

Supplemental Expert Report of Pablo Stewart, M.D.

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

December 9, 2013

I submit this supplemental report to address recently-produced documents and other information that was not available to me at the time of my initial report. In the interest of brevity I have tried not to repeat information set forth in my initial report; accordingly, the two reports should be read together. I reserve the right to supplement or modify these opinions as additional information becomes available.

Opinion: Inadequate medical records

1. [REDACTED] -His medical record is very disorganized with the pages out of order and entire sections missing. It is extremely difficult to follow the course of his treatment. The most current MAR is from May 2013. A random note indicates that he received a Haldol decanoate shot on 6/26/13 but this could not be confirmed from the medication orders section of the chart. There is an entry indicating that he is also being treated with lithium. Again, medication orders and laboratory data do not confirm this fact.
2. [REDACTED] -The medical chart is very disorganized. There are many loose pieces of paper in the chart and there is no problem list. It is very difficult to adequately follow his clinical course of treatment. I noted him to be psychotic with prominent manic symptoms, yet he was not receiving a mood stabilizing medication, at least as far as I could ascertain from this very messy and disorganized medical record.
3. [REDACTED] -See summary below.

Opinion: Inadequate medication system

1. [REDACTED] -The medical record does not contain any orders by a psychiatrist for any psychotropic medications. The MAR for May 2013, however, lists both Prozac and Remeron as being prescribed for this patient. Upon clinical interview the patient reports being prescribed Prozac for over a year but says that he hasn't gotten it for over a week because "they ran out of it." There is no way to confirm or deny this from the medical record. Also, the patient was not aware that he was prescribed Remeron.
2. [REDACTED] – According to the ADC Mortality Review, Mr. [REDACTED] was placed on "ten minute suicide watch for emotional lability" on October 29, 2012. He was seen on November 1 by the psychiatrist, who ordered Risperidone 2mg Qpm and Cogentin 1mg Qpm. These medications had not been delivered to Mr. [REDACTED] by the time he hanged himself four days later on [REDACTED]. ADC 138453.

3. [REDACTED]-The patient complained to me that he had not been receiving his medications for the 2½ weeks he had been on the CDU. He also complained to me that he was experiencing auditory hallucinations. A 6/28/13 psychology visit confirmed, "Mr. [REDACTED] has not received his psych medications. He will be referred to psychiatry. He states that it has been a month since he has had his medication." The most recent MAR in the medical record is from April 2013 so there was no way to confirm or deny the status of his medication administration. The medical record was also very disorganized but it appears that Mr. [REDACTED] was seen by a psychiatrist on 5/7/13 who discontinued his antipsychotic medication without documenting an adequate reason for this change in treatment.

Opinion: Lack of language interpretation for mental health treatment

1. [REDACTED]-The patient is Spanish speaking and carries the diagnosis of "Paranoid Schizophrenia" for which he is prescribed antipsychotic medication. Upon my clinical interview, the patient appeared to be responding to internal stimuli and was displaying EPS (legs were shaking.) He told me, in Spanish, that this problem with his legs had been going on for several months. There were no signed consents in his chart for psychotropic medication. A mental health note from 6/12/13 stated that the patient was unable to answer questions for his treatment plan due to "limited English." Surprisingly, the same clinician in another portion of the medical record documents that the patient "states he is doing well. He shared he loves to sleep and does not like to engage in activities." There is no indication who translated for the staff member, or if she has recently learned to speak Spanish.

Opinion: Inadequate access to care

1. [REDACTED]-I interviewed this patient on July 8, 2013. He was actively psychotic and reported to me that he had heard voices since at least 2008. At the time of my interview he was not receiving any medications. Mr. [REDACTED] informed me that "banging" helps him control the voices. A psychiatrist visit from 2/13/13 noted that the patient was experiencing side effects from Navane and discontinued this antipsychotic medication. No other antipsychotic medication was prescribed to replace the Navane. Of note, the next psychiatric visit didn't occur until just before my July 8, 2013 visit. This visit apparently occurred on July 2, 2013 and it included prescribing the patient a variety of psychotropic medications. But on July 8, the patient reported to me that he was not receiving any medications. Also, the medical record failed to document if the patient was receiving any medications from the July 2, 2013 order. This represents very poor care in that the patient should

have been continued on a different antipsychotic medication after he developed side effects from the Navane. Also, the staff should not have waited almost five months to restart him on psychotropic medication.

2. [REDACTED]-He is an actively psychotic individual who I evaluated on the Behavioral Health Unit. He had been placed on this unit due to his cutting himself. He reported that sometimes he still hears voices but that he tries not to listen and that the medications help. He has a history of psychiatric treatment and was being prescribed psychotropic medications in jail prior to his arrival at ADC. His jail medications were not continued at ADC and he eventually decompensated. It was only after this decompensation that he was restarted on medications. This is an obvious case in which the patient's jail medications should have been continued upon his arrival at ADC. He needlessly suffered due to this lapse in care.
3. [REDACTED]-This patient has a history of treatment with both antipsychotic and antidepressant medications. My evaluation revealed that he is experiencing psychotic symptoms and that he is not receiving any psychotropic medications. A review of his medical record lists his diagnoses as Mood Disorder and Conduct Disorder. The record also confirms that he was not being prescribed any psychotropic medications at the time of my evaluation. Of note Risperdal, Cogentin and Celexa were all discontinued on 5/21/13 due to his refusing to take them. There is no indication that the prescribing psychiatrist has made any attempts to encourage the patient to take his medications. The patient also sees a psychologist monthly but again there is no indication in the medical record that she was informed of his medication refusals or that she did anything to encourage the patient to take his medications as prescribed.

Opinion: Inadequate monitoring and management of medication therapeutic levels and side effects

1. [REDACTED]-This patient's problem list from 5/15/13 notes his diagnosis as "paranoid schizophrenia." He was seen by a psychiatrist on 3/7/13 who listed the diagnosis as "Psychosis NOS" and prescribed Haldol decanoate, 150 mg every three weeks. Of note, the recommended dose of this medication for the treatment of Schizophrenia is 50 mg every four weeks. On a follow up visit which occurred on 6/26/13, the psychiatrist noted that the patient had a tremor and was suffering from Tardive Dyskinesia but renewed his Haldol decanoate at the previously elevated dose of 150 mg every three weeks. This case raises several serious concerns about the quality of mental health treatment: 1) There is no documentation explaining why the diagnosis on the problem list and the psychiatrist's diagnosis are not the same; 2) The patient is being prescribed a tremendous amount of antipsychotic medication.

There is no justification noted in the chart for this high dose of medication; 3) Upon my examination, the patient was displaying significant medication-induced side effects (tremor and other involuntary movements consistent with Tardive Dyskinesia.) The psychiatrist noted these problems but yet failed to do anything about them. All of these issues represent very poor care.

2. [REDACTED] -See summary above.

Opinion: Miscellaneous poor care

1. [REDACTED] -This case demonstrated extremely poor care. A psychology note from 6/28/13 states "I/M is termed 'the monkey' by staff and inmates. This appellation may not be helpful." On 5/30/13 Dr. Sherman gives a telephone order for Haldol decanoate 100mg. She documents very clearly a diagnosis of Antisocial Personality Disorder with no auditory hallucinations but yet persisted in prescribing 100 mg of Haldol decanoate. There is no approved clinical indication for the use of an antipsychotic medication in the treatment of Antisocial Personality Disorder. Also, there were no mental health progress notes for the period August 2010 through February 2013.
2. [REDACTED] -This is yet another case where an inmate was prescribed an antipsychotic medication in the absence of an appropriate diagnosis. Mr. [REDACTED] was diagnosed by Dr. Harrison as suffering from Antisocial Personality Disorder and was treated with the antipsychotic medication Risperdal. He also went six months without seeing a psychiatrist, from September 2012 to March 2013, even though he was receiving antipsychotic medication.
3. [REDACTED] -Mr. [REDACTED] diagnoses are listed as "possible BPD 301.83; ASPD 301.70." Of note, both of these are personality disorder diagnoses. The patient reported to me that he was prescribed the antipsychotic, Risperdal, the antidepressant, Paxil and the mood stabilizer, Trileptal. This medication combination was confirmed in the medical record. The MAR for June notes that the Trileptal was "not available" for the period of June 1-8, 2013. Mr. [REDACTED] had a serious suicide attempt on 5/20/13 by medication overdose. He had another serious suicide attempt on 6/24/13 by swallowing razors. He was on a 30-minute watch when I evaluated him. There was no indication from the medical record why, even after two serious suicide attempts, Mr. [REDACTED] was not referred to a higher level of care. There is a very high risk that he will attempt to kill himself again. He deserves much more finely coordinated treatment that would include at a minimum diagnostic and medication reviews and referral to inpatient treatment.

Opinion: Lack of Mental Health Programming

In my initial report I noted that I observed an extraordinary lack of mental health programming in ADC, even in units that are designated to house prisoners with mental illness (pp. 37-40). My observation is confirmed by a July 9, 2013 email from defendant Pratt, in which he writes:

I just received an alarming phone call from [ASPC-Florence] Warden Hetmer regarding continued viability of [mental health] programming at CB1 and Kasson because staff have been redirected by [ASPC-Florence Facility Health Administrator] Parkinson??? We need some clarification. Visits are scheduled for next Monday.

AGA Review 22493. The final sentence is apparently a reference to my expert inspection of ASPC-Florence, which occurred on Monday, July 15. In a subsequent email on July 10, Mr. Pratt wrote to Corizon's Regional Vice President, "You may want to discuss with the Warden directly, as I think some damage control may be necessary." AGA Review 22492.

Both CB1 and Kasson are units that ADC has specifically designated to house prisoners with mental illness. It is extremely troubling that the "continued viability of [mental health] programming" in these units is in question.

Opinion: Inadequate Suicide Prevention

In my initial report I noted the sharp increase in prisoner suicides in ADC in 2013 (pp. 51-52). On November 28, 2013, Raymundo Morin, 130151, died by suicide at ASPC-Eyman. (Inmate Death Notification, December 2, 2013). This is the tenth suicide in ADC, and the sixth at ASPC-Eyman, thus far in 2013. Assuming that there are no additional suicides this year, this yields an annual suicide rate of 25 per 100,000

prisoners, which is significantly above the national average for state prisons of 16 per 100,000.

I also discussed my observation, at multiple institutions, that prisoners who were theoretically placed on “10-minute watch” for suicidal behavior or for other mental health reasons were not, in fact, being checked every ten minutes (p. 53). The tragic and entirely foreseeable consequences of this practice are evident in the mortality review of [REDACTED], who hanged himself on [REDACTED]. The reviewer concludes that Mr. [REDACTED] death was avoidable, writing that “[a]lthough ten minute watches were ordered and documented, it is the opinion of the reviewer that watches were not being done as ordered.” ADC 138454.

[REDACTED]

In my initial report I discussed serious lapses in the mental health care provided to Mr. [REDACTED] which directly contributed to his death by suicide on [REDACTED] (pp. 55-56). The psychological autopsy for Mr. [REDACTED] reveals additional grave concerns.

It is noted that “An HNR was received on the Monday after his suicide that was dated [REDACTED] stating that he would like to talk to a ‘psych doctor about his personal problems.’” ADC 197206. The Monday after Mr. [REDACTED] suicide was [REDACTED]. In other words, Mr. [REDACTED] HNR appealing for mental health assistance took *four days* to be received and reviewed. This is far below the standard of care. Obviously if this HNR had been triaged and acted upon within 24 hours, or even within 48 hours, Mr. [REDACTED] suicide would almost certainly have been averted.

The psychological autopsy also reveals that Mr. [REDACTED] was placed on watch on 4/15/12 for verbal suicidal ideation and a hunger strike, and on 5/12/12 for attempting to

jump off the top tier. ADC 197202. In other words, he was known to have a recent and significant history of self-harming behavior. And yet he was obviously not being adequately monitored, as he was able to commit suicide by strangulation, a method that takes a significant amount of time to cause death. That this occurred while Mr. [REDACTED] was “placed in the Wing One program at Kasson unit that allows inmates more access to mental health,” ADC 197206, certainly raises questions about the efficacy of this alleged mental health program.

[REDACTED]

In my initial report I expressed my view that “the extremely poor psychiatric care [Mr. [REDACTED] received directly contributed to his suicide” (p. 58). Documents I have subsequently received reveal additional egregious lapses in Mr. [REDACTED] care.

On [REDACTED], Mr. [REDACTED] was found hanging in his cell in Florence Central Unit. An ADC investigator later wrote, “Responding officers were unable to enter [REDACTED] cell due to a malfunctioning door. A tool kit had to be acquired and a panel removed before the door could be manually opened. Staff estimated there was approximately a fifteen minute delay before the ligature could be removed from [REDACTED] neck.” ADC 193394.

Obviously when a person is hanging by the neck, a delay of fifteen minutes in rendering aid will often be fatal. The inability to promptly render aid to prisoners who are hanging or have otherwise injured themselves poses a substantial risk of serious injury or death.

Mr. [REDACTED] had been prescribed four different psychotropic medications, all of which were “watch swallow.” This is an order written by the prescribing psychiatrist

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meaning that the nurse administering the medication must watch the patient take the medication and make sure that he swallows it. These medications were Sertraline 50 mg; Benztropine 1 mg; Risperidone 1 mg; and Diphenhydramine 25 mg. ADC 193394.

In the days after Mr. [REDACTED] suicide, an investigator interviewed the nurses responsible for distributing medication in Central Unit, and wrote the following:

Nurse Shaw admitted that she and other Nurses did not adhere to the “watch-swallow” mandate because it took them too long to complete their medication rounds. She said she would slide the medication packet under the cell door of those inmates. ... She said she marked inmate [REDACTED] as refusing his medication, when in fact she made no attempt to deliver meds to him.

ADC 193395. At least two other nurses told the same investigator that watch-swallow orders were disregarded. “[Nurse] Tolentino also said the nurses do not adhere to the watch swallow orders because it takes them too long to complete their rounds, as they are understaffed, and get little assistance from the Officers.” ADC 193407. “[Nurse Luedke] acknowledged the watch swallow orders were not adhered too [sic].” ADC 193407.

Finally, the investigator found that Mr. [REDACTED] medical record had been altered after his death:

On 3-13-12 while reviewing [REDACTED] [sic] medical file at the Facilities Health Administrators [sic] Office at ASPC-[Florence], It ws [sic] noticed that the Medication Administration Record (MAR) for the dates of March 1, 2, 3, & 4 had been altered. When compared to the copy I received on 3-04-12 which showed only the afternoon dose on 3-4-12 had been refused[, t]he original form in the file now showed all doses for those dates as refused.

ADC 193395.

Thus in Florence Central Unit, which houses large numbers of prisoners with serious mental illness, it appears to be standard practice for nurses to disregard the orders of prescribing psychiatrists when administering psychotropic medications. It is clear that

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falsification of medical records also occurs. I cannot overstate the shocking unprofessionalism and dangerousness of these practices. A mental health care system in which the orders of prescribing psychiatrists are routinely ignored is little better than no mental health care system at all. And a system in which records are falsified is a system in which there exists no reliable history of a patient's diagnoses, symptoms, and course of treatment. These practices pose a substantial risk of serious injury or death to patients.

I am informed that, of the 23 suicides that have occurred in ADC since January 1, 2011, psychological autopsies have been completed on approximately five. This is an appalling statistic. A completed suicide represents the ultimate failure of a correctional mental health program. Every suicide should be promptly and carefully studied to determine how it occurred and how future suicides can be prevented. To complete psychological autopsies on fewer than one-quarter of all suicides shows a startling level of indifference.

Moreover, the psychological autopsies that have been provided to me are wholly inadequate. The autopsy for [REDACTED], who hanged himself on [REDACTED], is less than a page and a half in length, and contains so many typographical errors as to make it difficult to follow. It is also dated June 19, 2013 -- approximately one month *before* Mr. [REDACTED] death. ADC 197200. The autopsy for [REDACTED], who hanged herself on [REDACTED], is not signed either by the clinician who prepared it or by the reviewing Medical Program Manager. ADC 197198. In addition, it notes that "there was a lapse in routine mental health psychological follow-ups when [Ms. [REDACTED] was] transferred from one unit to the next." ADC 197198. This is potentially a very significant fact, but the autopsy dismisses it without explanation: "withstanding

[sic] this lapse, the evidence suggests the outcome may not have been averted.” ADC 197198.

The autopsy for [REDACTED], who hanged himself on [REDACTED], was not reviewed by the Mental Health Program Manager or the Medical Program Manager until nearly a year after it was prepared. ADC 197211. The autopsy for [REDACTED], who strangled himself on [REDACTED], did not include any review of his medical chart and, apparently in violation of ADC policy, did not include an interview with his treating psychiatrist or medical staff. ADC 197205. This slipshod approach suggests that staff are merely going through the motions, and that ADC leadership is not requiring them to conduct serious psychological autopsies that will examine the cause of suicides and prevent future suicides.

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Dated this 8TH day of December, 2013 at San Francisco, California.


PABLO STEWART, M.D.

Exhibit A

- [REDACTED]: ADC138451-55
- [REDACTED]: ADC197192-98
- [REDACTED]: ADC197256-57
- [REDACTED]: ADC197199-200
- [REDACTED]: ADC197201-06, ADC192219-437
- [REDACTED]: ADC192973
- [REDACTED]: ADC193394-498
- [REDACTED]: ADC138589-93
- [REDACTED]: ADC197286-90
- [REDACTED]: ADC138346-50
- [REDACTED]: ADC197207-11

- Deposition Transcript and Exhibits: Vickie Bybee, 10/10/13
- Deposition Transcript and Exhibits: Carson McWilliams, 9/27/13
- Deposition Transcript and Exhibits: Richard Pratt, 11/7/13
- Deposition Transcript and Exhibits: Charles Ryan, 11/8/13

[illegible]

- [REDACTED], # [REDACTED]

Miscellaneous

- ADC166233-34: Tucson – CDU MH Roster
- ADC166235-43: Tucson – Rincon MH Roster
- ADC166244: Tucson – Minors MH Roster
- AGA_REVIEW_022492-94: Pratt email to Taylor dated 7/10/13
- PLTF-PARSONS-031179: Death Notification, [REDACTED], dated [REDACTED]

Tour Photos

- Perryville (Stewart) dated 7/18/13 (redacted): ADC163900-09
- Phoenix (Stewart) dated 7/19/13 (redacted): ADC163937-71
- Tucson (Stewart) dated 7/8/13 (redacted): ADC154561-65
- Yuma (Stewart) dated 7/23/13 (redacted): ADC163972-84