Third Supplemental Expert Report of Pablo Stewart, M.D.

Parsons v. Ryan, No. 2:12-cv-00601-DJH (D. Ariz.)

August 29, 2014

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).
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> "There are vacancies that impair the adequacy of staff," including nursing and medical records staff. ADC 211318 (Perryville).
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> "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).
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> "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).
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> "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).
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> "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).
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> "The Psyche Associate was also terminated which has added to the already heavy burden on nursing." ADC 211508 (Winslow).
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> "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).
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> "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").
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> 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).
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> Prisoner refusals of medication are not properly documented. 269140 (Eyman); 269172 (Florence).
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> Medication errors are not reliably reported. ADC 210325, 210748 (Eyman); 210347 (Florence); 210993 (Tucson).
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> 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.
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> "I continue to alert the facility on medication issues/concerns/questions." ADC 210791 (Florence).
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> "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.
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> "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).
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> **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).
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> **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).
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> **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).
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> **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], [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 problems 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.