir. 2014)) (emphasis added). Counsel may disagree with the Ninth Circuit but neither counsel nor the Court is free to ignore or rewrite precedent.

The Nature And Length Of The Professional Relationship With The Client

Both parties agree that Plaintiffs have represented the Class since the inception of this matter and so this factor weighs in favor of an enhancement.

Awards In Similar Cases

Defendants again argue that inmate litigation provides a useful comparator but do not acknowledge the vast differences between a discrete personal injury case and ongoing enforcement of a class action settlement. Defendants have not cited to any class action matters where an enhancement was sought and denied. Moreover, the post-enhancement hourly rate is similar to other class action enforcement actions. *See, e.g.*, *Trueblood v. Washington State Dept. of Social & Health Svcs.*, 2015 WL 12030114 (W.D. Wash., 2015) (awarding $1,267,769.10 in fees for 3,232.77 hours of work).

Conclusion

The Court finds that, taken together, these factors all weigh in favor of applying an enhancement to Plaintiffs' fee award.

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[6] It appears that Defendants pulled this paragraph from another brief because it quotes an answering brief and pin cites to cases that were not otherwise referenced in this response. In the future, the Court expects a more appropriate attention to detail.

Motion for Reconsideration[7]

The Court previously denied Plaintiffs' request for payment of hours billed by law clerks and for photocopying expenses. Plaintiffs moved for reconsideration of that request and the Court ordered full briefing. (Docs. 2518, 2551, 2589, 2623)

Plaintiffs argue that Section 1988 case law provides for reimbursement of both law clerk time and photocopying. However, this is not a Section 1988 case and so those opinions have limited precedential value in this matter.

Law Clerk Time. Plaintiffs have provided no evidence that their law clerks received any actual compensation (as opposed to law school credit). The Court understands that paralegals and attorneys are paid, albeit in ways that do not correspond to fee applications. However, the Court will not authorize reimbursement for a cost without any evidence that a cost was, in fact, incurred.

Photocopies. Defendants agree that, if "the Court is inclined to award Plaintiffs their copying costs . . . the .25 cent a page rate is reasonable." (Doc. 2589 at n.5) The Court notes that, based on real-world experience, this rate seems high but further notes that the Clerk of the Court charges between 10 and 50 cents per page. http://www.azd.uscourts.gov/sites/default/files/documents/fee%20schedule.pdf.

Accordingly, the Court will award Plaintiffs their copying costs at .25 cents a page. (Doc. 2544-1 at 159)

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[7] The Court notes that this covers only fee awards for enforcement matters under Paragraph 43 of the Stipulation. Ongoing monitoring expenses, including overhead, under Paragraph 44 are not implicated. (Doc. 2623 at n.1)

Final Amount

Based on the information submitted, the Court calculates attorneys' fees as follows:

Year	*Office*	*Hours Spent*	*Rate*	*Total*
2015	PLO	75.2	$213.00	$16,017.60
			2015 Total	*$16,017.60*
2016	PLO	703	$216.00	$151,848.00
	Eidenbach	237.7	$216.00	$51,343.20
	ACLU-NPP	437.5	$216.00	$93,150.40
			2016 Total	*$296,341.60*
2017	PLO	662.5	$219.00	$145,087.50
	Eidenbach	63.9	$219.00	$13,994.10
	ACLU-NPP	379	$219.00	$82,239.90
			2017 Total	*$241,321.50*
			2015-2017 Total	*$553,680.70*
			Total with 2.0 Multiplier	***$1,107,361.40***

(Doc. 2544-1 at 77; Doc. 2545 at 4; Doc. 2721)

The Court further calculates costs as follows. (Doc. 2544-1 at 159; Doc. 2545-1 at 118)

PLO	$118,806.40
ACLU-NPP	$33,824.18
Total	**$152,630.58**

Based on the foregoing,

IT IS THEREFORE ORDERED granting in part Plaintiffs' Motion for Fees. (Doc. 2276).

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IT IS FURTHER ORDERED awarding Plaintiffs $1,107,361.40 in attorneys' fees and $152,630.58 in costs, for a total of $1,259,991.98 pursuant to the parties' Stipulation. The Clerk of Court must enter judgment against Defendants accordingly.

IT IS FURTHER ORDERED granting in part and denying in part Plaintiffs' Motion for Reconsideration (Doc. 2518).

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

The Court's expert, Advisory Group, has made its final presentation to the Court and submitted a final report. Plaintiffs have asked the Court to issue an order that Defendants file a plan to implement these recommendations. (Doc. 2880) Good cause appearing,

IT IS THEREFORE ORDERED that, within 30 days of the date of this Order, Defendants shall file their plan to implement the recommendations contained in the final Advisory Group report.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

WO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

After more than three years, it is clear to the Court that Defendants are unable or unwilling to meet several of the Stipulation's requirements. Defendants have submitted, and the Court has adopted, multiple remediation plans. (Docs. 1619, 2030) Defendants have revised and re-revised these remediation plans and yet, pockets of non-compliance persist. For example, PM 42 at Eyman has been non-compliant since April 2017 and Defendants have stopped proposing substantive revisions to their remediation plan. (Docs. 2801-1 at 83-85; 2807 at 68) Similarly, PM 39 at Lewis has been non-compliant for eight of the last 12 months and Defendants most recent plan is that they "will continue to utilize the same corrective action plan as set forth in the [previous] update." (Doc. 2874-1 at 79-80)

For other performance measure/locations, Defendants have not even attempted a substantive remedial measure and have simply informed the Court that a new hire will solve the problem. For example, PM 50 at Tucson has been non-compliant for 11 of the last 13 months. Defendants informed the Court on May 9, 2018, that "A new clinical

coordinator has been hired and is currently in the process of on-boarding. Effects of this action should be reflected in the May audit." (Doc. 2803-1 at 5) At the Status Hearing, Counsel could not address basic issues and had no information about how hiring one new person could constitute a remediation plan or would solve the previous year's non-compliance. (Doc. 2807 at 165-166) Accordingly, the Court ordered a remediation plan. (Doc. 2810) In response, Defendants responded with an explanation of the hiring history of the clinical coordinator position. (Doc. 2858-1 at 2) However, when Defendants had the position filled, PM 50/Tucson was non-compliant so it is unclear to the Court, and Defendants do not explain, why refilling the position will solve the underlying problem(s) and create compliance.

In another example, PM 19 at Lewis has been non-compliant for at least 13 consecutive months. Defendants submitted a corrective action plan on May 9, 2018, that stated "A new DON [Director of Nursing] started March 12 and, upon arrival, began addressing medication administration issues. . . . Due to the large number of staff that will need to be trained on the new plan, full plan development and implementation will not be accomplished until July 2018." (Doc. 2801-1 at 39) This means that for the previous year, Defendants did not attempt to create a solution.

The Court further notes that the show cause hearing did not result in full compliance with the subset of PM/locations targeted by the OSC. Moreover, the OSC only covered some of the failing PM/locations and, in the year since the OSC was first raised, other PM/locations have been consistently non-compliant. For example, PM 42 at Florence has been non-compliant for 12 of the last 13 months, PM 42 at Lewis has been non-compliant for 8 of the last 10 months, PM 44 at Florence has been non-compliant for the last three months, PM 52 at Tucson has been non-compliant for 8 of the last 10 months, and PM 67 has been non-compliant for 10 of the last 12 months. (Doc. 2801-1 at 86, 88, 93, 162, 183) It appears that Peter has, in fact, been robbed to pay Paul.

Defendants have professed that they welcome ideas from Plaintiffs. (Doc. 2071 at 137-138) To the extent that this knowledge-sharing has occurred, it has not produced

compliance. Based on Defendants' representations to the Court and the monthly CGAR reports, it appears that Defendants do not have additional ideas or resources that they can rely upon to obtain compliance with the Stipulation. As a result, the Court has determined that it is not efficacious to require Defendants to submit yet another revised remediation plan. (Doc. 1185 at ¶ 36)

"The ongoing, intractable nature of this litigation affords the district court considerable discretion in fashioning relief." *Armstrong v. Brown*, 768 F.3d 975, 986 (9th Cir. 2014). Accordingly, as part of the Court's remedial authority under the Stipulation (Doc. 1185 ¶ 36), the Court will require Defendants to hire outside experts who can perform the analysis necessary to understand why deficiencies persist and to opine as to the policies and procedures necessary to compel compliance with the Stipulation.[1] Put another way, the Court expects that the experts will review existing policies and procedures, create a remediation plan based on their expertise, and that Defendants will then adopt the expert's remediation plan. The Court expects that, because the problematic performance measures cover different categories of care, different experts may be necessary to create remediation plans that are targeted to the varying needs and difficulties at different prisons. Specifically, the Court expects expert opinions on the following six categories:

- Pharmacy: PM 15 at Lewis; PM 19 at Lewis.
- Intersystem Transfers: PM 35 at Lewis.
- Access to Care: PM 39 at Lewis; PM 40 at Eyman; PM 42 at Eyman, Florence, Lewis; PM 44 at Eyman, Florence, Lewis.
- Diagnostic Services: PM 46 at Eyman; PM 47 at Eyman, Lewis, Phoenix, Tucson.
- Specialty Care: PM 49 at Tucson; PM 50 at Florence, Tucson; PM 51 at Florence; PM 52 at Eyman, Florence, Tucson.

[1] Because of Defendants' inability to hire and retain providers, the Court has ordered an outside consultant, Advisory Group, to opine on the hiring and retention of providers. Advisory Group presented its findings in open court on June 13, 2018. (Doc. 2880) The Court expects the additional expert(s) would opine on what Defendants' employees should do and/or how they should do it.

- Chronic Care: PM 54 at Eyman; PM 55 at Eyman.
- Infirmary Care: PM 66 at Florence; PM 67 at Lewis, Tucson.

IT IS THEREFORE ORDERED that, within 30 days of the date of this Order, Plaintiffs and Defendants shall each submit a list of two proposed experts for each of the following categories of care delineated by the Stipulation: Pharmacy, Intersystem Transfers, Access to Care, Diagnostic Services, Specialty Care, and Chronic Care. For each proposed expert, the parties shall submit a current CV/resume and confirm that s/he is available to serve as an outside expert to Defendants. The Court will then conduct its selection process.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge