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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Fred Graves, et al., Plaintiffs, v. Joseph Arpaio, et al., Defendants.	No. CV 77-479-PHX-NVW **PLAINTIFFS' ADDITIONAL FACTS/PROPOSED FINDINGS OF FACT IN OPPOSITION TO DEFENDANTS' MOTION TO TERMINATE**

Systemic Deficiencies in the Mental Health Care System at MCJ Place Patients at a Major Risk of Harm

1. Maricopa County Jail's (MCJ) mental health care system is inadequate to meet the serious mental health care needs of the prisoner population, and exposes them to an unreasonable risk of harm. Declaration of Pablo Stewart, ¶ 29.

2. MCJ routinely fails to send patients to a higher level of care when needed; fails to ensure timely access to providers; has inadequate suicide prevention and defective medication management practices; provides inadequate access to crisis beds and inpatient level of care; has under-utilized or inadequate mental health programs; and unnecessarily subjects seriously mentally ill prisoners to isolation conditions so harsh as to predictably exacerbate their illness. These deficiencies, working singly and in combination, cause unnecessary and avoidable suffering to detainees who have serious mental health needs in the Jail. *Id.*, ¶ 30.

3. Defendants have long known about the substantial harms that result from deficiencies in MCJ's mental health care programs, and have failed to undertake the measures necessary to correct these deficiencies. *Id.*, ¶ 31.

4. The areas of systemic deficiencies in the provision of mental health care at MCJ include the following key areas:

- inadequate intake procedures to ensure the continuity of care for mentally ill prisoners who were receiving mental health treatment before their arrest, and to initiate necessary care for newly booked detainees with serious mental illness, *id.*, ¶ 33;
- deficiencies in the Jail's system for responding to prisoner-initiated requests for mental health care, and for handling detention and nursing referrals of patients in need of mental health services, *id.*;
- an inappropriately restrictive threshold for admission to, and a too-lax threshold for discharge from, the Jail's mental health unit (MHU), resulting in seriously mentally ill prisoners remaining housed in

outpatient facilities and in segregation units, where they receive inadequate care, *id.,* ¶ 33;

- inadequate treatment offered to seriously mentally ill detainees in the MHU, including those in need of crisis stabilization and/or inpatient care; and a lack of timely access to hospital beds for seriously mentally ill prisoners who cannot be adequately treated at the Jail, *id.,* ¶ 33;
- inadequate treatment of mentally ill prisoners at the outpatient facilities, and in particular a lack of timely access to a provider at these facilities for unstable and seriously ill detainees, *id.,* ¶ 33;
- inadequate treatment coupled with unduly harsh isolations conditions for mentally ill prisoners housed in the Jail's Special Management Unit (SMU) and in segregation/closed custody units, *id.* ¶ 33;
- inadequate consultation with and intervention by mental health clinicians in any planned use of force incident, Declaration of Eldon Vail, ¶ 19;
- a failure to require consultation with mental health staff prior to security staff issuing findings and sanctions in the disciplinary hearing process, thereby increasing the likelihood that prisoners are punished for their mental illness, *id.,* ¶ 20;
- a lack of specialized training for those detention staff members assigned to work in the MHU, *id.*, ¶ 21**;** and
- inadequate internal monitoring of mental health practices. Declaration of Pablo Stewart, ¶ 33.

5. Many detainees at MCJ with serious mental illness remain in psychotic, depressed, manic, and potentially assaultive conditions for lack of adequate mental health interventions and transfers to more intensive mental health treatment programs. Declaration of Pablo Stewart, ¶ 34.

6. Seriously mentally ill detainees are particularly vulnerable to psychiatric

harm from the harsh conditions in the isolation cells in segregation and closed custody units at MCJ, especially in the Jail's Special Management Unit (SMU). *Id.*, ¶ 35.

7. The deficiencies in the Jail's mental health care system are inter-related and reinforce one another. For example, Defendants' practice of discharging seriously mentally ill detainees from the MHU even though they are clinically unstable leads to these detainees deteriorating further, given the deficiencies in the Jail's program to treat seriously mentally ill prisoners in the outpatient facilities. *Id.*, ¶ 36.

Deficiencies in the Jail's Intake Process:

8. Defendants fail to ensure that the Jail's intake process results in a timely assessment by a provider to continue or initiate necessary mental health treatment for mentally ill detainees. Declaration of Pablo Stewart, ¶ 46.

9. In 2011, the Court's mental health expert Kathryn Burns, MD, M.P.H., recommended that MCJ revise its policies and procedures to require that prisoners be seen by a psychiatrist after a positive screen according to three triage categories (urgent, emergent, and routine). *See* Ex. 6**,** Declaration of Kathryn Burns, MD, M.P.H. ["Remedial Plan"] at 2. If fully implemented, Dr. Burns' recommendations would likely result in timely assessments by a provider. Declaration of Pablo Stewart, ¶ 48.

10. Correctional Health Services (CHS), the Jail's medical provider, did not follow Dr. Burns' recommendation. CHS Policy J-E-05 undermines Dr. Burns' recommendation by providing that the prisoner can be seen by *either* mental health staff (a mental health assistant (MHA) or mental health professional (MHP)) for an assessment, *or* by a psychiatrist for an evaluation within the triage time frames. *Id.*, ¶ 49; Ex. E, Balaban Dec. at Bates 3407 000349.

11. Dr. Burns' remedial plan also requires that prisoners exhibiting active symptoms of mental illness be seen by a psychiatrist as soon as possible and in all cases within 24 hours. Remedial Plan at 2. The CHS policy, however, omits that requirement. Lack of a policy requiring that symptomatic prisoners at intake are seen

within 24 hours by a provider places them at an unreasonable risk of harm. Stewart Dec., ¶ 50.

12. Defendants' own QI studies show significant problems with the intake process. About a quarter of all prisoners who say at the time they are booked that they are on psychotropic medications are not seen by any mental health staff. Ex. C, Balaban Dec. (collected QI studies). For a significant percentage of detainees reporting a previous treatment history, CHS does not secure releases of medical information. Ex. B, Balaban Dec. (45% of patients between October 2010-July 2012 who reported a treatment history did not have signed releases in their records). Absent a release, the Jail cannot collect these patients' previous treatment records, which can be vital to understanding a patient's treatment history. Declaration of Pablo Stewart, ¶¶ 52, 55, 56.

13. After a positive intake screen, Defendants fail to ensure that detainees who exhibit to mental health staff active symptoms of mental illness (warranting an emergent code and an immediate provider encounter) are timely seen by a provider. In some cases mental health staff do not timely confirm and continue intake medications. It is critical that patients arriving at the Jail on confirmed psychotropic medications be continued on those medications. *Id.*, ¶¶ 51, 57, Ex. D, Stewart Dec. at 10-19. Examples of problems with the intake mental health system include the following:

14. Patient SA has a documented history of mental health treatment during previous jail stays. Her problem list includes diagnoses of psychotic disorder and bipolar disorder. Ms. SA was booked on September 28, 2012. Her intake screen was negative for mental health despite her history. On October 1, 2012, the jail received faxed records from Choices Network, a county-based mental health network, including a Magellan At-Risk Crisis Plan listing a diagnosis of schizophrenia, paranoid type, and a Magellan medication log listing Risperdal as her current medication. This packet was not countersigned by a provider until October 10, almost two weeks after Ms. SA's

admission. She was eventually seen by a psychiatrist on October 18. On exam, she was delusional, and rambled about going deaf. The psychiatrist ordered Risperdal, which she received the next day. In all, she was denied her confirmed medications for three weeks after her arrest. Ex. D, Stewart Dec. at 10-11.

15. Patient IL was booked on June 11, 2013. He was receiving treatment from Magellan, the county mental health network, at the time of his arrest, and had confirmed Magellan medication of Seroquel as of the time of his arrest. Mr. IL's intake screen was positive for mental health, noting Seroquel as his current medication and that he is Magellan enrolled, and had a Court-Ordered Treatment (COT) Order that expired May 8, 2013. Intake staff ordered a psychiatric evaluation for June 12, 2013, with urgency code 1. Mr. IL was not seen by a provider until two weeks later (June 25, 2013) and was not given medications (Celexa) until June 29, 2013, 18 days after his admission. *Id.* at 14.

16. Patient GG was not timely seen by a provider after a positive intake screening on Dec. 28, 2012. He was not seen by a provider for six days, despite a documented history of bipolar disorder and an urgency code 1 for his psychiatric evaluation. He had a current COT order at booking, and he was Magellan-enrolled, receiving treatment for bipolar disorder and showing Lithium Carb. and Fluoxetine as current medications (prescribed three weeks before his booking date). Mr. GG was not timely restarted on medications. On Jan.3, 2013, patient GG was seen cell side in the Special Management Unit (SMU) by PA Fleming, and was irritable and appeared labile. He complained about not receiving his prescribed medication. The next day, patient GG received a disciplinary action report (DAR) for threatening staff; he spit at two SMU officers and "proceed[ed] to ramble about nothing I could make out," according to one of the officers. He received his first dose of medication that evening, a week after admission. *Id.* at 16.

17. Patient UB has a long psychiatric history. Her problem list notes she was designated Seriously Mentally Ill (SMI) and had a COT Order on December 23, 2011, and was diagnosed with schizophrenia, paranoid type. Ms. UB was re-booked on April

10, 2012. Her intake screen was positive, noting she was taking psychotropic medications, and had been designated SMI. That day, Magellan faxed a medication log to the jail listing as current medications Celexa, Abilify, Benadryl, Haldol, and Haldol Decanoate. Her diagnosis from Magellan was paranoid schizophrenia, and the last Magellan progress note states that Ms. UB's hallucinations decreased on medications. Though a psychiatric evaluation was ordered for April 11 (urgency code 1), Ms. UB did not see a provider for eight days. She was cleared for Estrella housing. By the time she was seen by a provider, she was agitated and screaming. "Referred to officer as a murderer. . . Pt. is either quiet and nonverbal or screaming. Pt will not be safe on unit. Will move to P-5." Ms. UB was transferred to the MHU that day. *Id.* at 17.

Deficiencies in the Mental Health HNR and Referral Process

18. Defendants fail to ensure that there is a reliable system for detainees to make their mental health needs known for treatment by qualified staff, or for prisoners who have been referred by detention and medical staff for mental health care to be timely seen by qualified staff. As a result, seriously mentally ill prisoners do not receive timely and appropriate care. Declaration of Pablo Stewart, ¶ 59, Ex. D at 1-10. Prisoners can request mental health care via a Health Needs Request (HNR). Examples of inadequate and dangerous HNR and referral practices include the following:

19. Prisoner YF was booked on February 6, 2013. She was moved to Estrella. On Feb. 10, RN Diaz wrote that the office was called from C dorm. Reportedly Ms. YF was calling an officer a bitch and making other rude comments. The RN cautioned the officer to be careful with Ms. YF who can be aggressive with spitting and hitting. The next day, MHP Unsworth wrote that Ms. YF was seen at the request of detention. She was observed lying on a bunk completely covered. Staff reported she had not showered since being booked. The MHP noted that the patient was treated in the MHU during her last jail stay, but so far had not exhibited any behavior that would result in an MHU stay—auditory hallucinations and aggressive

behavior. Ms. YF was reported as talking with herself. MHP Unsworth consulted with "Josh PNP" who agreed there was no reason for MHU placement. Despite her presentation, Ms. YF was not seen by a provider. Ex. D. Stewart Dec. at 7.

20. On February 18, Ms. YF had a positive mental health/suicide addendum. She also had her History and Physical (H&P), which documented her previous mental health diagnoses. During her H & P, a significant mass was observed on her abdomen (20 cm). She refused assessment of the mass, and received no other medical treatment. She was not referred to mental health. On February 22, Ms. YF was referred for psychiatric services by detention staff, who wrote, "inmate seems confused, awake most of the day and night will not respond to officers cell is very dirty." Behavior noted on the form included unusual isolation, no sleep, severe mood swings, confused, unusually slow to respond, cannot follow simple requests, and auditory hallucinations. On the same day, MHP Unsworth saw Ms. YF, and wrote, "initially cooperative, however, demeanor rapidly became hostile and aggressive. She began cursing and name calling, refusing to answer any questions. She did report a recent psychiatric hospitalization. Ms. YF was not referred to a provider. *Id.* at 7.

21. On March 17, detention staff filed another psychiatric referral for Ms. YF, writing, "inmate has no orientation of any people, places, time or personal hygiene. Communication is impossible as she does not acknowledge any interaction has happened. She is usually found to be pacing or staring at random objects for extended periods of time." *Id.*at 8. That day MHP Page saw Ms. YF. The MHP wrote, "seen for DO referral. Pt seen at cell front. Pt was pleasant upon approach, when asked the last time pt showered, pt reported, '3 years ago,' when pt was asked to take a shower, pt responded, 'you worry about your pussy and I'll worry about mine.' Pt continued to become increasingly irritable and made comments such as 'you need to back your MH ass off, get the fuck out of my face, you are just some white trash bitch.' On exam, Ms. YF was "agitated, distractible difficult to redirect, odoriferous, yelling." MHP Page nonetheless found her "marginally stable for GP. Plan to consult with provider the next

business day." Ms. YF was discharged on March 21, 2013. She did not see a provider. *Id.* at 8.

22. On February 2, 2013 a detention officer referred prisoner MA to psychiatric staff based on delusional statements he had made. The referral form was stamped for a mental health assessment, urgency code 2, by February 5, but Mr. MA was not seen by mental health staff. On February 9, a detention officer wrote in a psychiatric referral form, "talks of hallucinations and his phlegm being sperm and embryo eggs, bizarre. Advises he was seeing Magellan recently." There is no stamp on this form, and Mr. MA was not seen by mental health staff. That same day, RN Diaz saw Mr. MA due to complaints of shortness of breath. She wrote, "says his brain feels strange. [Says] phlegm looked like semen and female embryo eggs. His talk became more and more bizarre during our conversation. Pt. became abusive with language so assessment stopped. Mental health referral made." Mr. MA was not seen for ten days. On February 19, MHP Berman saw Mr. MA, who was incoherent, animated, dirty and disheveled. His cell was littered with trash and he appeared to be responding to internal stimuli. Mr. MA was moved to the MHU that day. These delays in timely assessments following referrals left Mr. MA to unnecessarily suffer. Ex. D, Stewart Dec. at 6-7.

23. Prisoner JE was prematurely released from the MHU by doctor's order on July 9, 2013, despite medication non-compliance, recent placement on suicide watch, and recent manic and aggressive behavior ("yelling and banging on cell door with her shoulder calling it exercise," in an RN note from July 8). The day after her MHU discharge, Ms. JE was referred by detention staff to mental health for being "confused, also seen washing her clothes in the toilet pan." Nursing staff also saw Ms. JE that day for arguing with officers. On exam, she held a piece of paper in front of her face for staff to read. On the sheet were the words: in the blood of Jesus, defeated." Ms. JE was transferred to a lockdown unit (D Tower) until she could be evaluated by mental health. The next day, MHP Retter Rojas saw Ms. JE. The MHP found Ms. JE to be alert and oriented. Ms. JE explained the other prisoners had given her a hard time. On exam, she had intermittent eye contact and was disheveled. Despite her recent documented odd behavior and condition on exam, Ms. JE was not referred to a provider. Ms. JE

continued to deteriorate, ranting repeatedly about "the blood of Jesus" (July 10 and July 12). On July 15, she was Tased after she refused multiple orders to be handcuffed so she could be removed from her cell so it could be cleaned. There was not documented involvement of mental health staff in this incident. Ms. JE was ultimately sent to Maricopa Medical Center (MMC) on August 2. *Id.* at 5-6.

24. Deficiencies in the Jail's Health Needs Request (HNR) and referral process are longstanding and well-known. Stewart Dec., ¶60; *see also* Ex. 8, Burns Dec. at 5, App. B at 1(noting the case of a prisoner who committed suicide after not being timely seen by a provider following an HNR and a referral from detention staff after the prisoner's mother called the Jail and reported her son was suicidal).

25. In her remedial plan, Dr. Burns recommended that the Jail revise its policy and practice to require mental health staff (MHAs and MHPs) to timely assess all prisoners who file a mental health HNR, and to refer to a provider those prisoners in need of additional treatment according to four triage categories (urgent, emergent, routine, no referral), each of which has a set timeline for the provider appointment. *See* Remedial Plan at 3. If fully implemented, Dr. Burns' recommendations could substantially reduce the risk of harm to prisoners in need of a mental health assessment by a psychiatrist. Declaration of Pablo Stewart, ¶ 61.

26. CHS policy does not track Dr. Burns' remedial plan. CHS J-E-07, Ex. E, Balaban Dec. at Bates 3407 000358. The policy does not require that mental health staff assign triage codes for mental health follow-up after seeing prisoners in response to an HNR. *Id.* Nor does the policy otherwise set criteria for when a provider referral is required. *Id.* A December 2011 QI study by CHS found non-compliance rates of 28% for the triage code and 35% for a timely assessment. *Id.*, ¶¶ 63, 67. Dr. Burns also found ongoing problems with referral responses in her last report. Ex. 10, Burns Dec., at 3 ("issues related to referral responses persist and were identified by me, the ACLU, and CHS.").

27. In many cases where detainees are in mental health crisis, suffering hallucinations and delusions, and unable to follow simple commands, they are not

1 timely seen by a psychiatrist, even when detention officers file multiple referrals
2 essentially pleading with mental health staff to remove actively psychotic prisoners
3 from the unit. Declaration of Pablo Stewart, ¶ 70.
4 **Deficiencies in MHU Care and Access to Hospitalization:**
5
6 28. The MHU is the designated treatment facility for the most seriously
7 mentally ill prisoners, and those the Jail determines cannot be adequately treated and
8 safely housed elsewhere. Declaration of Pablo Stewart, ¶ 74.
9 29. Defendants fail to ensure that seriously mentally ill prisoners receive
10 adequate care in the MHU. There are problems with the adequacy, frequency, and
11 intensity of the treatment interventions MHU prisoners receive. The most acute and
12 restrictive units (P-5, P-3, P-1-B) operate as lockdown units. Many of the prisoners
13 housed there, and others housed elsewhere in the MHU, require an inpatient level of
14 care that is not provided at the MHU. However, Defendants fail to hospitalize those
15 prisoners who cannot be adequately treated at the Jail. *Id.*, ¶ 75, 85, Ex. D at 20-39.
16 Examples of inadequate care in the MHU and poor access to hospitalization include the
17 following:
18 30. Prisoner DT was admitted to the MHU on July 5, 2013 for being
19 paranoid, selectively mute, and for repeatedly injuring his penis, which required an ER
20 trip. He was placed in restraints in the MHU on four separate occasions from July 10-
21 16, 2013 for a total of over 57 hours for repeatedly injuring his penis. Mr. DT had
22 languished essentially untreated in segregation for months before being moved to the
23 MHU, despite displaying symptoms of acute illness, refusing to engage with staff, and
24 being referred by detention staff for "playing with his own feces . . .regularly walk[ing]
25 around in his cell stripped down of his clothing with feces and urine covering his floor."
26 He eventually was taken to the ER after repeatedly injuring his penis, and then was
27 discharged back to the Jail and admitted to the MHU on July 5. Patient DT has
28 remained paranoid, non-compliant, and psychotic in the MHU. In addition to being
restrained four times over a five day period in early July, Dr. Picardo on July 17
ordered that patient DT be handcuffed to a dayroom table for 6 hours, and that staff

1 "Place mattress in front of him to prevent him from banging his head on the table."
2 Despite these restraint episodes, patient DT remains housed in the MHU, where he
3 remains psychotic and non-compliant. On August 4, Dr. Picardo wrote, "seen cell side.
4 He has been nude due to his repeated acts of aggression. Yesterday he was seen
5 injuring his penis again. Unpredictable violence towards others, inappropriate affect,
6 sits silent for long periods of time. Need to try medication, concern he has underlying
7 mood dx or psychosis in addition to personality dx." Dr. Picardo prescribed "for acute
8 agitation give Haldol 10 mg IM and Benadryl 50 mg IM BID PRN x 10 days." Patient
9 DT has refused all medications. Plaintiffs' mental health expert Dr. Pablo Stewart
10 interviewed patient DT during his recent visit to the MHU. He was nude, very guarded,
11 suspicious, and largely uncommunicative. He clearly is suffering from acute mental
12 illness. He has not received adequate care at the Jail, and requires inpatient care or
13 hospitalization. Ex. D. Stewart Dec. at 20-21.

14 31. Prisoner AN was admitted on Feb. 26, 2012, and transferred to the MHU
15 that day after refusing to participate in the intake process and displaying psychotic
16 symptoms. She remained in P-5 in the MHU until her May 9, 2012 discharge. During
17 her MHU stay, she was symptomatic and non-compliant with treatment and medication,
18 as well as medical tests. She required a higher level of care. On April 17, a nurse
19 wrote that Ms. AN was "naked standing in front of her cell door." She did not
20 communicate with staff other than to a nurse and demanded to be let out of her cell.
21 She was disheveled and dirty and her cell was full of torn up Styrofoam, food, and
22 feces. According to a report from the night shift RN, she was dry Tased the night
23 before. According to a May 3, 2012 SNTP, Ms. AN "continues to refuse treatment and
24 continues to trash her cell. She keeps herself and her cell is very dirty, and she pushed
25 her food and garbage out under the cell door. Ms. [AN] reacts with hostility to the staff
26 if they try to engage her in any way. She will stand motionless looking down at a spot
27 on the floor, not making eye contact with anyone. Alternatively, she will also break out
28 into phases of yelling and screaming, demanding to be let out and using profanity. She
also smears feces on the wall and still refuses to give UCG test and will not answer
safety questions. Lastly, she has made threating verbalizations to the psychiatrist."

That same day, Dr. Fangohr wrote, "Psychosis, declines all medications and treatment efforts." On April 26, 2012, Ms. AN was found incompetent and unrestorable in her criminal case, and her criminal court granted a PAD petition. She was transferred to Desert Vista on May 9, 2012. *Id.* at 26-27.

32. Patient TW was admitted on December 14, 2012 and released on December 29. He was prematurely discharged twice from the MHU. He should have been stabilized through the MHU before his first discharge, rather than discharged from the acute unit. On Dec. 18, Mr. TW was transferred to the MHU after a detention referral for odd behavior and talking to himself, and placement in custodial restraints for threatening others and aggression. The MHU admission order reads, "hostile, aggression, threatening to others, paucity of thought, disorganized." The next day, a mental health assistant (MHA) examined Mr. TW, who was confused, psychotic, malodorous and spoke in a word salad. Two days later, Dr. Balaji discharged Mr. TW directly from P-3 to general population. At that point, Mr. TW had been on medications for three days. Dr. Balaji found he was not as internally preoccupied as before. *Id.* at 31.

33. Two days after discharge, detention staff referred Mr. TW for psychiatric services for being disoriented and incoherent. He was readmitted to the MHU. On MHU admission, Mr. TW was religiously preoccupied and paranoid. On Dec. 28, Dr. Balaji once again ordered his discharge from MHU though he remained disorganized, internally preoccupied, and tangential. He was released from the Jail the next day. *Id.*

34. Prisoner IV was admitted to the MHU on May 9, 2013 after reporting delusions about her dead brother and persons in her cell who were pulling her legs and trying to kidnap her. However, within two weeks she was transferred back to general population, upon her request, despite the fact that she received little or no treatment while in the MHU and consistently refused medication, and was grandiose, malodorous, and verbose. On May 23, 2013, Dr. Fangohr discharged Ms. IV from the MHU while finding "unclear if any/much psychosis because unclear what is true." Dr. Fangohr noted "probable delusional disorder," and that she was not petitionable for her medication refusals. Ms. IV was re-admitted on June 1, 2013, for assessment for a

1 PAD petition. She remains delusional, inappropriate, and disheveled. She refuses all
2 medications or offers of treatment. Her SNTP was last updated on June 25, 2013, with
3 no indication that staff has sought to hospitalize her. She requires an inpatient level of
4 care. *Id.* at 36.

5 35. The admission criteria for the MHU are too high in practice and the
6 discharge criteria too low. As a result, seriously mentally ill prisoners languish in the
7 outpatient facilities, while clinically unstable patients are discharged back to these
8 facilities. Stewart Dec., ¶ 80, Ex. D at 20-39.

9 36. Problems with MHU care are well-known, longstanding, and documented
10 by Dr. Burns. *See, e.g.,* Ex. 8, Burns Dec. at 8 (finding "inadequate, incomplete
11 admission assessments; premature release; unilateral discharge decisions made by
12 MHU without discussion, [poor] coordination or continuity of care with outpatient
13 providers; [and] concerns about the frequency, intensity and quality of treatment
14 interventions in the MHU."). In her Ninth Report, Dr. Burns documented over a dozen
15 cases of prisoners who were receiving inadequate MHU care. Declaration of Pablo
16 Stewart, ¶ 79.

17 37. Dr. Burns recommended that the Jail develop and implement appropriate
18 MHU admission and discharge criteria to ensure that clinically unstable and seriously
19 ill prisoners are timely transferred to and remain in the MHU. *See* Remedial Plan at 4-
20 5.

21 38. Since issuing her remedial plan, Dr. Burns has continued to document
22 problems with delayed admission to and premature discharges from the MHU. In her
23 Seventh Report, Dr. Burns found that prisoners continued to be prematurely discharged
24 from the MHU, and to suffer at outpatient facilities, where the "clinical threshold to
25 refer a patient to a higher level of care [that] is too high." Ex. 8, Burns Dec. at 10.
26 Among the individual cases Dr. Burns cited was a prisoner who remained housed at
27 Durango despite growing increasingly psychotic over a month-long period and refusing
28 medications and assaulting staff. *See* Ex. 8, Burns Dec. at 6 (Patient #5).

39. In her Ninth Report, Dr. Burns again found that prisoners were
prematurely discharged from the MHU, and that the admission criteria for the unit were

1 too stringent. Ex. 9, Burns Dec. at 8. Among the cases Dr. Burns cited was a prisoner
2 who had multiple MHU admissions and attempted suicide at an outpatient facility after
3 a premature MHU discharge (*id.* at 22 patient MK), and another prisoner who suffered
4 multiple manic episodes and was non-compliant in the Special Management Unit
5 (SMU) but remained housed there. *Id.* at 25 (patient EM).

6 40. On November 21, 2012, CHS reported to Dr. Burns that problems persist
7 with the timeliness of MHU transfers, based on a record review that Dr. Burns asked
8 CHS to carry out. In that report, CHS concluded that one patient "clearly should have
9 been referred to the MHU more quickly," another "would have fared better with a
10 referral to MHU as she was not stabilizing," while another "was not timely referred to a
11 provider by mental health staff as she deteriorated." Ex. D**,** Balaban Dec. (CHS
12 Responses to ACLU Report on Visits in April and October 2012) at 1 (patient 1), 8
13 (patient 10), and 11 (patient 18). In several cases, CHS found that the failure to transfer
14 patients to the MHU in a timely manner resulted from poor communication between
15 CHS staff members. *See, e.g., id.* at 1 (patient 1's delayed MHU transfer "stem[med]
16 from communication issues between intake staff and outpatient staff, between MHPs
and psychiatrist, and between medical staff and psychiatrist.")

17 41. Many prisoners spend their entire stay in the MHU in the acute units, and
18 are not moved to the step-down units, which offer greater out of cell time and more
19 psychosocial rehabilitation services. These services are structured programs that are
20 critical for seriously ill prisoners in the MHU. Without them, these prisoners are at risk
21 of growing more ill, and of not responding fully to the treatment they do receive. This
22 deterioration can take many damaging forms, including increased symptoms, and non-
23 adherence to treatment. Stewart Dec., ¶¶ 86, 88.

24 42. Though P-3 and P-5 are intake units, many prisoners spend weeks or
25 months housed in these units with little or no psychosocial rehabilitation programming.
26 No psychosocial programming is offered to prisoners in P-3 and P-5-B. *Id.,* ¶¶ 86, 88.

27 43. In P-3 and P-5-B, the prisoners are locked down 24 hours a day. Many of
28 these prisoners are acutely ill and require an inpatient level of care, which is not
provided in the MHU. Many of their cells are littered with trash, used food cartons, and

rotting fruit. The conditions in which these prisoners live exacerbate their mental illness and undermine the treatment they do receive. *Id.*, ¶ 87.

44. It is common for prisoners to be admitted to the acute units, spend their entire MHU stays in those units, and be discharged from them, all without ever being stepped down to the other MHU units, which offer more therapeutic conditions and greater access to out of cell activities and programming. The step-down units are extremely underutilized. *Id.*, ¶¶ 89, 91.

45. The Jail's failure to utilize the step down units results in clinically unstable patients being prematurely discharged from the MHU, and often in their being transferred back to the MHU after they grow acutely ill and behaviorally impaired. *Id.*, ¶ 90.

46. Prisoners are often seen cell side by mental health staff and providers rather than in a confidential setting. This cell-side contact undermines the therapeutic relationship between patient and staff that is critical to adequate care. *Id.*, ¶ 93.

47. The Jail does not provide an inpatient level of care to prisoners housed in the MHU and elsewhere who need such care. Therefore, the Jail must ensure access to an outside facility that can provide this level of care. The Jail fails to ensure timely access to hospitalization and to an inpatient level of care. This includes prisoners who spend months locked in isolation cells for up to 22 hours daily. Their living conditions, coupled with the lack of adequate care, results in their unnecessarily suffering. Defendants also do not consistently and timely petition for COT orders (involuntary treatment orders) for prisoners in need of acute stabilization, and do not timely renew and utilize existing COT Orders. *Id.*, ¶ 94, 102, Ex. D, *e.g.*, at 21, 27-28, 34.

48. The problems with access to hospitalization are well-known and longstanding. In her remedial plan, Dr. Burns recommended that "Defendants . . . ensure that prisoners are timely transferred to a psychiatric facility when they cannot be adequately treated at the Jail." Remedial Plan at 6. Full implementation of Dr. Burns' recommendations is essential to providing timely hospitalization to those prisoners in need of that care. Declaration of Pablo Stewart, ¶ 96.

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49. While other jail systems around the country transfer prisoners deemed incompetent to proceed in their criminal cases to a forensic facility to be restored to competency, Maricopa has chosen to keep its Restoration to Competency (RTC) program at the jail. As a result, Maricopa RTC patients do not have access to the hospital-level care provided to RTC patients in other systems. *Id.*, ¶ 97.

50. In her Tenth Report, Dr. Burns found that RTC patients continued to experience "delays in access to an inpatient level of care." Ex. 10, Burns Dec. at 5. Dr. Burns wrote that these delays cause "needless suffering to the inmates themselves, poor utilization of MHU beds as 'holding cells' when other inmates could benefit from a longer course of treatment in the MHU and diversion of staff resources to manage/monitor psychotic inmates at the expense of providing treatment to other inmates." *Id.*

51. Similarly, in her Ninth Report, Dr. Burns found that RTC patients' access to hospitalization and involuntary treatment was delayed, resulting in "needless suffering and in fact studies have demonstrated that delays in providing treatment result in slower and less complete or robust responses to treatment when it is eventually provided." Ex. 9, Burns Dec. at 13.

52. The County has claimed that the courts will not order RTC patients hospitalized absent a conditional release.[1] Even if this were true, it begs the question why the County has chosen to place the RTC program in the jail, rather than at a hospital, while at the same time failing to contract with a hospital to accept chronically ill prisoners in need of an inpatient level of care. As a result of the County's choices, seriously ill prisoners are denied timely and appropriate care. Stewart Dec., ¶ 100.

Deficiencies in Outpatient Care

53. Defendants fail to ensure that seriously mentally ill prisoners housed in the Jail's outpatient facilities (LBJ outpatient, 4th Avenue, Estrella, Durango, and

[1] *See* Joint Status Report to the Court Regarding Dr King and Dr. Burns's Tenth Report (rec. 2128) at 25.

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Towers) receive adequate mental health treatment, and are timely transferred to the MHU or an inpatient psychiatric facility when they need that level of care. As a result, these prisoners unnecessarily suffer due to undertreated illness, and are put at unreasonable risk of victimization by their fellow prisoners. Declaration of Pablo Stewart, ¶ 104-114, Ex. D at 50-64. Examples of outpatients who received inadequate care include the following:

54. Prisoner IV was booked on December 19, 2012 and cleared for Estrella, where she remained until being transferred to the MHU on May 9, 2013. Many opportunities to move her to the MHU were missed during her Estrella stay. She was actively symptomatic but not adequately treated. On her December 31 H & P, Ms. IV told RN Diaz, "I am a government of all the USA and Mexico I am so rich." Ms. IV refused an assessment by mental health professional (MHP) Unsworth. There was no follow-up. Ex. D, Stewart Dec. at 50.

55. Detention staff filed four referrals for psychiatric services (3/21, 4/5, 4/7, 4/15) all reporting severe symptoms (4/5: "dorm mates say this inmate gets very angry and speaks to the devil." 4/15 "unknown individuals from Mexico trying to kidnap her"). She was not seen by a provider until April 11, when NP Burgett saw her. On exam she was grandiose, hyper religious, distracted. NP Burgett nevertheless found her stable in GP. "Bizarre behavior and HNRs but no functional impairment or safety risk severe enough to warrant petition for COT. Does not want medication now." Ms. IV should have been moved to the MHU for more intensive treatment. *Id.*

56. On April 23 detention staff filed another referral after Ms. IV told an officer a man was pulling her legs and she spoke to the Mexican consulate. She was not seen by a provider. By May 3, 2013, Ms. IV was on lockdown. She was moved to the MHU on May 9 after telling NP Burgett that she "died for 28 days. I was already going to the cemetery 15 years ago." *Id.*

57. Prisoner KH was booked on February 13, 2013. Dr. Stewart examined Mr. KH in the MHU, and he appeared to be psychotic. His cell was littered with empty food cartons and rotten fruit. His outpatient mental health notes show that he was not seen by a psychiatrist between March 7, 2013 (Dr. Allison) and August 8, when he was transferred to the MHU for "psychosis, possible PAD," according to Dr. Jaffe's MHU admission order. Mr. KH needed more attention before then by a psychiatrist. His records indicate that he has been responding to internal stimuli (March 7), treatment non-compliance without adequate follow-up (April 4, July 18), feces in the corner of his cell (noted by a detention officer on July 24). His medications (Haldol D and Cogentin) were discontinued by PA Fleming on June 24 without a face to face assessment due to Mr. KH's ongoing refusals. *Id.* at 51.

58. Prisoner NC was not seen at appropriate intervals at Estrella by a provider, and she remained in Estrella despite her acuity. Her treatment and medication refusals were not timely or appropriately addressed. Ms. NC was discharged from the MHU on April 23, 2012. On May 10, and MHP saw her after a detention referral for her complaints of recent assaults by her boyfriend. On exam, she was labile, but she was not referred to a provider. Through June, Dr. Drapeau reported Ms. NC was sad, depressed, and anxious (May 10, June 6). She deteriorated. On July 9, Dr. Drapeau met with Ms. NC and noted that she had an extremely inappropriate affect and seemed more psychotic than on her June 6th appointment. She reported hearing voices; she was rambling and poorly organized. On examination, she was paranoid, delusional, and inappropriate, with a tangential thought process. Dr. Drapeau also noted that Ms. NC needed medications but declined them. Yet Dr. Drapeau found her marginally stable for general population and merely ordered a follow-up provider visit in a month. A July 31 visit with an MHP, during which Ms. NC was "inappropriate" and tearful and frightened, did not result in referral to a provider. Ms. NC was not seen by a provider until August 29, when Dr. Drapeau observed that she looked psychotic and delusional,

and smiled for no reason, and stated that she hears voices. She also continued to refuse medications. Dr. Drapeau diagnosed her with schizophrenia, and noted that she "likely belongs on p-5 but she begged not to go." Ms. NC was found incompetent and unrestorable and discharged from RTC on September 26, 2012. *Id.* at 58-59.

59. A mental health program limited to medications is inadequate for many mentally ill prisoners. Mentally ill prisoners housed in the outpatient facilities must have access to a full range of mental health services necessary to provide adequate care. This includes individual and group therapy, active treatment planning, and pharmacological treatment. But the treatment for many seriously mentally ill outpatients is limited to medication management and monitoring by mental health staff that is not frequent enough given the patient's acuity. With little or no access to critical psychosocial rehabilitation services and timely access to a provider, many seriously mentally ill prisoners end up decompensating. Declaration of Pablo Stewart, ¶ 104.

60. Defendants fail to ensure that seriously mentally ill prisoners are seen at appropriate intervals by a provider. Instead, they are seen exclusively by MHAs and MHPs, who fail to refer them on to providers for inappropriately long periods, despite their acuity. This includes prisoners who have been prematurely discharged from the MHU while unstable, those who are psychotic, those who are refusing medications and treatment, and those who need to be moved to the MHU or an inpatient psychiatric facility for adequate care. *Id.,* ¶¶ 106, 107.

61. Seriously mentally ill prisoners who are not timely transferred to the MHU or an inpatient facility are at risk of harm from their fellow prisoners. *Id.*, ¶¶ 107-110.

62. The problems with outpatient care are well-known and longstanding. Dr. Burns sought to remedy many of them through her remedial plan. *See* Remedial Plan at 7-8. Dr. Burns' plan requires timely provider access as well as access to a full range of mental health services, using the three levels of care (SMI, mental health chronic care,

1 and jail mental health) utilized by CHS to categorize patients on its mental health
2 caseload. *Id.*, ¶ 111.
3 63. CHS Policy J-G-04 "Basic Mental Health Services: Outpatient Levels of
4 Care" does not comply with Dr. Burns' recommendations, and sets assessment intervals
5 that place prisoners at an unreasonable risk of harm. It does not set admission and
6 discharge criteria for the three levels of care (SMI, mental health chronic care or jail
7 mental health), as Dr. Burns recommended. It does not set frequency of interventions
8 by discipline; it merely sets intervals without regard to who actually sees the patient.
9 *See, e.g.,* CHS Policy J-G-04-6(g)(i), Ex. E, Balaban Dec. at Bates 3407 000413. (SMI
10 patients seen once every 45 days, no specification of staff level, no requirement for
11 provider appointments). There is not even a requirement that clinically unstable SMI
12 patients be seen by a provider. *See id.*(ii) (requiring that these patients be "seen 2 to 4
13 times per month until stable and/or medication compliant."). SMI patients refusing
14 treatment need not be timely referred to a provider. *See id.* ¶(6)(i). If that same patient
15 has a history of suicide attempts, he need only be seen by mental health staff (not a
16 provider) once monthly. *Id.* The policy does not require a provider assessment even if
17 an SMI patient refusing services with a history of suicide attempts becomes
18 symptomatic, or is decompensating. *See id.* The policy does not set the frequency of
19 treatment team meetings or treatment plan updates, as Dr. Burns recommended. It only
20 calls for an initial treatment team meeting to develop a special needs treatment plan.
21 Declaration of Pablo Stewart, ¶¶ 112-14.
22 64. The Jail's failure to adhere to Dr. Burns' recommendations contributes to
23 placing mentally ill prisoners at risk of harm in outpatient facilities. *Id.*, ¶ 111.
24 65. Since issuing her recommendations, Dr. Burns has continued to find
25 serious and ongoing problems with the provision of outpatient care. In her Seventh
26 Report, Dr. Burns found the "problems with outpatient care previously identified
27 continue to exist." Ex. 8, Burns Dec. at 10. Dr. Burns continued,
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> These issues are quite serious and include infrequent contact/treatment intervals, even when patients are not doing well; over-reliance on psychotropic medications as essentially the sole treatment intervention in many instances; contact in response to an HNR rather than pro-active, planned, clinically driven, and focused treatment interventions; poor continuity of care upon discharge from MHU; and concerns that the clinical threshold to refer a patient to a higher level of care is too high.

Id. at 10.

66. In November 2012**,** CHS also reviewed multiple records for prisoners in outpatient facilities who were not seen in a timely manner, including one who "was not seen in [the] Outpatient area for 2 months" after a positive mental health screening. Ex. D**,** Balaban Dec. at 6 (patient 8). In total, CHS' report to Dr. Burns describes some form of non-compliance in outpatient care in more than half of the relevant cases reviewed. *See id passim* (patients 1, 2, 3, 4, 7, 8, 10, 12, 14, 18, 19, 20, 29, and 31).

Deficiencies in Medication Administration Practices

67. There are longstanding and well-known deficiencies in medication administration at the Jails. Dr. Burns made specific recommendations designed to ensure timely and appropriate medication administration practices, and documented clinical decision-making. Remedial Plan at 8-9. The Jail's failure to fully implement them contributes to dangerous medication practices at the Jail. Declaration of Pablo Stewart, ¶ 116, Ex. D at 46-50; Ex. D, Balaban Dec. (Nov. 2012 CHS Report documenting instances when medications were not timely continued after intake, the patient was not timely assessed after initiating medications, or where medication non-compliance was not timely addressed) (patients 1, 10, 16, 18, 20, 26, 29). Examples of inadequate medication practices include the following:

68. Prisoner SA consistently refused her anti-psychotic medication (Risperdal) from October-December 2012. MHP Retter Rojas saw Ms. SA on November 18, and noted she had been refusing her medications, and that she was

1 symptomatic, but did not refer her to the provider. On November 27, Dr. Drapeau saw
2 Mr. SA, described her as "verbose rapid speech irritable anxious." She did not address
3 her medication non-compliance. On December 13, Ms. SA got into a violent
4 altercation with detention officers. Dr. Drapeau saw her cell side and wrote., "she had
5 been refusing Risperdal 1-2 months and I was unaware." Ex. D. Stewart Dec. at 47.
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7 69. Prisoner QS was diagnosed as SMI through Magellan. A mental health
8 evaluation on October 31, 2012 diagnosed her with Bipolar Disorder with psychosis, as
9 well as PTSD. At that time, she was prescribed Zyprexa, Prozac and Benadryl.
10 However, her medications were discontinued on March 4, 2013, after she refused them.
11 There is no progress note in the chart explaining why her medications were
12 discontinued. Low dose Risperdal was started on March 25, 2013, but was
13 discontinued on April 11, 2013, as well. It is not clear why she is not receiving any
14 medications at this point. Per her chart, she remains very psychotic and is suffering
15 from psychotic symptoms. She was never restarted on her medications. *Id.* at 48.
16 70. Prisoner LL received poor monitoring of medications and inadequate
17 medication administration at Estrella from April to August 2012. Ms. LL's medications
18 were changed repeatedly throughout March, April, and May, but Ms. LL was not timely
19 seen by providers for follow-up during this time. For instance, on April 28, Ms. LL had
20 a sub-therapeutic lithium level, which was noted in a lab signed by a nurse two weeks
21 later, on May 9. However, Ms. LL was not seen for follow-up for almost a month (May
22 25). Subsequent changes to medication were also not timely monitored. Ms. LL's
23 extra-pyramidal symptoms (EPS) were not timely addressed; a nurse noted Ms. LL's
24 possible EPS on April 10, but it was not until June 5 that a doctor noted Ms. LL
25 "clearly has bilateral EPS." Subsequent changes to medication were not properly
26 monitored; Ms. LL submitted an HNR on June 10 complaining of problems with her
27 new regime, but she was not seen by a provider again until July 18. Additionally, Ms.
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LL's medication non-compliance was not appropriately handled; she was noted as a no-show/not-in-cell for a number of Haldol dosages throughout April 2012. *Id.* at 48-49.

71. In order to ensure the timely verification and continuation of medications at intake, Dr. Burns recommended that the medications management policy "mirror the screening/intake policy in terms of the triage categories for psychiatric assessment as emergent, urgent, or routine referrals." Remedial Plan at 9. But CHS Policy J-G-01-02 "Psychotropic Medication Management" does not set timelines for either verification of reported medications, or for prescribing verified medications after intake. Ex. E, Balaban Dec. at Bates 3407 000394. Declaration of Pablo Stewart, ¶ 117. Defendants still do not have a reliable system that ensures that prisoners are continued on their verified medications after intake. *Id.*, ¶ 57.

72. Dr. Burns recommended that psychiatrists "must document a clinical rationale supporting their medication choices and any changes made, including changes from medications previously prescribed in the community." Remedial Plan at 9. Defendants have failed to follow this recommendation, creating an unreasonable risk of serious harm to prisoners. Ex. 8, Burns Dec. at 13 (Burns noting in her Seventh Report as "an area that continues to need improvement" that providers failed to document a clinical justification for not prescribing medications to 80% (21/26) of prisoners who reported medications at intake). CHS QI studies show that from November 2010-July 2013, on average 72% of prisoners who reported medications at intake did not have a documented clinical rationale for why they were not prescribed medications at the Jail. Stewart Dec. ¶119 fn. 5; *see also* Ex. C, Balaban Dec. Absent a documented clinical justification, there is no reason why a prisoner who has been prescribed psychotropic medications by a provider in the community should be denied those same medications when they are jailed. Stewart Dec., ¶¶ 119, 129.

73. CHS policies and practices are also inconsistent with Dr. Burns' recommendation that medications may not be renewed, changed, or discontinued

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without a face-to-face encounter except in documented unusual circumstances. Remedial Plan at 9. *See* CHS Policy J-G-01-02.II.F.1 (a provider may renew a medication without seeing the patient if the "medication regime would be interrupted."); *id.* ¶II.F.3 (a provider may change a patient's medication without seeing him if a "clear rationale is provided and there is no known risk to the patient."); *id.* ¶II.F.5 (a provider may discontinue medications without seeing the patient if a "clear rationale is provided and documented."). In practice, Defendants have failed to ensure that a provider timely sees a patient when changing or discontinuing their medications. This practice creates an unreasonable risk of harm. Declaration of Pablo Stewart, ¶¶ 120-125, Ex. D, *e.g.*, at 46-50.

74. Since issuing her remedial plan, Dr. Burns has continued to find problems with medication practices following intake, including failing to follow-up with patients after discontinuing their medications, and failing to document the rationale for clinical decisions. Ex. 9, Burns Dec. at 19 (noting "problems . . .at Estrella with respect to prescriber medication changes without a face-to-face assessment."); Ex. 8, Burns Dec. at 13-14 ("[T]here were many instances of medication adjustments (dosage changes, discontinuation, etc.) without the face-to-face assessments in the records I reviewed at Estrella.").

75. Defendants fail to ensure that patients refusing their medications are timely seen by a provider. A refusal of medications can indicate that a patient is clinically deteriorating, or is suffering side or adverse effects from the medications. Defendants' failure to ensure that these patients are timely seen by a provider increases the risks of their unnecessarily suffering due to increased symptoms, self-harm, victimization from other prisoners, or altercations with staff due to behavior that is a product of their mental illness. Declaration of Pablo Stewart, ¶¶ 126-127, Ex. D, *e.g.*, at 46-50, 58-59.

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76. The Jail's failure to refer to providers those patients who are refusing their medications is exacerbated by the fact that the Jail still uses a uses a defective medication administration record (MAR) that creates an unreasonable risk that prisoners who are refusing medications are not identified and timely referred to their provider. Declaration of Pablo Stewart, ¶ 128.

Deficiencies in Involuntary Treatment and Use of Force Practices

77. Involuntary treatment should only be used as a last resort when other measures have been tried and have failed. When treatment is forced on a patient improperly it harms the therapeutic relationship between patient and provider, which places the patient at an unreasonable risk of harm. *Id.*, ¶¶131-132.

78. Dr. Burns proposed changes in policy and practice regarding involuntary treatment procedures to ensure "that these treatment measures are used as a last resort when other measures have tried and failed or are impractical under the circumstances." Remedial Plan at 5. This recommendation, as well as Dr. Burns' other recommendations regarding involuntary treatment, are consistent with sound mental health practice. Defendants' failure to implement them has contributed to putting prisoners subject to involuntary treatment at risk of harm. Declaration of Pablo Stewart, ¶ 132.

79. CHS' Restraint Policy (Policy J-I-01, Ex. E**,** Balaban Dec. at Bates 3407 000470-472)) does not establish written criteria for when to initiate, maintain, or discontinue restraint use, as Dr. Burns recommended. The policy does require that the provider establish release criteria in the restraint order. CHS Policy J-I-01.2.b.v. But few if any provider orders actually establish written release criteria. Declaration of Pablo Stewart, ¶ 134.

80. CHS' forced medication policy does not require that forced medications be used only after less restrictive methods have failed. Rather, it allows forced medications to be ordered "when less restrictive or intrusive alternatives are not

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available or indicated, or would not be effective." CHS Policy J-I-02.2., Ex. E, Balaban Dec. at Bates 3407 000473; Declaration of Pablo Stewart, ¶ 135.

81. Prisoners may be placed in therapeutic restraints because they are injuring themselves, and/or pose an ongoing threat to others, and cannot be redirected. They may also be treatment and/or medication non-compliant. Defendants sometimes use restraints for exceedingly long periods of time, and restrain the same prisoner multiple times. These episodes can be indications that a patient requires a higher level of care or hospitalization. Declaration of Pablo Stewart, ¶ 136.

82. Restraints should not be used as a substitute for adequate treatment. Defendants have failed to ensure that prisoners restrained multiple times, or for long periods, have been timely transferred to a higher level of care, or hospitalized. *Id.,* ¶¶136-139.

83. For example, Prisoner DT 849158 was placed in restraints in the MHU on four separate occasions from July 10-16, 2013, for a total of over 57 hours, for repeatedly injuring his penis. Mr. DT had languished essentially untreated in segregation for months before being moved to the MHU, despite displaying symptoms of acute illness, and being referred by detention staff for "playing with his own feces . . . regularly walk[ing] around in his cell stripped down of his clothing with feces and urine covering his floor." He eventually was taken to the ER after repeatedly injuring his penis, and then was discharged back to the Jail and admitted to the MHU on July 5. Patient DT has remained paranoid, non-compliant, and psychotic in the MHU. He has not received adequate care at the Jail, and requires inpatient care or hospitalization Declaration of Pablo Stewart, ¶ 137.

84. After patient DT was restrained four times over a five day period in early July, Dr. Picardo on July 17 ordered that patient DT be handcuffed to a dayroom table for 6 hours, and that staff "[p]lace mattress in front of him to prevent him from banging his head on the table." Dr. Picardo did not document any less restrictive treatment that

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had failed with patient DT. This is a prime example of the improper use of restraints. There are many safeguards that must be followed for therapeutic restraints, and they were not followed here. Declaration of Pablo Stewart, ¶ 138.

85. Defendants have failed to ensure that providers document some clinical rationale supporting forced medications, and document other interventions that had been tried and failed before involuntary medications were ordered. Requiring a clinical rationale is important: it discourages unnecessary resort to forced medication. Declaration of Pablo Stewart, ¶¶ 140-141.

Deficiencies in Use of Force Practices on Mentally Ill Prisoners

86. In December 2011, prisoner Ernest "Marty" Atencio died after a violent altercation with at least 7 deputies in the intake area of the Fourth Avenue Jail. During the altercation Mr. Atencio was Tased. Before he was Tased, Mr. Atencio appeared to be passively resisting staff, with his hands at his sides. Declaration of Pablo Stewart, ¶ 142.

87. Mr. Atencio's family reported he had a history of mental illness, at least one of his arresting officers believed he was suffering from mental illness at the time of his arrest, and he reported at intake that he had a history of suicidal thoughts. *Id*.

88. Following Mr. Atencio's death, Lambert King, MD, the Court's medical expert, made a series of recommendations to address the problems he found in reviewing Mr. Atencio's treatment and death. Dr. King found that the Maricopa County Sheriff's Office (MCSO) Use of Force policy "contains no provision for prior consultation with mental health professionals whose advice, experience and capabilities might be utilized in an effort to avoid use of force on a mentally disturbed detainee who is passively resisting control." Ex. 9, Declaration of Lambert King, MD, FACP, filed herewith, at 21.

89. Dr. King's recommendation is in line with accepted correctional mental health practice. Declaration of Pablo Stewart, *¶* 144. Mental health staff have

specialized training that makes them especially equipped to de-escalate a potential confrontation with detention staff so that force need not be used. *Id.*, ¶¶144-145.

90. It is also a sound correctional practice to require mental health staff to attempt an intervention prior to a planned use of force with mentally ill prisoners and to document those efforts to intervene in the reports that follow a use of force incident. Declaration of Eldon Vail, ¶ 41. Jail and prison systems around the country require, when feasible, the involvement of mental health staff in planned use of force incidents involving mental health caseload prisoners. *Id.*, ¶¶ 42-44.

91. It is particularly important that mental health staff are involved in planned use of force incidents that are initiated by a mental health order. For example, a provider orders a patient to be moved for additional treatment (such as therapeutic restraints), the patient refuses orders to cuff up so he can be moved, and then force is used. In these circumstances, the provider should be consulted because in some cases the provider might decide to change or delay treatment, or provide treatment without moving the patient. At MCJ, providers never have the opportunity to make this clinical decision, since they are not notified when their patients are refusing to comply. As a result, these prisoners are exposed to an unnecessary risk of harm. Declaration of Pablo Stewart, ¶ 146.

92. The MCSO policy on use of force makes no reference to a mental health intervention in a planned use of force event. There is no policy requiring that mental health staff be notified when a mental health caseload prisoner is potentially subject to a planned use of force. Ex. E, Balaban Dec. at Bates 3407 002051-002055; Stewart Dec.., ¶ 147. The absence of such a requirement in a planned use of force event creates an unreasonable risk that seriously mentally ill prisoners will be subject to unnecessary harm. Declaration of Eldon Vail, ¶ 33.

93. Defendants fail to ensure that mental health staff are consulted and involved in planned use of force incidents, even when there is ample time for them to be notified and to attempt to de-escalate the situation, and even though the prisoners

may be so impaired that they cannot readily comply with an officer's orders. In these circumstances, the involvement of mental health staff is essential to assess the condition of the patient, and to intervene in an effort to de-escalate. Declaration of Pablo Stewart, ¶ 148.

94. There have been a number of incidents of planned uses of force against mentally ill prisoners in the MHU where there was ample time for mental health staff to respond to the scene and attempt to de-escalate the situation, but where there is no evidence that this intervention occurred. As a result, seriously mentally ill prisoners were subjected to force that may have been avoidable had mental health staff intervened. Declaration of Eldon Vail, ¶¶ 35-40; Declaration of Pablo Stewart, ¶¶148-152.

95. In one incident, a mentally ill detainee refused to leave her classroom cell. She was not posing a danger to herself or others, and there was time to involve mental health staff while the prisoner remained secured behind the locked classroom door. Mental health staff was not consulted or involved in an effort to de-escalate the situation and gain her compliance. She was Tased. Had mental health staff been consulted, they could have notified detention staff that the prisoner was pregnant. The MCSO policy on Tasers states, "officers who are aware a female subject is pregnant shall not use the TASER devise unless deadly force would be justified due to the danger created by the secondary impact or the possibility of muscle contractions leading to premature birth." This is clearly a case where deadly force would not remotely have been appropriate. Declaration of Eldon Vail, ¶ 36. The use of a Taser on a pregnant woman created an unreasonable risk of inducing labor. Declaration of Pablo Stewart, ¶150.

Deficiencies in the Disciplinary Process for Mentally Ill Prisoners

96. Defendants do not ensure that mental health staff is consulted when a mentally ill prisoner is charged with a disciplinary infraction. As a result, mentally ill

prisoners are at an unreasonable risk of being punished for behavior that is the product of mental illness. Declaration of Eldon Vail, ¶¶ 52, 53, 57, 61.

97. In her remedial plan, Dr. Burns recommended that the Jail revise its policies to ensure that mental health staff has meaningful input into the disciplinary process for prisoners on the mental health caseload. Remedial Plan at 11-12.

98. CHS policy J-A-08 (Communication on Patients' Health Needs) requires the following: "Health care professionals advise Detention staff of patients' special needs that can affect housing, work, program assignments, disciplinary measures, and admissions to and transfers from institutions." Ex. E, Balaban Dec. at Bates 3407 000021. This language does not require an "internal process that reviews . . . whether the mental health input is actually considered by security staff in their deliberations around disciplinary infractions," as Dr. Burns recommended. Declaration of Eldon Vail, ¶ 49.

99. MCSO Inmate Disciplinary Policy and Procedure DJ-2 also does not require consultation with mental health staff for disciplinary hearings conducted with mentally ill inmates. Ex. E, Balaban Dec. at Bates 035369-035373; Vail Dec., ¶ 50.

100. There is no place on the Disciplinary Actions Reports (DAR) form to indicate whether or not a consultation with mental health took place. Instead, in some reports there is a notation in the margin showing that a consultation did occur. *Id.*, ¶ 52.

101. Mental health staff are rarely consulted as part of a disciplinary hearing. Likewise, the disciplinary sanction proposed is rarely set aside or mitigated as a result of mental health input. *Id.*, ¶ 53.

102. There is no coherent system to track what is occurring in hearings for all mentally ill prisoners in the Jail who are charged with infractions. The lack of a structured system articulated in policy and followed in practice creates an unnecessary risk of harm to mentally ill prisoners. *Id.*

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103. A sanction regularly and routinely applied to mentally ill inmates found guilty by an MCSO hearing officer is disciplinary segregation. *Id.*, ¶ 54. Placing seriously mentally ill prisoners in long-term isolated housing as a result of disciplinary sanctions can create an unreasonable risk of harm of their decompensating. Declaration of Pablo Stewart, ¶¶ 196, 197.

104. Mentally ill prisoners are sentenced to segregation for up to thirty days after being found guilty of relatively minor behavior by MCSO hearing officers. One mentally inmate was found guilty because an American flag sticker had been removed from the wall of his cell. His sanctions were thirty days disciplinary segregation, thirty days of full restriction and seven days of nutra loaf meals. Another inmate, found guilty of the same behavior, was sanctioned to seven days of disciplinary segregation, full restriction and nutra loaf. In neither of these cases was there any indication there was a consultation with mental health staff before assigning these severe sanctions. Declaration of Eldon Vail, ¶¶54-56.

105. There are numerous instances of mentally ill prisoners being punished for behavior that potentially was the product of their mental illness. These include a prisoner who refused to leave disciplinary segregation after his disciplinary time had ended, and was given 15 more days in disciplinary segregation; a prisoner given 30 days in disciplinary segregation for masturbating in his cell and laughing when told by the officer to cover himself up; and a prisoner who covered his cell windows, defecated and urinated on a paper and shoved it under his cell door, and was forcibly extracted from his cell, and given 30 disciplinary segregation and thirty days full restriction. In each of these examples, the prisoner was found guilty without the benefit of a mental health consultation that may have shown the behavior was solely a result of their mental illness. Declaration of Eldon Vail, ¶ 57.

Deficiencies in Suicide Prevention

106. The conditions under which prisoners are kept on suicide watch in the MHU are so punitive that some suicidal prisoners will deny their suicidality in order to be released from these conditions. Systemic deficiencies in mental health care at the Jail also contribute to the risk that suicidal prisoners will commit suicide. Declaration of Pablo Stewart, ¶ 153.

107. There have been at least five suicides at the Jail since December 10, 2010. In each, problems with the care these prisoners received contributed to the risk of their committing suicide. Declaration of Pablo Stewart, ¶¶ 155-188.

108. Patient JC committed suicide on Feb. 26, 2011. Dr. Burns found the following problems with Mr. JC's care: no treatment to prevent or ameliorate alcohol withdrawal, no system to flag the patient's history of suicide attempts and risk factors that should warrant an immediate referral, and no referral from medical staff for a known history of depression and suicide attempt. Ex. 8, Burns Dec. at App. B at 2-3 (patient #2). There is an ongoing problem with medical staff failing to refer to mental health patients in mental health crisis, and those with positive mental health findings in their H & P's. Declaration of Pablo Stewart, ¶¶ 155, 161, 162.

109. Prisoner SC hanged himself on February 27, 2011. Dr. Burns identified the following deficiencies in the care of Mr. SC: the threshold for referral to psychiatry was too high, the patient was not assessed in response to a second medical referral, there was a lack of a comprehensive suicide risk assessment, and the follow-up interval of two weeks that mental health staff ordered for Mr. SC was too long given that he was in acute distress when seen. Ex. 7, Burns Dec. at App. B at 4 (patient #3). There are ongoing problems with a too-high threshold for being referred to a provider, untimely assessments following referrals, and follow-up intervals for outpatients in acute distress remaining too long. Declaration of Pablo Stewart, ¶ 171.

110. Prisoner CF committed suicide on December 10, 2010. Dr. Burns reviewed Mr. CF's suicide, and identified the following problems regarding his care: a failure to follow-up on an HNR complaining of depression; an inadequate evaluation by the MHP on November 28, 2010 after Mr. CF threatened to hang himself; no referral to a provider for the suicide threat; no suicide risk assessment; an inappropriately long follow-up interval planned for the patient; and no timely follow-up by the provider following a telephone order for anti-anxiety medications. Ex. 8, Burns Report at App. B at 1 (patient #1).

111. Many of the problems Dr. Burns identified as contributing to Mr. CF's suicide continue to plague the Jail: nursing staff do not consistently refer to mental health prisoners in acute psychiatric distress, MHAs and MHPs do not timely and appropriately refer on to providers prisoners who require treatment by a psychiatrist, mentally ill prisoners in the outpatient facilities are not seen at appropriate intervals, and there is not consistent psychiatric follow-up to telephone orders for medication. Declaration of Pablo Stewart, ¶ 180.

112. CHS conducted reviews of the care provided to all three prisoners identified above, and even developed action plans to correct the deficiencies in their care that may have contributed to their committing suicide. Compliance with the action plans has not been consistently measured via quality improvement studies, and these reviews did not result in concrete improvements to practice that corrected all of the shortcomings in these prisoners' care. *Id.*, ¶¶ 161-165, 171, 177.

113. Prisoner AH committed suicide on July 21, 2013. He reported a history of suicide attempts at both booking and to mental health staff. Three weeks before his death, he asked a provider to be put back on Abilify, on which he had had good results. He was not put back on his reported medications. Rather, he was started on a different medication, but there was no clinical justification given as to why he was not restarted on a medication that worked for him. He made several complaints that his new

1 medication was ineffective and of ongoing anxiety, but he did not receive Abilify
2 before he hanged himself. *Id.,* ¶¶ 181-186. The problem of providers failing to
3 document a clinical justification for declining to continue prisoners on their medications
4 is longstanding. Ex. 8, Burns Dec. at 13 (Burns noting in her Seventh Report as "an
5 area that continues to need improvement" that providers failed to document a clinical
6 justification for not prescribing medications to 80% (21/26) of prisoners who reported
7 medications at intake).
8 114. Patient LH P954608 committed suicide by hanging on March 23, 2013.
9 He committed suicide one day after being taken off of suicide watch and transferred to
10 MHU P-1 No mental health staff assessed Mr. LH for the entire time he was on MHU
11 P-1. He went from close monitoring on suicide watch to no monitoring in the 22 hours
12 before his death. Also, Mr. LH was able to hang himself in the unit used to step down
13 prisoners immediately after being taken off suicide watch. That unit should not have
14 hanging points which would allow a prisoner coming off suicide watch to hang himself.
15 *Id.,* ¶¶ 187-188
16 115. The danger of prisoners attempting suicide immediately after being taken
17 off suicide watch is exacerbated by the punitive conditions that prisoners endure on
18 suicide watch in the MHU. Prisoners regularly are stripped of all clothing, and given
19 only a safety smock. They are locked down in their cells 24 hours a day. Their daily
20 human contact can be limited to cell side interactions with mental health staff. These
21 punitive, isolating conditions do not help a patient become less suicidal. And they raise
22 the risk that in future these same prisoners will hide their true suicidal feelings because
23 they do not want to be exposed to such conditions. Declaration of Pablo Stewart, ¶
24 189.
25 116. The 4th Avenue Jail is the main intake facility for MCJ. It is critical that
26 intake facilities like 4th Avenue have in place adequate systems to monitor prisoners at
27 risk of self-harm. An adequate suicide prevention system must include observation
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cells that allow an officer or staff to see any and all prisoners in those cells. Direct visual observation is the standard of care for suicidal prisoners: video observation can be an adjunct, but never a substitute, for direct observation. *Id.*, ¶ 192.

117. At 4th Avenue, prisoners identified at risk of self-harm are placed in safe cells until they are either cleared by mental health staff, or can be transported to a hospital or the MHU for additional monitoring. The window in these cells is too high for an officer or staff of average height to be able to observe all areas of the safe cell. Declaration of Pablo Stewart, ¶ 193.

Deficiencies with Mental Health Care for Segregation Prisoners:

118. There is an enduring population of seriously mentally ill prisoners at the Jail who are housed in isolated confinement. Locked down in single cells for 22-24 hours a day, they enjoy little human contact, have little or no access to programming, extremely limited access to recreation, and in the Special Management Unit (SMU) endure the harshest living conditions. Prisoners subject to isolated confinement are those housed in the acute units of the MHU (P-3 and P-5-B), those single-celled in Estrella's closed custody and segregation units, where there is also no programming in three towers; and those in the SMU. Declaration of Pablo Stewart, ¶ 194.

119. The SMU conditions are particularly harsh. Prisoners there are secured behind two security doors. They are locked down at least 22 hours daily. The only times they are daily released from their cells is for one hour of exercise alone in a walled area next to their cells, and an hour to use a small anteroom equipped with a phone. The configuration of the unit makes it exceptionally difficult for them to communicate with fellow prisoners. A number of seriously mentally ill men are housed there, in filthy and hazardous conditions. *Id.*, ¶ 195.

120. Mentally ill prisoners are prone to have their mental illness deteriorate and decompensate under isolated conditions. This deterioration often takes the form of acting out and otherwise behaving in ways that constitute rule infractions. Their illness

exacerbates the psychological and behavioral reactions they have to the pain and stress of isolated confinement (in an environment that they should never have been placed in, in the first place). Declaration of Pablo Stewart, ¶ 196.

121. There is a well-settled body of scientific literature that establishes the risk of harm posed to seriously mentally ill persons who are placed in isolated confinement. The recognition of this risk has led professional mental health organizations to prohibit the placement of the seriously mentally ill in such units or, if it is absolutely necessary (and only as a last resort) to confine them there, but under strictly limits and with significant amounts of out-of-cell time and enhanced access to care. For example, the American Psychiatric Association ("APA") has issued a Position Statement on Segregation of Prisoners with Mental Illness stating:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. [2]

Declaration of Pablo Stewart, ¶ 197.

122. The Jail disregards a substantial risk of harm to seriously mentally ill prisoners by placing them in isolated confinement, and providing them with inadequate care while housed there. The harsh conditions in the Jail's lockdown units, particularly in the SMU, require enhanced care and monitoring of the seriously mentally ill, but at the Jail, they receive less effective care in these units than in the general population. Declaration of Pablo Stewart, ¶ 199, Ex. D at 39-46. Examples of inadequate care for prisoners housed in segregation include the following:

123. Prisoner BV has remained housed in the SMU since September 2012. He does not engage in treatment, is seriously ill, and refuses medication and treatment. There are no provider assessments in his record from September 19, 2012-July 23,

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[2] AM. PSYCH. ASSOC., POSITION STATEMENTS: SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2012), *available at* http://www.psychiatry.org/advocacy--newsroom/position-statements.

2013. He should not be housed in the SMU. He requires an inpatient level of care. Ex. D, Stewart Dec. at 39.

124. On January 4, 2013, Mr. BV received a DAR for refusing to leave his unkempt cell. When he was removed, bedbugs were found in his mattress and linens. He was not referred to mental health staff. *Id.*

125. There are periodic notes through July 2013 reporting Mr. BV is malodorous, non-compliant, refusing medications, and responding to internal stimuli (e.g. MHP notes of November 27, 2012, November 28, 2012, January 10, 2013, March 1, 2013, April 9, 2013, May 22, 2013). He was not referred to a provider after any of these encounters, and nothing happened with his treatment. On July 18, MHP Berman saw Mr. BV cell side, and wrote, "sheet is wet, floor out to hall is flooded, trash and food littered on floor. Pt says shower caused flood. Makes popping sound with his mouth, said he does it to pass the time. Says mood is fine. May be experiencing internal stimuli, is distracted. Disheveled, dirty, malodorous. May be activity psychotic and responding to internal stimuli. May need PAD, will increase f/u." Five days later, NP Burgett saw Mr. BV. This is the first documented provider encounter since September 2012. NP Burgett wrote, "Cell is in disarray, clothes stuffed in toilet. Says doing well. Says getting out soon. Affect constricted. Assessed as schizophrenic d/o. Barely stable in close custody. Surprisingly coherent and organized in speech." *Id.* at 39-40.

126. Dr. Stewart examined Mr. BV, who was malodorous and appeared to be responding to internal stimuli although he was vehemently denying experiencing any psychotic symptoms. He is not being treated with any psychotropic medications for unclear reasons as he is clearly gravely disabled. He requires an inpatient level of care. *Id.*at 40.

127. Prisoner MM was incarcerated from January 23, 2013-March 14, 2013. She was cleared for lockdown housing at Estrella despite her acuity at intake and her

confirmed mental health history. She remained in lockdown housing during her entire jail stay. She received inadequate treatment while in lockdown. *Id.*

128. Ms. MM's January 23 intake mental health screening and Magellan records confirm she is active SMI and has a current COT Order (exp. 2/4/13). The screen noted that Ms. MM refused to answer questions. On January 24, Dr. Crisham wrote that Ms. MM is SMI through People of Color Network, a county mental health provider. Per the Magellan record, Ms. MM was reported as being at times agitated, aggressive, and sometimes refusing medications and appointments. Dr. Crisham noted that Ms. MM refused to participate in the interview after initially responding to questions. Dr. Crisham ordered Prolixin 5 mg q am, 10 mg q hs, Vistaril 50 mg q hs, Cogentin 2 mg bid, Depakote ER 400 mg bid, and Prolixin d 50 mg IM q 2 weeks. Dr. Crisham cleared Ms. MM for Estrella, despite her non-compliance with the interview. *Id.* at 40-41.

129. On January 30, Dr. Drapeau reported that Ms. MM thought she could let her out of jail by calling a judge. She told the provider that she will take shots for all medications except Tegretol. Dr. Drapeau also noted some delusions and reported that she said "you never know who invented the cell phone." Dr. Drapeau nevertheless found Ms. MM stable for lockdown housing. *Id.* at 41.

130. On January 31, CHT de la Torre wrote that the patient was scheduled for a blood draw which was not done due to Ms. MM discontinuing the medication on her own. She was not referred to mental health staff. Her refusal was not addressed. *Id.*

131. On February 4, MHP Page recorded seeing Ms. MM cell side. She refused a confidential visit and was reportedly lying on her bed yelling, "what do you have to talk about, what do you have to talk about." *Id.*

132. On February 15, MHP Espinoza saw Ms. MM at her cell door acutely at detention officers' request. The patient was reportedly yelling and talking about needing a double dose of medication. She reported that they are talking to her through

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the speakers and accusing her of killing someone. Ms. MM was reportedly alert and oriented, but more delusional today. Her hygiene was good and her cell clean. MHP Espinoza wrote that there were no self-harming behaviors. MHP Espinoza planned for her to see a psychiatrist that day. Dr. Drapeau did order Prolixin D 50 mg IM q 2 weeks, Prolixin 10 mg q am 20 q hs, Vistaril 50 mg q am 100 mg q hs, Cogentin 2 mg bid, Tegretol ER 400 mg bid, all x 90 days. But, there is no corresponding note from Dr. Drapeau. On February 25, Ms. MM's labs showed Tegretol low 3.8 (8-12). The labs were countersigned by Dr. Drapeau on February 27, but Dr. Drapeau did not see her. *Id.*

133. On February 26, MHP Page wrote that Ms. MM was not seen in a confidential space. She reported that she does not need mental health services and asked about information from 1998 when she was incarcerated. *Id.* at 42. Ms. MM was released on March 14, 2013. She was not seen by a provider in the last 7 weeks of her incarceration. *Id.* at 42.

134. Prisoner ML has a documented mental health history, including treatment via Magellan and a COT Order (exp. September 8, 2012). Mr. ML is housed in the SMU despite his acuity. He requires an inpatient level of care. *Id.* at 45.

135. On May 3, Mr. ML saw Dr. Frazier at the request of the psychiatric provider for refusing his Depakote. He denied being mentally ill and said medications would kill him. On May 13, PA Fleming re-ordered Depakote 500 mg po bid x 90 days without seeing Mr. ML. PA Fleming next saw Mr. ML two weeks later, on June 4, and wrote, "stopped Depakote because he is sure he is not mentally ill. Denies ah/vh. Tangential thought processes and paranoid delusional thought content." Two days later, PA Fleming again saw Mr. ML cell side. On exam, he was irritable and paranoid, and refused services. *Id.* at 45-46.

136. Dr. Stewart examined Mr. ML, who was very psychotic with very loosely associated thoughts and very delusional thought content. He went on at length about

how he is not mentally ill. The patient refused both his Depakote and his Risperdal and the staff really did not do anything to encourage him to take these medications. He is very ill and requires a much higher level of care than he is currently receiving. *Id.* at 46.

137. The problems with inadequate care in the lockdown units are well-known and longstanding. In her Ninth Report, Dr. Burns wrote, "In general, inmates in SMU housing are locked down and isolated during their jail stay. In some instances, this may be for periods of months or years. The long-term effects of segregation of all inmates, and particularly SMI inmates, are well known." Ex. 9, Burns Dec. at 17. Dr. Burns found that there were a number of prisoners who had bounced between the SMU and MHU multiple times, and recommended that these cases be discussed collectively. She concluded, "[T]here is a general consensus that permitting SMU inmates access to out-of-cell opportunities for structured therapeutic activities would be beneficial for all involved (more normal and therapeutic interactions for the inmates, fewer crises and adverse incidents, easier management from a custody perspective with less call for use of force, cell extractions, etc.) The SMU environment is harsh for the inmates as well as the people [who] work there." *Id.* at 18.

138. Dr. Burns also reviewed several cases of prisoners who had received inadequate care while housed in Estrella segregation, and those whose closed custody (CC) status interfered with adequate care. These included patient MM, a well- known SMI patient who was discharged from the MHU in spite of her ongoing psychosis and "sent to closed custody where access to care [is] highly problematic." *Id.* App at 31. Dr. Burns concluded, "[c]losed custody classification presents problems with inmate movement/participation in treatment in P6 [The MHU's female step-down unit] and there are no structured therapeutic activities in segregation at Estrella." *Id.* Dr. Burns also reviewed the record of patient CG, who was discharged from the MHU to Estrella and not seen at appropriate intervals though she was considered for MHU readmission.

Id. App at 31. Dr. Burns found, "[d]ocumentation indicates inmate was seen at cell front due to 'safety concerns' but further investigation indicates she is *seen at cell front due to detention staff enforcement of security protocol for closed custody inmates*—not because mental health staff are concerned about their safety." *Id.* (emphasis in original).

139. Dr. Burns found eight months later that "[i]ssues associated with isolation in the 4th Avenue Special Management Unit (SMU) housing persist." Ex. 10, Burns Dec. at 8. Dr. Burns noted that, beyond visits by mental health staff on rounds and by provider for medication management, SMU prisoners "receive little treatment other than medication unless transferred to the MHU." *Id.*

140. Defendants fail to ensure that adequate mental health care is provided to prisoners with mental illness in the Jail's segregation units, particularly in the SMU. This population has a very high level of acuity. For many of these prisoners, psychosocial rehabilitation services are an essential element of care, especially in the harsh conditions of isolation. Yet there are no psychosocial services provided for SMU prisoners, and no programming for almost all of the women housed in Estrella's lockdown units. Declaration of Pablo Stewart, ¶¶ 204, 205.

141. Defendants fail to ensure that isolation unit prisoners are seen at appropriate intervals by mental health staff. They are denied timely access to a psychiatrist and they shuttle between the MHU and the lockdown units without any consideration by qualified staff as to the effect of lockdown housing conditions on their mental health. They remain housed in the SMU and Estrella segregation despite being actively psychotic and non-compliant with treatment. Declaration of Pablo Stewart, *¶* 206.

142. For SMU prisoners, virtually all of their contacts with mental health staff occur at their cell doors. The lack of an appropriate confidential contact compromises the care these patients receive. Declaration of Pablo Stewart, *¶* 207.

143. There is no valid penological justification for Defendants' practice of denying prisoners in the SMU access to a private treatment room for a mental health assessment, while allowing prisoners to receive medical services in private treatment rooms. A prisoner undergoing a mental health assessment presents no greater a security risk than when the same prisoner is receiving medical services. While there may be some prisoners who need additional security to ensure safety for prisoners and staff, that is appropriately handled on an individual basis. Declaration of Eldon Vail, ¶62.

144. Defendants have failed to institute adequate safeguards to ensure that seriously mentally ill prisoners are excluded from isolated confinement housing when clinically contraindicated. Declaration of Pablo Stewart, ¶ 208.

145. The only regular monitoring of mentally ill prisoners by mental health staff are segregation rounds that appear from the records to be brief, empty contacts that rarely, if ever, result in referral to providers or enhanced care. Declaration of Pablo Stewart, ¶ 210.

146. Placing seriously mentally ill prisoners in the Jail's isolation units, particularly the SMU, poses an especially serious risk of harm. The combination of toxic conditions and inadequate care endangers these patients' health and safety. *Id.*, ¶ 211.

Deficiencies in Specialized Staff Training Regarding Mentally Ill Prisoners

147. In January 2011, Dr. Burns recommended that Defendants "review [their] detention officer training curriculum to revise or supplement it for officers assigned to posts dealing with mentally ill inmates;" namely, those assigned to intake, the MHU, and the Jail's segregation/isolation units. Ex. 5, Burns Dec. at 25. Dr. Burns was prompted to make the recommendations after a series of incidents where MHU prisoners who were already in restraints were assaulted by detention staff. *Id.* Dr. Burns recommended that Defendants model their additional training on Crisis Intervention Team (CIT) training, which in other jurisdictions had reduced the

incidence of arrests, assaults, and injuries to both law enforcement officers and the mentally ill. Dr. Burns concluded, "[R]eviewing and supplementing the curriculum for detention staff assigned to posts dealing with inmates most at risk and at highest risk of serious mental health problems would likely yield similar beneficial results in the jail." *Id.*

148. Four months later, Dr. Burns reviewed general mental health materials related to the training provided to all detention officers, and found it appropriate, but continued to recommended a review of the curriculum "in order to revise or supplement it as necessary for officers assigned to posts dealing with inmates most at risk and at highest risk of serious mental health problems (booking/receiving area, MHU and all segregation unit posts). Ex. 7, Burns Dec. at 8. In her Seventh Report, Dr. Burns noted that all MHU officers had received an additional 30 minutes of training "on the topics of trauma, stress, and compassion fatigue/self care." Ex. 8, Burns Dec. at 16. Dr. Burns did not identify additional training for segregation unit or intake staff, and has not reported on any additional training since issuing her Seventh Report.

149. The training offered to MCSO detention staff to prepare them to work with mentally ill prisoners is not effective. There is inadequate specialized training for those assigned to work in mental health units. This training is a critical element to successfully manage the mentally ill in a confinement setting. Declaration of Eldon Vail, ¶ 21.

150. MCSO detention employees receive annual training for a two and a half hour class called Handling the Seriously Mentally Ill. This training appears to be a broad overview of subject matter related to working with the mentally ill that is targeted for a class of people who do not regularly or routinely work with that population. It is not of sufficient length or depth to prepare correctional officers to work with the mentally ill on a daily basis. Declaration of Eldon Vail, ¶ 67.

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151. The deposition transcripts of some detention officers involved in the events leading to the death of Ernest Atencio support this conclusion. In each deposition when asked about the training they received regarding mentally ill inmates, detention officers were unable to recall what they were taught. *Id.*, ¶ 68.

152. Given the officers' lack of retention of the information presented in the training materials, as reflected in the depositions, the training they received was not effectively reinforced in the workplace. Declaration of Eldon Vail, ¶ 69.

153. Officers assigned to work in the MHU must be carefully selected as having the capacity to work with this population, and then they must be extensively trained on an ongoing basis in conjunction with mental health staff to emphasize that it takes both disciplines working together to successfully manage the mentally ill. The evident lack of specialized training contributes to an unreasonable risk of seriously mentally ill prisoners being punished for behavior that is the product of mental illness, and planned use of force incidents occurring without the involvement of mental health staff. Declaration of Eldon Vail, ¶ 70.

Deficiencies in the Jails' Quality Improvement Program:

154. The Jail has not instituted an adequate system to review internally its mental health care system to ensure that it is providing adequate treatment. An adequate quality improvement (QI) system is an essential element of a correctional mental health care system, because it leads to identifying and correcting systemic problems with mental health care. CHS has developed action plans after critical incidents such as suicides. But it has not produced QI studies showing whether those critical action items have been implemented. Declaration of Pablo Stewart, ¶¶ 214-215.

Systemic Deficiencies in the Medical Care System at MCJ Place Patients at a Major Risk of Harm

155. A health care system must be able to meet the serious medical needs of all detainees – both those who are generally in good health as well as those who suffer

1 from serious or even life-threatening conditions.[3]

2 156. Dr. Robert L. Cohen, MD was retained by Plaintiffs' counsel to provide
3 expert opinions concerning the medical care provided to detainees at the Maricopa
4 County Jail. Cohen Decl. ¶1.

5 157. The most meaningful way to assess the care provided by a system is to
6 look at those patients who have medical needs that require the system to function in a
7 coordinated, efficient, and compassionate manner. Cohen Report at 2-3.

8 158. Accordingly, reviewing the charts of healthy, 20-year-old patients does
9 not permit a comprehensive assessment of access to and quality of care. Cohen Report
10 at 2

11 159. The operative concept in assessing a health care system is to identify risks
12 of harm, regardless of whether those risks materialized into actual poor outcomes.
13 Cohen Report at 3.

14 160. Health care in a jail, like health care in the community, is an organic
15 system. Accordingly, it is difficult to divide it into individual, discrete components. It
16 is difficult to identify distinct and separable aspects of care that are in need of
17 remediation as many of these aspects overlap. Cohen Report at 4.

18 161. Taking these aspects of care together and individually, detainees at MCJ
19 do not receive adequate care to meet their serious health needs. Cohen Report at 4

20 162. These deficiencies in care are endemic to the system. Cohen Report at 4.

21 163. CHS and MCSO have been aware of these deficiencies for years. CHS
22 and MCSO were periodically reminded of several of these deficiencies by Dr. King's
23 reports. CHS and MCSO have had several years to remedy them but have not done so.
24 Cohen Report at 4.

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27 [3] Dr. Robert L. Cohen, MD, Report on Medical Care at the Maricopa County Jail,
November 18, 2013, attached to Declaration of Robert L. Cohen (hereinafter, "Cohen
28 Report") at 2.

164. In addition to the deficiencies previously identified by Dr. King, there are other areas in which deficiencies place patients at risk of significant harm. Cohen Report at 4. Multiple aspects of the continuum of care at MCJ are wholly inadequate. Cohen Report at 18.

165. Although CHS has made progress since 2008, deficiencies in care continue to place patients at a major risk of serious harm, including risk of pain, deterioration of health, unnecessary morbidity, and death. Cohen Report at 4.

166. Ameliorating the risks posed to patients is imperative and will require considerable effort and additional resources. Cohen Report at 4.

Deficiencies in Screening and Intake

167. Intake includes screening incoming detainees for health issues, ensuring continuity of care from the community, initiating necessary health care, timely provision of indicated medications, and access to health care staff and facilities appropriate to meet identified health needs. Cohen Report at 4.

168. CHS uses a screening form with questions about various medical issues.[4]

169. However, the screening process should not end with the completion of a form. Rather, the data obtained at screening must be used to identify patients in emergency or urgent need of medical attention and then ensure that those patients receive such medical attention on a timely basis. In addition, intake screening data must be used to continue critical medications. Cohen Report at 5.

170. A "provider" means a physician, physician assistant, or nurse practitioner. A nurse is not a "provider." Cohen Report at 13 n.6.

171. In most cases patients identified at screening as having serious acute or chronic medical conditions must be seen on an emergency or urgent basis by a provider. This is the only way that a proper plan of care can be developed and to ensure that

[4] Defendants' Statement of Facts, Doc. No. 2158, at ¶¶12, 50.

unstable patients are not forgotten about until and deteriorate to the point of needing (preventable) hospitalization – or to the point of death. Cohen Report at 5.

172. Dr. King, the Court's medical expert, recommended that "all patients with significant acute or chronic medical conditions" should have "'a hands-on'" physical examination and completion of an initial assessment and plan to include the ordering of medications, pertinent labs and a scheduled follow-up specific to their needs." Dr. King advised that "[t]he foregoing tasks will be completed no later than 24 hours after jail entry, and in most cases much sooner."[5]

173. Dr. King also recommended that all persons found to have clinically significant findings during screening should have an initial health assessment no later than 24 hours following screening. King Sixth Report at 35-36. Dr. King "worked closely with CHS' executive leaders" in making the above recommendations. King Sixth Report at 32.

174. Even after CHS began 24-hour provider coverage at intake Dr. King wrote that "I don't think there is a convincing set of data documenting increased volume of face-to-face evaluations by providers of patients with serious acute and chronic medical conditions. There appear to be gaps in the degree to which clinicians are documenting their work, both with respect to entries in medical records and in recording specific types of encounters for purposes of statistical tracking and analysis."[6]

175. Dr. King also observed that "…there continue to be instances in which complicated patients with serious medical needs [ ] are not being assessed and treated

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[5] Dr. Lambert N. King, MD, PhD, FACP, Sixth Report on Medical Compliance with Second Amended Judgment, March 31, 2011, attached as Exhibit 7 to the Declaration of Lambert King (hereinafter, "King 6th Report") at 35-36.

[6] Tenth Report of Lambert N. King, MD, FACP on Correctional Medical Services Compliance with Second Amended Judgment, January 2013, attached as Exhibit 10 to the Declaration of Lambert King (hereinafter, "King 10th Report") at 4, 19 ¶1.

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by physicians, physician assistants or nurse practitioners during the first 24 hours after receiving screening." King 10th report at 20 ¶2.

176. There is a maxim in medicine that states that "if it wasn't documented, then it didn't happen." That is, if there is no evidence in a chart that an event occurred, then the only reasonable conclusion is that the event did not occur. Cohen Report at 5 n.2.

177. Dr. King's most recent report, submitted earlier this year, cites several examples in which patients presenting with serious medical conditions at screening did not receive timely face-to-face examinations with providers.[7]

178. CHS fails to ensure that patients presenting with serious medical conditions at screening are timely examined in person by a provider, placing patients at a risk of harm.[8]

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[7] King 10th Report at 12 ¶3 (patient with hepatitis C and advanced liver disease), 10-11 ¶2 (deceased patient should have had a prompt and thorough provider evaluation at intake), 13 ¶5 (patient with diabetes, hypertension, and asthma later diagnosed with pulmonary fibrosis requiring oxygen treatment), 13 ¶7 (patient with diabetes, heart, liver, and kidney problems), 14 ¶8 (patient with hypertension and on multiple medications), 16 ¶15 (patient with history of myocardial infarction and hypertension).

[8] Cohen Report at 6; Cohen Report at 20-21 (Patient 3: no examination by a physician of a critically ill man with diabetes in severe alcohol withdrawal), 54 (Patient 44: "a failure of the intake screening process to follow up on an obvious serious abnormality – decreased vision and a swollen eye. There was a three day delay in being seen by a provider for diagnosis and treatment of an orbital fracture."), 22 (Patient 5: patient on Hepatitis C treatment), 26-27 (Patient 11: patient with diabetes and hypertension), 33 ("Medical and nursing staff knew that [Patient 20] had heart disease, but were unable to have him see a provider for three days."), 33-35 ("[Patient 21] was extremely sick at this time, and he should have seen a physician urgently… instead he was placed in a queue, for routine evaluation."), 35-36 (Patient 22: elderly patient with Parkinson's and hypertension), 36-37 (Patient 23: Patient with late-stage lung cancer that had spread to brain and adrenal glands not seen by provider until 8 days after screening), 37-38 (Patient 24: patient with cardiovascular disease including history of two heart attacks and a stroke), 38-39 (Patient 25: patient with interrupted tuberculosis medications), 39-40 (Patient 26: failure to request urgent evaluation of patient with COPD at screening contributed to "unnecessary deterioration and consequent hospitalization"), 40-41 ("It was a failure of the screening program that [Patient 27] was not referred for urgent evaluation because of his multiple serious medical problems and his advanced age"), 41

179. In the community, a patient presenting with potentially life-threatening symptoms would never be seen briefly by a nurse and then sent back out to wait until something catastrophic occurs before seeing a doctor. Such should not happen at a jail. Cohen Report at 5.

180. In his most recent report, submitted earlier this year, Dr. King noted that, with regard to patients presenting with serious medical needs at intake, CHS providers needed to be "far more proactive… not only in seeing such patients but also in ordering and accessing basic laboratory tests to promptly identify patients with marginal kidney or liver function, fluid or electrolyte disorders, anemia, or infection." King 10th Report at 20 ¶2.

181. In that report, Dr. King discussed the case of a patient with complicated medical needs who was suffering from withdrawals. The patient was never examined by a provider and no labs were ordered until two weeks after screening. The patient died three days later. Dr. King wrote that "this case is an example of the need to ensure that patients with acute and complex chronic illnesses upon intake are being thoroughly and timely evaluated by qualified practitioners and that timely laboratory tests are also

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(Patient 28: pregnant woman not seen by a provider until 12 days following screening), 43-44 (Patient 31: patient in alcohol withdrawals with history of delirium tremens), 45-46 (Patient 33: provider contacted, but did not see, patient with history of cirrhosis and esophageal bleeding and who reported vomiting blood the day of screening), 47-48 (Patient 35: patient with "life-threatening issue of bleeding esophageal varices"), 50-51 (Patient 38: patient with hypertension and history of diabetes), 55-56 (Patient 46: 61-year-old woman with hypertension, diabetes, and pulmonary disease), 56-58 ("At screening [Patient 47] said she had a bad liver. For this reason she should have had a prompt history and physical examination by a provider. This was not offered her."), 60 (Patient 52: diabetic patient with unilateral vision loss), 61-62 (Patient 54: in patient with liver disease, kidney disease, diabetes, bleeding disorder, hypertension, leg swelling and bowel problems – "The failure to provide him timely treatment represents, in the extreme, the chronic failure of intake screening to identify seriously ill patients, the failure of providers to evaluate these patients when they are aware of their serious medical needs…").

being done." King 10th Report at 10-11 ¶2. Dr. King provided other similar examples in his report.[9]

CHS continues to fail to ensure that necessary treatment, including labs, is initiated for patients who present with serious medical needs at intake, placing patients at risk of harm.[10]

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[9] King 10th Report at 13-14 ¶7 ("I believe that this patient is another instructive example of a patient who should have been seen and examined by a provider shortly after intake. Furthermore, I believe basic laboratory tests (comprehensive metabolic panel and complete blood count) should have been done at the time of intake. The purpose of doing such tests would be to timely identify significant kidney dysfunction that merited earlier medical attention."), 15 ¶11 (woman with hypertension, alcohol and opiate dependence, and possible leg abscess – was not seen by a provider and appropriate tests not ordered at intake to assess kidney function until two weeks later.), 12 ¶3 (patient with hepatitis C and advanced liver cirrhosis who did not have appropriate labs or provider visit at intake).

[10] Cohen Report at 20-21 (Patient 3: "No laboratory studies were drawn, no EKG was obtained. There was no physical examination by a physician for this critically ill man with diabetes in severe alcohol withdrawal."), 22 ("Although she was on a complex medical regimen, requiring close monitoring of laboratory values for complete blood count, [Patient 5] was not seen by a physician, no laboratory studies were obtained, and she was not continued on her medication."), 22-23 (Patient 6: HIV patient for whom no labs were not obtained until three weeks after admission), 25 (Patient 9: patient with uncontrolled diabetes – labs not obtained until 10 day after screening), 27-28 (Patient 13: serum levels of seizure medications not ordered until three months after intake), 35-36 (Patient 22: no blood pressure treatment until 10 days after booking in 71-year-old man with significantly elevated blood pressure and Parkinson's disease), 37-38 (Patient 24: failure to obtain labs and immediate EKG following screening in a patient with severe cardiovascular disease including severe cardiomyopathy), 38-39 (Patient 25: no emergency x-ray, provider examination, or isolation of a patient with interrupted tuberculosis treatment that had been started in Mexico), 45-46 (Patient 33: no labs drawn or treatment started at intake for patient with history of bleeding esophageal varices), 50-51 (Patient 38: no EKG or labs obtained in patient with hypertension, diabetes, and unstable vital signs), 61-62 (Patient 54: "No laboratory studies were ordered to determine the extent of his liver disease, his kidney disease, his bleeding problems, his diabetes, or his gastrointestinal issues."), 63 (Patient 56: no blood tests, coagulation tests, or EKG were obtained to determine if 61-year-old patient with a history of atrial flutter had a stable heart rhythm at intake).

Lack of Adequate Care for Patients with Drug and Alcohol Withdrawals

182. Treatment of withdrawals refers to the identification, prevention, and treatment of symptoms of withdrawals from drugs or alcohol, including medical detoxification. Cohen Report at 8.

183. Among the most common serious medical needs of men and women entering MCJ are the complications of alcoholism and drug addiction, including life-threatening or extremely painful withdrawal symptoms.[11]

184. Withdrawal from opiates is a serious medical need that inflicts significant suffering and pain. Cohen Report at 3.

185. Withdrawal from alcohol is a serious medical need that carries with it a risk of mortality. Cohen Report at 49.

186. Signs and symptoms of withdrawal from benzodiazepines include agitation, delirium, suicidal ideation, extreme elevation in body temperature, hallucinations, tremulousness, weakness, and disorientation.[12]

187. In Dr. King's third report, he wrote: "In my First Report (section # 11, page 9), I documented that CHS does not offer continued treatment with methadone for pretrial detainees who are enrolled in community-based methadone programs for control of heroin addiction. Furthermore, the existing CHS protocol for assessment and treatment of alcohol and/or opiate withdrawal does not meet any reasonable standard of medical care for patients on a stable methadone maintenance regimen or for those who are dependent on high doses of illicit methadone alone or in combination with heroin." King 3rd Report at 10 ¶18. He further wrote, "[w]ithout a comprehensive evidence-based program for safe assessment and treatment of alcohol and drug (including

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[11] Dr. Lambert N. King, MD, PhD, FACP, Third Report on Correctional Health Services Compliance with Second Amended Judgment, March 1, 2010, attached as Exhibit 3 to the Declaration of Lambert King (hereinafter, "King 3rd Report") at 9 ¶17.

[12] Declaration of Gabriel B. Eber, Exhibit 1, CHS Withdrawal Guidelines, at Bates No. 034575-56.[12]

opiates) withdrawal, CHS will not be positioned to meet the Second Amended Judgment requirements # 6,7, and 8." King 3rd Report at 11 ¶24.

188. CHS does not have the ability to treat opiate-dependent patients (other than pregnant women) with methadone.[13]

189. Generally, nurses at MCJ attempt to maintain COWS and CIWA monitoring as required by protocol. Cohen Report at 8.

190. These protocols are appropriate as outpatient tools for some patients; they are inadequate for patients with complex multisystem illnesses, and they are not designed as a substitute for the clinical judgment of a physician or mid-level provider. Cohen Report at 8.

191. Patients with severe narcotic withdrawal may suffer severe pain because they do not have access to effective therapy for their withdrawal syndrome. Cohen Report at 8.

192. CHS fails to ensure that complex patients suffering from withdrawals are properly managed and monitored by providers.[14]

193. In April and May 2013, there were two deaths of patients suffering from withdrawals at MCJ.[15]

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[13] Joint Status Report to Court Regarding Dr. King And Dr. Burns's Tenth Reports, Doc. 2128, at 5.

[14] Cohen Report at 9, 20-21 (Patient 3: no examination by provider and insufficient treatment for alcohol withdrawals), 35-36 (Patient 22: 71-year-old man with significant hypertension at risk for benzodiazepine withdrawal who required prompt provider evaluation but who was managed with a protocol), 43-44 (Patient 31: poorly managed alcohol withdrawals in patient with history of delirium tremens), 45-46 (Patient 33: patient with end stage liver disease, severe alcoholism, and history of seizures not evaluated in person by provider before being placed on alcohol withdrawal protocol), 48-49 (Patient 36: patient arriving under the influence of alcohol and with history of severe withdrawals not evaluated by provider), 41-43 (Patient 30: patient not seen by provider until several days following seizure related to clonazepam withdrawal).

[15] Cohen Report at 43-44 (Patient 31), 48-49 (Patient 36).

194. In one case, the patient arrived at the jail on April 29, 2013[16] reporting that he drank heavily. He was noted to be suffering from alcohol withdrawal at screening. He had a documented history of delirium tremens that had been so severe that he required placement of a tube in his trachea. Cohen Report at 43 (Patient 31).

195. Delirium tremens is one of the most serious manifestations of alcohol withdrawal and is associated with high mortality. Patients who have experienced delirium tremens in the past are at great risk of experiencing them again if they are in alcohol withdrawal. Cohen Report at 43. CHS advises providers that the mortality rate from delirium tremens is approximately 5%.[17]

196. The patient was prescribed chlordiazepoxide (Librium) per the detoxification protocol without seeing a provider first. Cohen Report at 43.

197. He became tremulous, extremely agitated, and threw himself on the floor. He was placed in a safe cell. The following day, his agitation decreased on medication and he was sent to general population. That night, his blood pressure rose to 220/120 and he was tremulous and disoriented. A provider was called by telephone and said that the patient should drink water. A lowered dose of Librium was given and the patient was sent back to his cell with blood pressure still at 190/116. Cohen Report at 43.

198. The next morning he began to size uncontrollably and died in status epilepticus. He had never been seen by a provider while at MCJ. This patient's death was preventable. He required hospitalization and should not have been managed by nurses only on a fixed protocol. Cohen Report at 44.

199. The second mortality involved a patient who arrived at the Jail on May 26, 2013, under the influence of alcohol. His jail health record showed a history of

[16] Dr. Cohen's report lists this patient's booking date as April 19, 2013. This is a typographical error.

[17] Eber Decl. Ex. 1, CHS Withdrawal Guidelines, at Bates No. 0345783.

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serious withdrawals. He was started on the CIWA and chlordiazepoxide (Librium) protocol. Cohen Report at 48 (Patient 36).

200. On May 29, he complained of visual hallucinations and itching, suggestive of tactile hallucinations, which prompted concern by nursing staff. The next day, he told nursing staff that he drank three 6-packs of alcohol per day. He was having tremors and was slurring his words. A provider was contacted by telephone and the patient was given Lorazepam. Cohen Report at 48.

201. The following day, the patient was noted to have unequally responsive pupils and to be stumbling. He was sent to the emergency room where he died. Causes of death include pneumonia, pancytopenia, hepatic encephalopathy (failure of brain function due to liver failure), and sepsis. Cohen Report at 49.

202. This patient was at too high of a risk to be managed on an outpatient basis; he should have been evaluated frequently by a provider. However, he was never seen by a provider at MCJ. Cohen Report at 49.

203. Dr. King wrote that "substantial compliance" requires that MCSO have "medically suitable beds" to house patients at risk for severe alcohol and drug withdrawal. King 10th Report at 20 ¶4.

204. Such a facility should be a medically-supported inpatient setting. Cohen Report at 8.

205. CHS has set aside beds at its Durango facility for "some inmates who require more intensive clinical service/monitoring."[18]

206. However, according to Dr. Alvarez, only patients classified for minimum custody are eligible for such care. Cohen Report at 8.

207. There are no written documents governing the beds at Durango and the care that is purportedly provided there. During discovery, Plaintiffs asked Defendants to produce "policies and procedures, as that term is defined on page 3 of the request, for

[18] Defendants' Statement of Facts, Doc. 2158, at 6 ¶24.

the clinical service/monitoring area of the Durango facility." Defendants responded that "flow charts, of which Defendants have previously produced many. Regarding policies specific to treatment/monitoring of inmates at Durango, there are no documents responsive to this request."[19]

208. CHS fails to ensure that patients at risk for severe withdrawals are placed in medically suitable housing or timely sent to the emergency room.[20]

CHS' Tuberculosis Control Program Places Patients at Serious Risk

209. Tuberculosis (TB) is a disease caused by Mycobacterium tuberculosis that adversely affects public health around the world. In the United States, TB control remains a substantial public health challenge in multiple settings. TB can be particularly problematic in correctional and detention facilities, in which persons from diverse backgrounds and communities are housed in close proximity for varying periods. Effective TB prevention and control measures in correctional facilities are needed to reduce TB rates among inmates and the general U.S. population.[21]

210. Tuberculosis is spread by droplets in the air produced by the sneezes or coughs of persons with active infection. CDC Guidelines at 4, 49. Tuberculosis infection may be active or latent. *Id.* at 50. Only persons with active infection may spread the disease to others. *Id.* at 4. These droplets may remain in the air for prolonged periods of time after being released. *Id.* at 49. Tuberculosis is particularly

[19] Eber Decl. Ex. 2, Defendants' Amended Response to Plaintiffs' First Request for Production of Documents, at 2.

[20] King 10th Report at 15 ¶11 (patient with hypotension and risks of alcohol and drug withdrawal); Cohen Report at 20-21 (Patient 3: alcohol withdrawal), 43 (Patient 31: "emergency hospitalization at that point, in the evening of 4/30/13, might have saved his life.").

[21] Eber Decl. Ex. 3, Centers for Disease Control and Prevention. Prevention and control of tuberculosis in correctional and detention facilities. *MMWR Recomm Rep*. 2006; 55(RR-9):1 (hereinafter, ("CDC Guidelines"). Dr. King stated that the CDC Guidelines are "authoritative" and relied on them in making his recommendations regarding to tuberculosis control. King 10th Report at 5-6.

dangerous in persons with HIV infection. *Id.* at 4. Correctional facilities are prone to high rates of tuberculosis infection. *Id.* at 3.

211. The tuberculosis control program at the Maricopa County Jail is a failed program that affects everyone in the jail and everyone who comes into contact with the men and women who live and work at the jail. Cohen Report at 10.

212. According to the Arizona Department of Health Services, "Arizona has consistently ranked as one of the highest states in the nation for percentage of TB cases diagnosed while incarcerated." The Department states that "[r]outine evaluation of all inmates for TB during the intake process allows for diagnosis of both latent and active TB in this population."[22]

213. In 2011, there were four cases of active pulmonary tuberculosis identified by CHS at the Maricopa County Jails.[23]

214. In 2011, the Arizona Department of Health Services identified 64 cases of tuberculosis diagnosed among patients at correctional facilities, excluding patients ages fourteen years and younger. Thus, the four cases identified by CHS that year represent 6.25% of the 64 total correctional cases.[24]

215. A study published in 2005 found that in 1999 and 2000, there were 300 cases of tuberculosis in Maricopa County. Of these, 73 cases (24.3%) had a history of being incarcerated in the Maricopa County Jail. Of those 73 cases, nine of them had been in the jail while they had active tuberculosis. The authors noted that "[e]ffective tuberculosis control in correctional facilities requires early recognition of active cases during admission screening. Outbreaks in correctional facilities have resulted in part

[22] Eber Decl. Ex 4, Arizona Department of Health Services, *2012 Tuberculosis Surveillance Report*, at 13.

[23] King Decl. Ex. 9, Ninth Report of Lambert King, MD, FACCP on Medical Compliance with Second Amended Judgment, at 19 (hereinafter, "King 9th Report").

[24] Eber Decl. Ex. 5, Arizona Department of Health Services, *2011 Tuberculosis Surveillance Report*, at 15.

from the absence of adequate screening programs for early detection of active tuberculosis to prevent transmission." One of the authors of this study was a physician employed by CHS.[25]

216. A person with active tuberculosis at the Maricopa County Jail can infect large numbers of people because of the close confines of the institution. Cohen Report at 60.

217. Between January 1, 2012 and November 8, 2012, there were two cases of active tuberculosis at the jail. A total of 246 detainees and staff were identified as having been possibly exposed to the infection. Some detainees and staff who had previously tested negative for tuberculosis subsequently tested positive. King 10th Report at 5.

218. The Centers for Disease Control and Prevention characterize correctional facilities as being either "minimal risk" or "nonminimal risk" for tuberculosis. To qualify as minimal risk, a jail must satisfy four criteria: (1) no cases of infectious tuberculosis at the facility within the past year; (2) the facility does not house substantial numbers of inmates with risk factors for tuberculosis, such as injection drug use or HIV; (3) the facility does not house substantial numbers of new immigrants from areas of the world with high rates of tuberculosis; and (4) employees at the facility are not otherwise at risk for tuberculosis. CDC Guidelines at 4.

219. Any facility that does not satisfy all four criteria is a nonminimal risk facility. The Maricopa County Jail does not meet at least three criteria. Thus, the Maricopa County Jail is a nonminimal risk facility. CDC Guidelines at 4.

220. The CDC Guidelines require that persons who do not report symptoms of active tuberculosis at screening be screened within seven days of arrival using one of three acceptable screening methods. CDC Guidelines at 8. The seven-day timeframe is

[25] Eber Decl. Ex. 6, Jessica R. MacNeil et al., Jails, a Neglected Opportunity for Tuberculosis Prevention, 28 AM J PREV MED 225, 225-27 (2005).

consistent with the Arizona Department of Health Services regulations governing correctional facilities. Ariz. Admin. Code § R9-6-1203(A)(3).

221. There are structural delays in screening for tuberculosis at MCJ. Cohen Report at 10.

222. At the time of filing their motion for termination, CHS did not perform skin testing until ten to fourteen days following screening.[26]

223. CHS ties tuberculin skin testing (TST) to the detainees' initial health assessment. However, under CHS policy, two groups of detainees do not receive post-intake initial health assessments: (1) newly-arriving detainees who have had jail-administered initial health assessments within the previous year with no change in health status; and (2) detainees who have received assessments as part of a hospitalization or prenatal care visit.[27]

224. In reality, by design, tuberculosis screening at MCJ does not begin until 12-14 days after admission, often longer, and sometimes does not occur at all. Because the skin test cannot be read until two days after being placed, this adds another two days of risk. Cohen Report at 38. Delays in identifying prisoners with active tuberculosis place prisoners and staff at risk. Cohen Report at 39.

225. Dr. King identified a patient who was denied a tuberculosis screening test because he had had a health assessment during a previous incarceration four months earlier. The patient later required transfer to the ER to rule out tuberculosis. At the ER, he received a TST, which was positive. King 10th Report at 13 ¶6. Dr. King noted that "[t]here is also no exemption in the applicable CDC guidelines for TST testing for a readmitted inmate who has had a previous negative TST on a prior jail admission." *Id.* at 5-6.

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[26] Defendants' Statement of Facts, Doc. No. 2158, at ¶39.

[27] Ex. 19 to Joint Status Report to Court Regarding Dr. King And Dr. Burns's Tenth Reports, Doc. 2128.

226. CHS's internal audits show that a significant proportion of detainees who are eligible for an initial health assessment with TST are not TST-tested within CHS's own 14-day timeframe. As many as 7.7% of detainees across all facilities were either not tested at all or not tested within 14 days of arriving during the most recent months for which data was provided to Plaintiffs' counsel (January through July 2013). Eber Decl. ¶13.

227. Concomitant HIV infection is a leading risk factor for the progression of latent tuberculosis to active tuberculosis. Cohen Report at 23. The CDC Guidelines require that health staff at nonminimal risk jails perform chest x-rays on patients with HIV - or who are at risk for HIV infection but whose status is unknown – during their initial intake screening. CDC Guidelines at 8.

228. The requirement that patients with HIV receive a chest x-ray has been adopted by the Arizona Department of Health Services to govern care at correctional facilities. Ariz. Admin. Code § R9-6-1203(A)(6).

229. CHS leaves the decision to order chest x-rays for patients with HIV to nurses. Defendants' Statement of Fact, Doc. No. 2158, at ¶42.

230. CHS does not ensure that patients with HIV uniformly get timely chest x-rays to screen for tuberculosis. Cohen Report at 22-23.

231. Patients taking medications to treat tuberculosis are subject to delays and interruptions of their treatment.[28]

232. CHS fails to ensure that patients needing chest x-rays to diagnose tuberculosis have those x-rays timely ordered, performed, and/or reviewed by a provider.[29] In one instance, there was a four-month delay in obtaining an x-ray for a patient who had a very positive tuberculosis screening result. When the x-ray was

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[28] Cohen Report at 38-39 (Patient 25), 58 (Patient 48), 64 (Patient 58).

[29] Cohen Report at 22-23 (Patient 6), 32 (Patient 19), 38-39 (Patient 25), 58 (Patient 48), 59 (Patient 49), 59-60 (Patient 51).

ultimately performed, the result was consistent with active tuberculosis. Cohen Report at 59 (Patient 49).

233. These failures are not new. The study published in 2005 and co-authored by the CHS physician identified "at least two missed opportunities to diagnose TB due to failure to follow up on abnormal chest x-rays."[30]

234. Patients with possible tuberculosis are subject to other deficiencies in care, including delayed reading of tuberculosis skin tests and lack of provider involvement in care.[31]

Inadequate Access to Medication and Pharmacy Services

235. A pharmacy services system must be able to timely, safely, and accurately provide patients with uninterrupted access to medications until discontinued by provider order. This includes medications ordered at intake and throughout the patient's incarceration. Cohen Report at 6.

236. There are systemic medication-related failures in MCJ's medical program. Cohen Report at 6.

237. Patients who arrive at the jail taking critical medications are subject to delays in receiving those medications. These delays can place patients at serious risk of harm.[32]

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[30] Eber Decl. Ex 6, Jessica R. MacNeil et al., Jails, a Neglected Opportunity for Tuberculosis Prevention, 28 AM J PREV MED 225, 227 (2005).

[31] Cohen Report at 59 (Patient 50), 38-39 (Patient 25); King 10th Report at 13 ¶4.

[32] Cohen Report at 63 (Patient 56: cardiac patient with delay in receiving cardiac medications), 26-27 (Patient 11: four-day delay in antihypertensive medications), 27 (Patient 12: 5-day delay in statin, 7 day delay in Flomax), 37-38 (Patient 24: cardiac patient with delays in cardiac medications), 32-33 (Patient 20: delays in cardiac medications in patient with congestive heart failure secondary to cardiomyopathy), 19-20 (Patient 2: 11 day delay in meds for rheumatoid arthritis), 28, 38-39 (Patient 25: two day delay in TB medications).

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238. Patients taking critical medications in the community may have those medications discontinued or not restarted upon arrival at the jail. These delays place patients at a serious risk of harm.[33]

239. In one case, Patient 5 arrived at the jail on May 29, 2013. She was taking medications to treat her hepatitis c infection. These medications were not continued at the jail. She asked to see a physician to discuss this issue but never was seen. She went without her medications for six days. The medications were finally ordered the day after she was discharged by the jail. Prematurely discontinuing ribavirin, one of the hepatitis c medications, can significantly reduce the likelihood that the months of treatment will be successful in suppressing the virus. This lack of continuity of medication may have severe consequences for Patient 5. Cohen Report at 22.

240. Patients arriving at the jail on medications to treat HIV infection and related conditions are subject to delays in receiving those medications. Interruptions in HIV medications are associated with the development of resistance, which can render the medications useless.[34]

241. Patients at the jail experience interruptions in medications prescribed for them.[35]

14-day Initial Health Assessments

242. The purpose of the initial health assessment which, according to NCCHC, must occur within 14 days of booking, is to document a complete history and physical,

[33] Cohen Report at 39-40 (Patient 26: no inhaler ordered at intake for patient with chronic obstructive pulmonary disease).

[34] Cohen Report at 22-23 (Patient 6: three day delay in antiretroviral medication), 40-41 (Patient 27: four day delay in HIV medication), 30-31 (Patient 17: three day delay in fluconazole).

[35] Cohen Report at 51-52 (Patient 39: interruption in insulin), 54-55 (Patient 45: interruption in insulin), 30-31 (Patient 17: interruptions in med for HIV patient with CMV infection), 58 (Patient 48: interruption in tuberculosis medications); King 10th Report at 13 ¶4 (tuberculosis medication).

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and to establish or review the database of laboratory studies available for the patient. It provides an opportunity to speak with the patient, to obtain information about past history, allergies, family history if relevant, and a complete review of systems. It is accompanied by a complete physical examination, of the unclothed patient. Cohen Report at 12.

243. CHS's policy is to exclude patients who were seen at a hospital within 14 days of arriving at the jail from receiving 14-day initial health assessments. Cohen Report at 12.

244. This exclusion is problematic. Exams provided at hospitals are often quite different – and serve a very different purpose – from 14-day health assessments. The hospital record generally records an acute, emergent problem, and does not provide the database that the 14 day history and physical is designed to obtain. In particular, patients with emergency hospitalizations which occurred in the first two weeks of their incarceration at MCJ are the patients whose care will most benefit from the time spent in performing a comprehensive history and physical. Cohen Report at 12.

245. For example, a patient with a history of two heart attacks and a stroke arrived at the jail but was not evaluated by a provider at screening. Two days later, he had trouble breathing and was sent to the hospital, where he was found to have had another heart attack. Upon return to the jail, a note was written into his medical chart stating "PE done @ MMC 5/11/13." Thus, because the patient had had an emergency, no new 14-day initial health assessment was performed even though CHS had failed to have a provider timely assess him *before* the emergency hospitalization. Cohen Report at 37-38 (Patient 24).

246. CHS does not provide 14-day initial health assessments to patients "readmitted to jail when the last health assessment was performed within the last 12 months and the initial receiving screening shows no change in health status." Cohen Report at 12, quoting CHS Policy J-E-04.

247. Because the CHS screening process fails to adequately assess the health status of patients with serious medical needs, it is dangerous to make an exclusion based on a determination that a patient's "initial receiving screening shows no change in health status." Cohen Report at 12.

248. It should also be noted that, because tuberculosis screening is tied to the occurrence of the 14-day health assessment, patients who do not get such assessments may fall through the cracks and never get necessary tuberculosis screening. Cohen Report at 12.

249. It is problematic that RNs perform the majority of 14-day health assessments. RNs are not trained to perform a comprehensive history and physical examination. The health assessment is a comprehensive evaluation of the patient's present history, past medical history, and the physical examination. It also includes ordering and evaluating the results of laboratory and other diagnostic tests, and the consideration and incorporation of supplementary medical records including hospital charts and available consultations. All of this material must be combined into a comprehensive assessment of the patient's problems, a plan for the treatment of those problems, and plans for future monitoring of the response to treatment. RNs are not trained to perform this complex clinical function, and it is outside the scope of their practice. Cohen Report at 12-13.

250. In one instance, a patient with severe congestive heart failure arrived at the jail taking multiple cardiac medications and with elevated blood pressure. The patient's 14-day initial health assessment was performed by a RN. The RN documented a normal exam except for cavities. The RN did not mention or document that the patient had congestive heart failure. She wrote that the patient was a "50-year-ol male with no medical concerns at present time." A physician counter-signed the RN's exam six days later, one hour after the patient was found dead. Cohen Report at 13, 52 (Patient 40).

251. In another example, a complex patient with liver disease had her 14-day initial health assessment performed by a RN. Although a physician counter-signed the RN's exam the same day, there is no evidence that the physician examined the patient. Cohen Report at 13, 56-57 (Patient 47).

Insufficient Provider Involvement in Patient Care Creates Risks of Harm

252. Provider involvement in patient care refers to the degree to which patients have appropriate access to physicians, physician assistants, and nurse practitioners to meet serious medical needs. The term "provider" refers to physicians, physician assistants and nurse practitioners. It does not include nurses. Cohen Report at 13.

253. CHS fails to ensure that providers are sufficiently involved in the care of patients with serious – and even life-threatening – medical needs.[36]

254. CHS sets the threshold for seeing a provider at a high level that places patients at risk. Cohen Report at 13.

255. In one example, a patient with dangerously uncontrolled hypertension submitted two separate HNRs requesting care for high blood pressure and management of his antihypertensive medications. On neither occasion was he seen by providers. A few days later, he went into cardiac arrest, but survived. Cohen Report at 31-32 (Patient 18).

256. In another example, a patient with lung cancer that had spread to his brain and adrenal glands asked to speak with a provider about his cancer treatment; he was not seen until six days later. Cohen Report at 36-37 (Patient 23).

[36] Cohen Report at 13; Cohen Report at 24-25 ("In [Patient 8]'s case, the lack of access to a qualified provider cause[d] him almost a week of severe untreated knee pain, and almost a week of ineffectively treated infection"), 44-45 (Patient 32: patient with abscess and cellulitis not assessed promptly by provider); 45-46 (Patient 33: provider did not see patient with cirrhosis and recent hospitalization who was vomiting blood).

257. In one case, a psychiatrist took steps to ensure that a patient would *not* have adequate access to medical care. The front of the patient's health care chart read, in black marker, "**This man fakes mandowns. Do not send to MMC for unwitnessed mandowns or symptom exaggeration. If patient has a mandown return him to MHU P3. Per Dr. Picardo 6/4/2013**" (emphasis in original). Cohen Report at 63-64 (Patient 57).

258. Regardless of this patient's medical or mental health history, it is categorically wrong and dangerous to issue a blanket order denying treatment to a patient for a potentially life-threatening emergency. Cohen Report at 64.

259. Nurses play a critical role in any health care system but are not substitutes for providers. Nurses lack the training to assess, manage, and treat serious medical conditions. Accordingly, overreliance on nursing care places patients at great risk. Cohen Report at 13.

260. CHS uses nurses to manage skin infections and abscesses even when those infections are severe enough to ultimately require transfer to an emergency room.[37]

261. Nurses lack the training to diagnose, treat, and manage cellulitis and skin and soft tissue infections.[38]

262. CHS has nurses use a "Skin and Soft Tissue Infection" nursing protocol sheet. The sheet is one page and contains various check boxes that nurses are supposed to check based on their observations.[39]

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[37] Cohen Report at 24-25 (Patient 8), Cohen Report at 44-45 (Patient 32), 47-48 (Patient 34).

[38] Cohen Report at 25 (Patient 8: "Appropriate treatment of an infected knee requires that a trained provider listen to the patient's history, examine the knee, and make a judgment about the need for antibiotics, imaging studies, and surgical consultation. This is not the province for RNs."), 45 (Patient 32: "Nurses are not trained to diagnose and treat skin infections. These infections must be examined and treated by providers."), 48 (Patient 35: "Nursing staff is not trained in the diagnosis and treatment of complex skin infections involving the hand.").

263. Such protocol sheets are not a substitute for clinical judgment and place patients at risk. Cohen Report at 25, 45.

264. CHS fails to ensure that nurses act within their scope of knowledge and practice.[40]

265. CHS inappropriately relies on Licensed Practical Nurses (LPNs) to independently provide care to patients with serious medical needs.[41]

266. For example, a patient with severe cardiovascular disease complained that he could not breathe. He was seen by a LPN who noted that the patient was pale, had a rapid pulse, and very low blood pressure. The LPN said that the patient was not short of breath and could walk, although slowly. There is no indication that the LPN measured the patient's oxygen saturation. The LPN advised the patient to drink fluids. No provider was contacted. The patient was sent back to his housing unit. The following day, the patient was found to have had a heart attack. Cohen Report at 37-38 (Patient 24).

267. A LPN cannot evaluate shortness of breath in a patient with serious heart disease. Cohen Report at 38.

268. The LPN's actions may have contributed to the patient's heart attack. Cohen Report at 38.

269. When nurses do attempt to involve providers in the care of patients, providers frequently give orders by telephone without ever seeing the patient in person

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[39] Eber Decl. ¶14 and Ex. 7, Skin and Soft Tissue Infection protocol, at Bates No. 034628.

[40] Cohen Report at 35 ("When [Patient 21] complained of extremely disturbing symptoms, nurses acted well beyond their scope of knowledge and practice, wrongly assessing him as not having any urgent neurologic, cardiac or renal problems… This is characteristic of medical care at MCJ…").

[41] Cohen Report at 50 (Patient 38: LPN assessed cardiac patient for shortness of breath and did not contact provider), 37-38 (Patient 24: LPN assessed patient with chest pain and did not urgently call a provider).

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or examining the patient. CHS fails to ensure that providers examine patients when nurses seek assistance.[42]

270. In one instance, a patient with recent chest pain told a nurse that she had a history of abnormal heart rhythm. A note from detention staff stated that the patient was feeling like she was having a heart attack. The nurse spoke with a provider. The provider did not speak with or see the patient. Instead, the patient was treated for withdrawals, given water to drink, and sent back to her housing unit. Two hours later, the patient collapsed and died without having seen a provider. Cohen Report at 52-53 (Patient 41).

271. In another instance, a nurse assessed a seriously mentally ill patient who had been assaulted by other detainees. Although a provider countersigned the nurse's note documenting the assessment, the provider did not evaluate the patient. Two days later, the patient's injuries were found to include a fractured orbit and injury to his lung that required placement of a chest tube to keep his lung from collapsing. These injuries were life threatening. Cohen Report at 28-30 (Patient 16).

Lack of Access to Laboratory and Radiology Services

272. Access to laboratory and radiology services means that provider orders for lab tests and radiological studies (x-rays, etc.) are conducted in a timely manner and that results are timely reviewed and followed up upon by providers. Cohen Report at 16.

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[42] Cohen Report at 13-14, 54 (Patient 38: nurse contacts provider about patient with chest pain, rapid heart rate and hypertension on December 21, 2012 at 0700 but provider does not see patient), 44-45 (Patient 32), 34 (Patient 21: when called by nurse, provider does not examine patient with intermittent numbness and tingling in left extremities), 47-48 (Patient 35: after speaking with nurse, provider does not see patient complaining of abdominal pain and vomiting blood who had recently been sent to the emergency room), 43-44 (Patient 31: provider does not see patient after being contacted about a patient in severe withdrawals in a safe cell), 25-26 (Patient 10: provider contacted by nurse but did not examine patient who complained of lightheadedness and painful urination), 24-25 (Patient 8: provider orders antibiotic by phone for large infected area but does not examine patient).

273. With regard to labs and radiology, there are two operative time frames: (1) the time between when a lab/study is ordered and when it is performed; and (2) the time between when the results become available for review and the time when the provider actually reviews those results. Delays in either end of the process place patients at unnecessary risk of serious harm. Cohen Report at 16.

274. Communication of critical laboratory values and abnormal radiological studies, timeliness, tracking, and review of laboratory and diagnostic tests, and quality control of on-site laboratory testing are central components of access to care. King 9th Report at 13-14, 23.

275. In Dr. King's most recent report, he concluded that "[t]here are weaknesses in the capacity of CHS to manage, coordinate, and control the quality of its internal and external laboratory and radiology services." King 10th Report at 20 ¶6.

276. Chart reviews by Dr. King and Dr. Cohen support Dr. King's conclusion and demonstrate that CHS fails to ensure that patients have timely access to laboratory and radiology services and timely and appropriate review of and follow-up on results.[43]

277. In one example, a patient told medical staff that he suffered from idiopathic thrombocytopenic purpura, a disorder that can cause excessive bleeding or bruising due to low platelet levels. A doctor ordered lab tests. Although the results were available for the doctor to review the following day, the results were not reviewed until three days later when the patient was transferred to the emergency room. Cohen Report at 61 (Patient 53).

[43] King 10th Report at 16 ¶14 (delay in obtaining chest x-ray); Cohen Report at 27-28 (Patient 13: in seizure patient, serum levels of medications not reviewed until two weeks after being becoming available and no follow-up action taken), 55-56 (Patient 46: in patient with history of valley fever, chest x-ray ordered on May 30, 2012 was not performed until five days later and then not reviewed until eight days later), 56-58 (Patient 47: no provider review of very abnormal labs showing anemia and liver disease), 59 (Patient 49: no follow-up on positive PPD result for more than four months), 59 (Patient 50: tuberculosis skin test not read until more than six weeks after result was available), Cohen Report at 59-60 (Patient 51: five-day delay in reviewing chest x-ray that showed lung infiltrate).

Assessment of Patients by Medical Staff Following the Use of Force

278. Post-Use-of-Force-Assessment refers to a physical examination by an appropriately credentialed clinician following the use of force on a detainee by correctional staff. Cohen Report at 17-18.

279. It is critically important that all prisoners be evaluated by medical staff following the use of force. King 10th Report at 18 ¶1; Cohen Report at 18.

280. The current MCSO use-of-force policy does not require such an assessment following the use of force. Instead, the decision to seek medical attention is left to the discretion of detention officers.[44]

281. Not having health staff present prior to the use of force results in health staff being unaware of prior circumstances that may have caused injuries of medical complications. King 9th Report at 20-21 ¶3.

282. The determination that a detainee has sustained injuries from the use of force is one that should be made by qualified medical staff, not detention officers who have no medical training. King 10th report at 18-19 ¶2.

283. Detention staff lack the medical training to determine if a detainee has been injured. King 10th report at 18-19 ¶2.

284. Following the use of force, it is critically important the medical staff perform a careful history and physical examination of the detainee in a confidential setting. Cohen Report at 50.

285. The emotions of an officer involved in the use-of-force incident may influence his or her decision to seek medical care for the detainee. Vail Decl. ¶24

286. Requiring officers to assess patients beyond the documentation of obvious and serious injuries would place detainees at risk of harm. Declaration of Eldon Vail ¶26.

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[44] Eber Decl. Ex. 8, MCSO Policy CP-1, Use of Force, at Bates No. 002054; King 9th Report at 20 ¶3.

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287. Following the use of force, there is a risk of undetected injuries. Cohen Report at 18; Vail Decl. ¶24.

288. The current MCSO policy is dangerous and is likely to lead to harm. Vail Decl. ¶18.

289. It is standard practice in other jurisdictions to require a medical consultation following every use of force incident. Model policies authored by the National Institute of Corrections and the National Sheriffs' Institute for Jail Operations contain such requirements. Vail Decl. ¶¶25-26.

290. There is no reason that MCSO cannot simply articulate a policy and provide proper guidance to detention staff that medical assessments are required following the true use of force. MCSO could draft a policy that excludes from the requirement certain officer interventions such as the search, escort, or unresisted application of authorized restraints. Vail Decl. ¶¶28-29.

291. The failure to provide such guidance creates an ongoing and systemic risk of harm to detainees. Vail ¶30.

292. Medical and mental health care provided to a detainee following the use of force is germane to the requirements of the Second Amended Judgment. King 9th Report at 20.

Patients Lack Timely Access to Consultations with Specialists

293. Access to specialty consultations means that patients are able to timely see specialists when ordered by a provider. Cohen Report at 17.

294. CHS fails to ensure that patients have access to specialty consultations.[45]

295. For example, one patient fell in the shower and broke his jaw. He was sent to the emergency room and returned with an urgent referral for follow-up with a

[45] Cohen Report at 25-26 (Patient 10: two-month delay in urology consultation and cystoscopy for diagnosis and treatment of bladder cancer), 21-22 (Patient 4: delay in follow-up consultation for patient with fractured jaw), 23-24 (Patient 7: MRI and cardiology consults).

surgeon within three days to repair his jaw. Seven days passed and the patient had not yet seen the surgeon. During this time, he developed serious bacterial infections of his fractured jaw and required hospitalization. The patient ultimately had surgery more than a week later: weeks after the fracture. Cohen Report at 21 (Patient 4).

296. This delay resulted in substantial increased pain and development of a serious infection of the face. Cohen Report at 21.

Access to Infirmary Care and Medical Observation

297. The Third Amended Judgment requires that "[a]ll pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. *When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services*." Third Amended Judgment, Doc. 2094, at ¶7 (emphasis added).

298. The threshold for transferring complex patients from intake to the infirmary should be directed in favor of timely transfer. King 3rd Report at 16 ¶48.

299. In 2011, CHS agreed to implement Dr. King's recommendation that an observation area be created at intake to house patients whose medical conditions and/or physical disabilities required a higher level of care and monitoring. CHS and MCSO agreed to a six-month time frame for creating this facility.[46]

300. Dr. King later modified this recommendation based on representations by MCSO and difficulty in converting space at intake. King Sixth Report at 36-37. In modifying his recommendation, Dr. King stated that CHS must "ensure that all newly received patients whose clinical condition indicates need for an infirmary level of care

[46] King Decl. Ex. 6, Fifth Report on Medical Compliance with Second Amended Judgment, December 29, 2010 (hereinafter, "King Fifth Report"), at 12 ¶15.

will be transferred to the LBJ Infirmary no later than 24 hours after booking" and that CHS establish "a formal, continuous system of medical record review/monitoring to confirm that this 24 hour timeline is being met." Dr. King required CHS to conduct monthly and quarterly reviews and to track, trend, and report infirmary transfers. King Sixth Report at 37.

301. In their First Request for Production of Documents, Plaintiffs requested that Defendants produce "[a]ll Documents relating to the monitoring or auditing of Health Care provided to detainees including, but not limited to, continuous quality improvement, quality assurance, clinical performance reviews, peer reviews, in-service trainings, internal or external audits, technical assistance, accreditation, reports, contract monitoring, health care record reviews, or metrics from January 1, 2013 through the Response Date." The Response Date was defined as August 9, 2013.[47]

302. Although there is a process study related to infirmary policies and procedures (Bates Nos. 000807-08), none of the documents produced in response to this request reflects the reporting and monitoring requirements required by Dr. King. Eber Decl. ¶16.

303. Patients who have complex medical problems but who do not require infirmary-level care should be housed in a medically-supervised setting where they can be adequately observed. Cohen Report at 33

304. CHS fails to ensure that patients in need of infirmary care or observation-level care have access to such care.[48]

[47] Eber Decl. ¶15; Eber Decl. Ex. 9, Plaintiffs' First Set of Requests for Production.

[48] King 10th Report at 15 ¶11 (patient with accelerated hypertension). Cohen Report at 32-33 (Patient 20: patient with congestive heart failure who needed to be in a medical supervised setting), 48-49 (Patient 36: patient with alcohol withdrawal who needed treatment in an appropriate hospital or infirmary setting), 62 (Patient 55: elderly patient with cognitive impairment who required infirmary placement), 55-56 (Patient 46: 61-year-old woman with diabetes, hypertension and pulmonary disease who required admission to an appropriate clinical observation facility pending evaluation), 61-62

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305. For example, in one case, an 80-year-old man with multiple cardiac problems arrived at the jail. His behavior was noted to be bizarre. And his responses to questions inappropriate. King 10th Report at 11 ¶4; Cohen Report at 62 (Patient 55).

306. Over the next three months, the patient remained in general population where he was confused and disoriented. He got into fights with other detainees and upset nursing staff. Cohen Report at 62.

307. The patient required a catheter but was unable to care for himself. On June 19, 2012, he pulled out his catheter and was sent to the emergency room. King 10th Report at 11 ¶4.

308. Upon return from the ER, he was placed in the infirmary for the first time in his three months of incarceration. The following day, he became more confused and was sent out to the hospital for suspected sepsis. He died the following week. King 10th Report at 11 ¶4.

309. Given his frailty, challenging behavior, and medical history, and in accordance with paragraph 7 of the Second Amended Judgment (SAJ), he should have been placed in the infirmary upon intake. King 10th Report at 11 ¶4.

310. CHS failed to identify the patient's special needs. Cohen Report at 62. In accordance with paragraph 6 of the SAJ, the receiving screening should have been sufficient to recognize and provide services to the physically handicapped. King 10th Report at 11 ¶4.

311. This patient suffered greatly in the three months prior to his infirmary admission. Cohen Report at 62.

312. Patients in the infirmary receive mental health services through as solid window. Cohen Report at 15.

(Patient 54: patient with multiple chronic medical conditions who should have been placed in an appropriate medical setting at intake).

313. Patients in the infirmary have no access to recreation, exercise, or time outdoors. Some patients have not seen the sky in months. Patients in single cells in the infirmary are in conditions that amount to solitary confinement. However, detainees in the regular solitary confinement units are permitted one hour per day of out-of-cell time. Patients in the infirmary are not. Cohen Report at 15.

CHS's Copayment Policy Places Patients at Risk

314. During his visit, Dr. Cohen was given a copy of the CHS copayment policy which has been in place since May 28, 2013. Eber Decl. ¶11.

315. According to this policy, CHS charges patients a $5.00 copay for nursing assessments and nursing sick call.[49]

316. CHS charges patients a $10.00 copay to see a provider, regardless of whether the visit is for follow-up on an existing issue. *Id.*

317. CHS charges patients $5.00 for each medication and refill. *Id.*

318. CHS charges patients $10.00 for each admission to the Mental Health Unit (MHU), the Infirmary, or a hospital. CHS charges patients $10.00 for each visit with a specialist. *Id.* Ten dollars is the maximum amount that prisoners may be charged for co-payments per Arizona law. *Id.*

319. In every jurisdiction with which Dr. Cohen is familiar, involuntary use of care (e.g., hospitalizations, transfers to the infirmary, placement in a mental health unit) is exempt from co-payment. In every jurisdiction with which Dr. Cohen is familiar, there are copayment exemptions patients with chronic conditions who need hospital care, medications, infirmary care, and specialist visits. Cohen Report at 17.

320. MCJ's unique copayment policy places patients at risk of significant an irreversible harm. Cohen Report at 17.

[49] Eber Decl. Ex. 10, CHS Copayment Policy (Effective May 28, 2013).

Deficiencies in Care for Patients with Chronic Medical Conditions

321. Normal blood sugar, as measured by finger stick, ranges from 70-110mg/dl. Cohen Report at 25.

322. CHS fails to ensure that patients with diabetes receive proper monitoring of blood sugar, including involvement by providers in care, and dosing and treatment with appropriate insulin regimens.[50]

323. Treatment with an insulin pump is standard approach to management of diabetes and is beneficial to many patients. Cohen Report at 55.

324. By policy, CHS does not allow patients to be treated with insulin pumps.[51]

325. Treatment with rapid-acting insulin is a standard approach to diabetic management and is beneficial to many patients. Cohen Report at 55.

326. By policy, CHS does not allow treatment with rapid-acting insulin.[52]

327. Sliding scale insulin coverage refers to the practice of administering pre-determined doses of insulin based on blood sugar as measured by finger sticks. Sliding scale coverage can be a reasonable short-term approach when blood sugars are monitored frequently. Cohen Report at 54.

328. Sliding scale coverage is not appropriate for patients with poorly-controlled diabetes at MCJ because blood sugar is measured only twice daily, and this greatly limits the amount of insulin that can be given to a patient. The twice-daily sliding scale system is inadequate for many patients and, in general, does not provide for well-controlled diabetes. Cohen Report at 54, 55.

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[50] Cohen Report at 25 (Patient 9: no provider notification when blood sugars reach 521 and 530mg/dl), 27 (Patient 12), 51-52 (Patient 39: no provider contacted for blood sugar of 482mg/dl in patient who ultimately developed ketosis the next day), 54-55 (Patient 45: patient with history of diabetic ketoacidosis told to drink water and recheck in 5 hours when blood sugar reached 588mg/dl), 26-27 (Patient 11).

[51] Cohen Report at 55; Eber Decl. Ex. 11, CHS Clinical Guidelines for Diabetes, at Bates No. 034499.

[52] Cohen Report at 55; Eber Decl. Ex. 11, at Bates No. 034499.

329. Patients with insulin dependent diabetes, and persons receiving insulin need to eat more frequently than twice a day, will routinely need to monitor their blood sugar more than twice a day, and receive insulin more than twice a day. At present, all recommended insulin regimens for patients with insulin-dependent diabetes (Type 1) require insulin administration at least three times per day. Cohen Report at 51, 55.

330. CHS uses sliding scale coverage inappropriately.[53]

331. Diabetic retinopathy can cause blindness. King 10th Report at 15 ¶10, Cohen Report at 60. Patients with diabetes require periodic dilated eye exams to check for diabetic retinopathy. Many diabetic patients at MCJ have not had stable care and have not necessarily had baseline or follow-up dilated eye exams in the past year. King 10th Report at 14-15 ¶10.

332. Based on standards promulgated by the American Diabetes Association, Dr. King provided a "specific recommendation that patients who have diabetes be scheduled for initial eye examinations within one month of booking unless they have such an exam documented as having been done in the community or during a prior MCJ admission within the past year." King 10th Report at 14-15 ¶10.

333. The "ready access to care" provision of the SAJ encompasses timely evaluation of diabetic retinopathy. King 10th Report at 14-15 ¶10.

334. Current CHS practice is to not screen for diabetic retinopathy until six to twelve months into incarceration.[54]

335. CHS fails to ensure that patients with other chronic medical conditions receive adequate care.[55]

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[53] Cohen Report at 54-55 (Patient 45), 51-52 (Patient 39).

[54] King 10th Report at 14-15 ¶10; Eber Decl. Ex. 11, CHS Clinical Guidelines for Diabetes, at Bates No. 034503.

[55] Cohen Report at 27-28 (Patient 13: seizure disorder), 19-20 (Patient 2: patient with rheumatoid arthritis who did not receive care in accordance with national standards), 35-36 (Patient 22: hypertension), 39-40 (Patient 26: chronic obstructive pulmonary disease), 41-43 (Patient 30: Parkinson's disease).

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3 DATED this 27th day of November, 2013.
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CERTIFICATE OF SERVICE

I hereby certify that on November 27, 2013, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

- Michele Iafrate
- Kelly Flood
- Amy Franciscus
- Christina Rubalcalva
- Sherle R. Flaggman
- Daniel J. Pochoda
- James Duff Lyall
- Larry Hammond
- Sherad Desai
- Margaret Winter
- Gabe Eber

I hereby certify that on November 29, 2013, I served the attached document by first-class mail on the Honorable Neil V. Wake, United States District Court, Sandra Day O'Connor U.S. Courthouse, Suite 524, 401 West Washington Street, SPC 52, Phoenix, AZ 85003.

s/Eric Balaban