CONFIDENTIAL REPORT
OF ROBERT L. COHEN, M.D.

Parsons, et al. v Ryan, et al.

No. 2:12-cv-00601-NVW

NOVEMBER 8, 2013

Confidential Information – Subject to Protective Order

TABLE OF CONTENTS

I, Robert L Cohen, declare:

1. I am a medical doctor and expert in the field of correctional medicine, with 30 years of experience in the field. I have been appointed by federal courts to serve as a monitor in cases challenging the provision of medical care to prisoners, including in Michigan, New York State, and Florida. I have also been a member of the New York City Board of Corrections since 2009, served as a representative of the National Commission on Correctional Health Care for 17 years, provided primary care to jail inmates at Rikers Island, and published extensively on health care for the incarcerated.[1]

2. I have been retained by plaintiffs' counsel in the *Parsons* case as an expert in correctional health care. I have been asked to give my opinion about in the adequacy of the Arizona Department of Corrections (ADC) health care delivery system. My billing rate in this action is $300 per hour, with a daily rate for out of town work of $2500.

3. At plaintiffs' request and in order to develop my opinions, I conducted an investigation that included visits to the two largest prison complexes (Lewis and Eyman), interviews with prisoners at those two prisons, including the named plaintiffs, and review of medical charts of prisoners with serious chronic medical diseases, hospitalizations, emergency care and specialty consults for those prisons.[2] In addition, I reviewed the testimony of ADC, Corizon, and Wexford staff, documents produced to plaintiffs' counsel by ADC regarding health care delivery, and various monitoring reports and data

[1] A copy of my Curriculum Vitae is attached as Appendix A. Included in my CV is a list of all publications I have authored in the last ten years, and a list of all other cases in which, during the previous four years, I have testified as a witness at trial or by deposition.

[2] I also requested to review the medical files of all inmates from those Lewis and Eyman who had died in the previous 12 months. Prior to the tours, the Defendants were given the list of names of charts that I wanted to review. During the tours, however, I was able to review only one deceased prisoners' chart, because ADC policy is to send the medical charts to headquarters after a prisoner's death, and none of the other files were on site at the prisons or otherwise available for me to review.

created by ADC and its contractors for the two prisons I visited, and for Douglas, Safford and Winslow prisons. Finally, I reviewed the records for ten patients who died in ADC custody in 2011 and 2012, and physician reviews of these records prepared at my direction . [3]

4. The methodology I used for selecting the medical charts to review is as follows. First, I reviewed the ADC monitoring reports for the two prisons for the months leading up to the tours. Ten to 15 names of prisoners identified by Defendants' monitors as receiving inadequate chronic, specialty, or emergency care were selected from each list at random. Second, I reviewed the "Monitored Conditions" reports produced by Defendants that listed, as of March 2013, all prisoners housed at the institutions with chronic conditions or diseases including tuberculosis, hypertension, diabetes, cancer, cardiac conditions, COPD/asthma, seizures, HIV, AIDS, Hepatitis C, pregnancy, or other respiratory conditions. Approximately 10 to 12 prisoners with diabetes, five to 10 prisoners with HIV, 10 to 12 prisoners with hypertension, and five to 10 prisoners with seizure disorders were selected at random. Some of the individuals selected had more than one chronic condition, or had been identified in Defendants' monitoring reports. Third, I reviewed the most recent Emergency Transports reports produced by Defendants for the prisons and a sample of about 5 to 10 names was selected at random. I also reviewed the lists of those referred for specialty consults, provided by Defendants and from which names were selected. Fourth, I also reviewed medical charts for some patients that I encountered during my site visits, and an additional chart provided to plaintiffs' counsel by the patient's family. [4]

[3] A complete list of the documents that I reviewed for purposes of preparing this expert report is attached as Appendix B.

[4] Throughout this report, I cite patient examples illustrating the systemic care deficiencies that I have identified. Rather than include a case study for each in the body of this report, I have attached as Appendix C a patient by patient summary that I prepared after interviewing patients and reviewing medical charts, reflecting a more comprehensive discussion of the charts for the patients cited in this report.

5. The ten files I reviewed for prisoners who had died (excluding the file mentioned in footnote 2), were the selected as follows. Three of the files were chosen because defendants had produced mortality reviews that I could compare to the medical records. The remaining seven were chosen because they were among the most recent deaths for which plaintiffs have received medical records.

I. OPINIONS

6. Based upon my extensive background in correctional medicine, experience as a medical monitor in several states, and my investigation into the conditions in the Arizona prisons, my opinion is that the ADC health care delivery system is fundamentally broken and is among the worst prison health care systems I have encountered.

7. Because of this profoundly deficient system, prisoners with serious medical conditions are regularly deprived of necessary medical care and suffer substantial harm, and even death, as a result. Moreover, all prisoners in this system are at risk of serious harm and/or death, because the system as a whole is not equipped to provide them with necessary medical care when they experience serious medical needs.

8. The ADC's system, as it currently exists under Corizon's management, is disorganized, under-resourced, understaffed, and completely lacking in the capacity to monitor itself and correct the systemic dysfunction that currently exists. Thus, unless ADC dramatically reverses its course, it will continue to operate in a way that harms patients by denying them necessary care for serious medical conditions.

9. The ADC prisons I visited are unable to sustain the basic delivery of medical care because of limited clinical staffing and the overwhelming number of prisoners who have serious, long-standing, and complicated medical care needs, causing lengthy treatment delays. The long delays in care needlessly compound and aggravate

medical conditions that, had they been addressed sooner would have been managed and resolved. The documents I reviewed, including ADC contract monitoring reports, medical records and death reviews, establish that the conditions I observed are typical throughout the state.

10. Prisoners with chronic conditions, including HIV, diabetes, cancer, seizure disorders, hepatitis and hypertension, are particularly at risk in the ADC's system. While many patients with chronic illnesses can be managed and live with relatively stable health, ADC's system lacks an adequate tracking and management system to ensure that patients have regular provider visits and medication renewals. Not surprisingly, I found numerous patients at both prisons who were much sicker than they would have been had they been adequately managed. In fact, there were multiple cases in which the lapses were so shocking and dangerous that I felt ethically obligated as a medical professional to bring them to the immediate attention of the ADC and Corizon staff.

11. Defendants' medication delivery systems are inadequate for the size of the population they serve, and are plagued by short-staffing at a number of their prisons. Too many prisoners, with too few staff and insufficient resources, leads inevitably to medication delays and inadequate treatment documentation. The result is that ADC prisoners receive their medications late or not at all, and suffer as a result, as was evident in my patient interviews and review of charts.

12. Unless medical records and scheduling information are managed, organized, and maintained effectively, appropriate health-care services cannot be provided. ADC lacks the ability to adequately manage and maintain medical records and patient scheduling information.

13. A functioning Quality Assurance program is a critical element in any medical care system, enabling the system to assess and evaluate care provided its patients so that systemic deficiencies may be identified and addressed. To the extent that any medical quality assurance activities are occurring in the ADC, they are plainly

inadequate.

14. There are more prisoners requiring specialized placement for medical reasons than Arizona can accommodate. Arizona has not provided adequate medical beds for disabled prisoners, aged inmates, and prisoners who need some form of sheltered living due to their medical or mental health conditions.

15. The clinical spaces that I toured are too small for the prison population, and in all but one or two cases, I never observed any actual medical care being delivered in these spaces. Rather, I observed locked, dark and empty rooms that I was told were exam rooms, but lacked basic medical equipment. Medical equipment was broken, covered in dust, and in some cases based on logs attached to them, had not been repaired or checked in more than a decade.

16. My observations at the prisons and extensive review of documents demonstrate that the gross systemic deficiencies in the ADC's health care delivery system are deeply rooted, long-standing and will require substantial effort to remedy. During the last 15 months, the ADC medical care system has shifted from ADC management, to Wexford and then to Corizon, but privatization has failed to resolve the long-running health care problems. Rather than invest in addressing the serious systemic deficiencies in their program, ADC chose to outsource their system to the lowest bidder, not once, but twice. At no time during this series of management hand-offs has ADC demonstrated the will or capacity to address these deep-seated issues.

II. BASES FOR MY OPINIONS

A. Case Study

17. I discuss many examples of poor medical care in this report, but I present the case of [redacted] here because it vividly illustrates the myriad systemic breakdowns that have plagued ADOC, Wexford, and Corizon, over a period of many months, and the impact these breakdowns have on patient care.

18. I interviewed Mr. [redacted] at his cell on Eyman's Browning Unit and reviewed his medical record. Mr. [redacted] developed severe throat pain in April 2012. He was finally treated on 6/5/12 with amoxicillin for a sore throat. The condition did not respond. On 7/14/12 Mr. [redacted] placed one of many "health needs requests" (HNRs) complaining of unrelenting pain. He wrote, presciently: "This is a severe, possibly lethal problem and I need someone there to take some action to treat this problem." Mr. [redacted] was not seen by the nurse practitioner until July 20, six days later. The abscess ruptured spontaneously four days after that. He was seen by a physician at a local hospital who ordered two types of antibiotics, but he received only one. The infection persisted, and Mr. [redacted] remained in extreme pain. His suffering continued.

19. On 8/17/2012 he was again prescribed a course of two antibiotics and again the medical staff provided only one. He placed an HNR on 8/21/2012 requesting that this problem be addressed. The nursing staff elected to take no action, and to refer the problem to the health care practitioner on 8/24/2012. ADC 135625. That day, the Nurse Practitioner, Jane Houdeshel asked that the medications be "pulled out of RDSA". (unknown abbreviation). ADC 136602. On 9/19/12, Mr. [redacted] was finally seen by Dr. Joel Cohen, an ENT surgeon, who recommended a tonsillectomy. ADC 136603. Although he was in great pain, and suffering from a persistent infection unresponsive to multiple courses of antibiotics, surgery for removal of his tonsils was not performed for over two months, on 11/20/12. The surgical pathology report was faxed to Dr. Cohen the next day, 11/21/12. The tonsils showed moderate to poorly differentiated squamous cell carcinoma of the left tonsil, involving full thickness of the submitted material, extending into the muscle, and extending to the margin of the resection.

20. Although Dr. Cohen saw the surgical pathology report (ADC 136593) on 11/21/12, no follow-up was scheduled for the patient. For the next three and a half months, Mr. [redacted]'s cancer was not treated.

21. On 3/3/13 Mr. [redacted] placed an HNR. He was not seen for more than

three weeks, until 3/28/13. He told Mr. Salyer, the Physician Assistant (PA) that he had been experiencing throat problems since January. Mr. [redacted] noticed swollen lymph nodes on the left side of his neck. He told the PA that Dr. Cohen, the ENT surgeon, had told him he had a "Huge ugly tonsil." Mr. Salyer examined Mr. [redacted] and confirmed that he had adhesions and significantly swollen lymph nodes. On that day, Mr. Salyer requested Corizon approve an ENT urgent consultation because of these findings, but Mr. [redacted] waited almost seven more weeks to be seen by Dr. Cohen.

22. Dr. Cohen saw Mr. [redacted] on 5/14/2013. He noted bilateral neck masses. He performed two fine needle aspiration biopsies. Since Dr. Cohen already knew that Mr. [redacted] had untreated cancer of the tonsil, it is unclear why he performed these biopsies. Dr. Cohen asked for a CT scan of the neck in preparation for radiation therapy. On 6/7/13, Dr. Cohen sought an emergency consultation with an oncologist.

23. On 6/17/13 Mr. [redacted] placed another HNR complaining of increasing throat pain, and asking for follow up on the referral for a CT scan and an oncology appointment. ADC 136631. On 6/24/13, one week later, he received his response: "Your consultation has been approved and appointment has been scheduled." The CT scan, which had been urgently recommended on May 14 was not performed until July 2, 2013, four months after Mr. [redacted]'s HNR complaining about swollen lymph nodes. The CT scan showed "bilateral submandibular complex solid contrast enhancing masses and associated anterior neck lymphadenopathy, likely nasopharyngeal malignancy." In plain English: large solid masses in his salivary glands, swollen lymph nodes, and the diagnosis of nasopharyngeal cancer, a cancer of the upper throat.

24. Remarkably, but entirely consistent with prior delays, this CT report was sent to the Eyman medical staff on 7/2/13 but not reviewed by health care staff until 7/8/13. On that day, Mr. [redacted]'s scheduled oncology appointment was inexplicably cancelled. He was finally seen by oncology more than a month after the emergency consult was requested. On July 13, PA Ainslie reviewed the oncology recommendations

for PET/CT scan, Dental evaluation, Medical Oncology Consultation, and 21st Century Oncology Consultation. ADC 136612. These consultations requests were written on July 13, but were not faxed for approval to the Corizon Clinical Coordinator until 7/15/13. ADC 136613-616.

25. Two days later, at the time of my visit to Eyman-Browning, on 7/17/13, [redacted] still had not received any treatment for the cancer. Mr. [redacted]'s treatment for an extremely painful, life-threatening condition was characterized by consistent failures to provide basic medical care. His pain was ignored for months. His failure to respond to the minimal treatment offered was ignored. Even when he was ordered treatment, he was not provided the ordered medications. Repeated urgent requests for specialty consultation were delayed for weeks and months. Urgent surgical treatment for a painful condition was delayed for months. The extensive cancer left in his neck after his left tonsil was removed was ignored. In March 2013, he noted increasing lymph nodes. Medical, nursing staff and central office staff all became aware of his untreated cancer, but for the next four months, no treatment was offered.

26. In my more than three decades of doing this work, I have never seen such callous disregard demonstrated over and over again. Beginning in March 2012, medical staffs were fully aware that [redacted] was in severe pain, and did not treat him. When they finally realized that he had an uncontrolled infection, they delayed treatment. When he required surgery, the surgery was delayed. When he was diagnosed with cancer, his biopsy was ignored. When he sought care for the spreading cancer in March 2013, he again experienced delay after delay. Four months after the rediscovery, he had received no treatment. This is a horrifying example of a failed system that places every seriously ill man and woman it serves at extreme risk.

B. Failed Medical Care System

27. Although shocking, Mr. [redacted]'s case is not anomalous. Instead, it is a

tragic but predictable outcome of an appallingly poor medical care system that lacks the essential building blocks of an effective health care delivery system and has for years been inadequately staffed, funded and resourced. Moreover the types of lapses and delays I found in Mr. [redacted]'s case are consistent with the types of problems I found repeatedly in reviewing files and talking with patients.

28. Based on my experience in correctional health care systems, a sound system for a large statewide prison system like Arizona's must include at least the following nine elements: (1) a centralized organizational and management structure; (2) written policies and procedures that are implemented and followed consistently; (3) qualified medical staffing; (4) prompt intake/screening; (5) timely access to primary and specialty medical care, including for the chronically ill; (6) adequate clinical facilities; (7) medication distribution system; (8) a functioning medical records system; and (9) quality assurance, including a viable death review process. ADC's health care delivery system is broken because these essential elements, to the extent they exist, are ill-functioning and are so under-resourced and poorly managed that they are largely ineffective.

29. Despite the fact that these deficiencies are and have been amply demonstrated, including in Wexford's and Corizon's care data, ADC's contract monitoring reports, and individual medical charts, ADC has failed to develop and fund adequate staffing patterns and to allocate sufficient resources necessary to address the longstanding systemic problems.

30. When Wexford Health took over ADC's medical care delivery system, it found it "had to start from the basics and rebuild a dysfunctional program," and advised ADC that this was a task "far beyond the scope of the project described in the RFP." Wexford 000049. Meeting with ADC officials in November, 2012 Wexford staff set forth the myriad system failures it had uncovered, and admitted that "[t]he current class action lawsuits are accurate." Wexford 000130.

31. Based on my investigation, that admission is unfortunately as accurate

today with respect to Corizon as it was with respect to Wexford in November, 2012. A survey of cases I reviewed while visiting prisons in July shows no significant changes in care for many prisoner patients who have been the victims of continuing poor care from the Arizona Department of Corrections, Wexford, and now Corizon. To illustrate, and as set forth below and in more detail in Appendix C, [redacted]'s diabetes has been poorly controlled since November, 2012, his insulin regimen has been chaotic and dangerous for close to a year, and he has not been provided with an ophthalmology consult for close to a year; [redacted]'s diabetes care has been poorly managed from at least October 2012 until the current time; [redacted]' diabetes has been poorly controlled and his medications mismanaged since January, 2013; [redacted]' diabetes has been poorly controlled since December, 2012 and medical staff failed to recognize that fact; [redacted]'s diabetes and hypertension have been poorly managed since November, 2012; [redacted] has been waiting for cataract surgery since September, 2012, and his pain medications have been mismanaged during that same period of time; [redacted], a diabetic, has not had a required eye exam for over two years; [redacted] has not had the urology specialty consult that was ordered for him on January 1, 2012; [redacted] has been waiting 18 months for necessary eye surgery; [redacted] has had care for his HIV disease mismanaged since January, 2013; [redacted]'s HIV care has similarly been mismanaged since February, 2013; and [redacted] as described above, has not received treatment for a dangerous cancer that was diagnosed in November, 2012.

32. I also found numerous cases where the medical care mismanagement is clearly solely the responsibility of Corizon, including: [redacted]'s hypertension has been mismanaged since May, 2013; [redacted]'s medications were not renewed and critical lab results were not reviewed under Corizon; [redacted] suffered a delay in getting a necessary urology consultation under Corizon; [redacted] received no timely cardiology consultation through Corizon after his pacemaker failed; [redacted]

[redacted]'s MRSA has been mismanaged by Corizon; [redacted] has had no clinical or cardiology consultation follow-up under Corizon following an acute heart attack; [redacted] waited six months to receive treatment for his kidney cancer and relief for the severe pain he suffered from bony metastases; and [redacted] died because Corizon mismanaged his coccidioidomycosis pneumonia beginning in May, 2013. In all of these cases, these patients' suffered harm and serious risk of harm, needlessly.

33. These continuing and sometimes lethal failures to provide adequate medical care to prisoners with serious and long-standing medical problems demonstrate anew that management of patients with serious medical care problems and complications cannot be done on the cheap. Corizon, like Wexford and the Arizona Department of Corrections before it, has proved again that where corners are cut in providing medical care by having too few professional staff and an inadequate budget, patients will suffer, and sometimes die, because of systemic neglect. Prisoners are getting lost in the medical care system; their serious chronic diseases are not being followed as closely as they should be; and requests for necessary outside medical consultation are going unfilled.

1. Central Management

34. Although the ADC health care services were privatized, ADC is ultimately accountable and responsible for the statewide administration of health care. ADC created a Health Services Contract Monitoring Bureau, mostly comprised of administrators and health care staff who oversaw the delivery of health care by ADC prior to privatization. However, in terms of day-to-day activities, it appears that the contractor Corizon functions largely on its own in terms of deciding how (and whether) to deliver medical care.

35. The failures of the existing management structure are well-illustrated by the ADC's Health Services Contract Monitoring Bureau, which, on a monthly basis, generates lengthy reports regarding compliance with the health care contract at each of

the prisons. Although these reports consistently document ongoing failures to comply with the contract requirements in many critical areas, including requirements to screen and process sick call requests timely, to implement chronic care treatment plans and to deliver necessary medications, it is not clear who, if anyone, ever reviews these reports. The head of the Bureau testified he does not read the reports on a monthly basis. Gross Dep. 13:17-14:2; *see also* Campbell Dep. 143:2-5 (Program Evaluation Administrator who supervises contract monitors does not read all of the monthly MGARs).

36. The ADC's most recent Quarterly Monitoring Reports, covering April through June 2013, document Corizon's consistent non-compliance with critical program measurements for sick call and chronic disease management for the state's two largest prisons, Lewis and Eyman. ADC 137754, 137780. These non-compliance findings are repeated in each of the months of July through September, 2013. These findings are entirely consistent with the extreme level of dysfunction that I observed when visiting those two prisons. Indeed, as part of the monthly auditing program, Corizon is required by contract to develop Corrective Action Plans (CAPs) for every performance measure with an unsatisfactory score. However, they frequently fail to produce the CAPs. Headstream Dep. 146:19-148:2 (despite repeated findings of noncompliance, Lewis did not submit CAPs). Defendants also have failed to produce the CAPs for review by Plaintiffs' counsel or me.

37. Despite these repeated failures, ADC management has failed to enforce the CAP requirement. Haldane Dep. 56:12-57:17; 143:12-143:17; Medel Dep. 160:17-161:15; Campbell Dep. 130:22-131:8. Instead, they continue to generate audit reports month after month that bear witness to gross systemic failures without addressing them, or requiring their contractor to address them.

2. Written Procedures

38. A constitutionally adequate correctional medical care delivery system for a

prison system with 33,000 prisoners must have and consistently follow comprehensive written policies and procedures. My review of documents and observations at Eyman and Lewis, and review of the MGAR reports establishes that there is a system-wide practice of not following the ADC and Corizon policies and procedures because, among other things, a failure to provide adequate staffing, supervision and resources to promote compliance.

3. Qualified Staffing

39. The foundation of any sound health care delivery system is staffing adequately trained and in sufficient number to address the patient population's health care needs. Without a sufficient number of clinicians on staff, it is simply impossible to ensure that prisoners receive the care that they require.

a. Insufficient Allocated Positions

40. Corizon's current clinical staffing allocation is so alarmingly low that, even if all positions were filled, which is not the case, it would be impossible for the system to delivery adequate health care to the number of prisoners currently in the ADC system.

41. Inadequate clinical staffing has long been a problem for ADC. Institutions were not fully staffed by ADC during the April 2-July 1, 2012 transition period from ADC to Wexford. Pratt Dep. 21:22-22:12. One doctor characterized that time as a period of "a great exodus of staff, both from the mental health and medical areas that weren't being filled." Crews Dep. 18:5-12.

42. Staffing continued to be a problem under Wexford. "It was an understood" that staffing levels at the institutions was one of Wexford's concerns prior to taking over delivery of health care. Pratt Dep. 29:6-10. "A smaller staffing ratio creates a greater risk." (Shaw Dep. 125:5-6) As ADC's Joe Profiri wrote, "Based on the documentation from Mr. Pratt the core problem is staffing. The inadequacy of staffing levels are the root cause of all other deficiencies, none of which can be effectively remediated or sustained

with any success until staffing deficiencies are corrected. Wexford should be laser focused on addressing staffing." AGA_Review_00037464.

43. Given that staffing had been identified as a critical issue under ADC and Wexford, I was stunned to learn that Corizon, upon taking over the system in March, 2013, apparently eliminated 30 medical service positions, including almost one third of the staff physician positions and about 15% of the RN positions. AGA_Review_00006402.

44. The next month, ADC monitor, Mark Haldane, reported staffing problems for nurses at Eyman prison. "[T]he tentative schedule for May has large gaps in nursing coverage. It appears that there are days that there is no coverage in any of the cell blocks." AGA_Review_00013126. He further explained, "Even at current staffing levels, nurses are finding ways around standard practice… making errors …and omitting some tasks. . . . Apparently nursing staff at all Eyman units are being cut." *Id*. He concluded with, "staffing remains a concern of nursing supervisors at Florence and Eyman and many others (including me)." *Id.*

45. Currently, the full-time clinician staffing allocated for each of the larger prisons, and Phoenix, with its specialized missions, is extraordinarily thin.[5] Douglas complex, which houses approximately 2,200, is allocated no physicians and only a single mid-level practitioner (*i.e.,* a nurse practitioner or physician's assistant). Eyman, Lewis and Yuma, with approximately 5,300, 5,400 and 4,500 prisoners respectively, are each allocated only a single physician and three mid-level practitioners. Tucson houses over 5,000 prisoners, including the sickest prisoners in the system (Robertson Dep. at 32:3-

[5] Under Corizon, each of the prisons is allocated a Medical Director, and I believe that position must be filled by a physician. I have been told that the Medical Director may have clinical duties. However, given the administrative duties typically demanded of a Medical Director in a prison complex serving several thousand people, it is not possible for the director to have a full clinical schedule, thus I have not included them in my count of clinicians.

15), yet has only two physician positions and three mid-level positions. With 4,060 prisoners, Florence has two physician and two mid-level positions. Perryville, which has the only intake unit in the state for women and houses over 3,700 women prisoners, has two physician and five mid-level positions. Phoenix is a smaller facility with approximately 680 prisoners, but it has several specialized missions, with a 40 bed licensed acute mental health unit and a 135 bed licensed intermediate mental health unit, a transitional care unit for mental health inmates, and the state's primary intake unit for men, Phoenix has only a single physician position and four mid-level positions. ADC 153777-153793.

b. Failure to Fill Allocated Positions

46. As noted above, staffing at this level would be grossly inadequate for the number of Arizona prisoners if all positions were filled, but Corizon has not been able to fill even these few positions. According to the July 2013 Arizona staffing report, 4.5 of the state's 10 physician positions were vacant. *Id.* The September 2013 report shows some improvement, but the system is still short almost three full physician positions, and more than four of its ten Medical Director positions are vacant. ADC 155099.

47. In addition, many other key allocated positions have been vacant. July: ADC 153779 (Eyman had no Medical Director, a 37.8% vacancy rate for RNs, and a 60% vacancy rate for RN Supervisors); ADC 153782-83 (Lewis lacked a Medical Director, and had a 32% vacancy rate for RNs) and Bybee Dep. at 50:3-7 (Lewis does not have a Facility Health Administrator); ADC 153791 (Winslow, allocated a full-time medical director and mid-level practitioner has only a half-time director); September: (Douglas has no medical director and only nurse practitioner position is vacant); (Eyman has no medical director); (Lewis has no medical director, and 32% vacancy rate for RNs); (Safford has only 1 LPN for 6.10 positions); (Winslow's one nurse practitioner position is vacant). ADC 155099.

48. Dr. Robertson opined that Corizon has been unable to fill its clinical staff positions because they do not pay enough (Robertson Dep. at 96:9-96:23), and the COO of Corizon testified Corizon has increased the salary matrix for physicians and medical directors but the number of applicants for those positions did not increase after the salary changes. Bybee Dep. at 52:13-53:1.

49. Corizon's staffing deficiencies have been evident and documented at the Eyman complex since the start of their contract in March of this year. 4/9/13 MGAR, ADC 088836 (In 4/13, Eyman site manager reported that he did not have a medical director or director of nursing at Eyman and had only two providers, one physician and one mid-level). ADC's monitor wrote on 4/12/13, "There is no provider on any unit at Eyman Complex today…. Some inmates are going weeks without medications. For example, [redacted] wrote an HNR stating, 'I have been without my seizure medications since the 23rd of March and I've begun having some bad seizures. My meds were renewed last month. I've written medical and the nurse said she called pharmacy, yet still I have no meds.' . . . . His chart sits on a provider cart on a yard… with no provider. They have been without a provider for 6 weeks." AGA_Review_00015753. Regarding Browning unit, he writes that he had been told their chronic care appointments were "pretty good," but then found their "HNR referrals were backlogged to December." *Id.*

50. Serious problems are documented at other prisons as well. 4/25/13 MGAR, ADC 088893 ("[Lewis] staffing patterns not supportive of required performance measures at present."), 4/17/13 MGAR, ADC 088995 ("[Staffing at Safford] continues to be an area of potential concern. Corizon has approved fewer nurses than previously were employed."), 4/16/13 MGAR, ADC 089077 ("There has not been a contractor physician at the Winslow or Apache medical units as of this date during the month of April with the exception of one day at each unit that a doctor did chart reviews and saw a total of three inmates"), 4/19/13 MGAR ADC 089081. (Noting that Winslow needs a medical

director, mid-level provider, LPN, medical technician, x-ray technician, and a PCT).

51. The ADC has continued to document the staffing problems since then. 7/31/13 MGAR, ADC 137224 (As of July 31, 2013, "although several vacancies have been filled [at Eyman], there are presently no staff working on site in several key positions. These include nursing supervision (3x), Medical Director, Clinical Coordinator, and the Assistant FHA."), 9/5/13 MGAR, ADC 154043 (As of September 5, 2013, the following positions [at Douglas] were not filled: 1 FTE medical director, 1 FTE mid-level practitioner, 1 FTE dental assistant, 0.75 FTE dentist, 0.90 FTE LPN, 0.40 FTE nursing assistant, 0.50 FTE RN…These are critical positions to have unfilled as the staffing plan submitted by Corizon allows for no back-up coverage built into it).

52. The monitoring reports also suggest that Corizon does not employ sufficient temporary staff to meet the medical needs of the inmate population. 4/22/13 MGAR, ADC 088911 ("Current staffing patterns [at Lewis] are affecting nursing and provider lines. All locum and registry nursing has been cut with no noted replacement of F/T staff to cover shortages at present.").

53. Very predictably, inadequate staffing drives appointment backlogs and treatment delays. 4/15/13 MGAR, ADC 088843 ("Provider staffing is woefully inadequate. As of April 12, complex-wide [at Eyman] there were over 450 charts in provider review carts."), 7/22/13 MGAR, ADC 137342 ("Though efforts at increasing current staffing levels [at Lewis] continue, the shortages in all areas to include providers for medical and psychiatry and in areas of nursing clearly compromise the ability of current staff to manage the extensive medical needs of the population."), 4/16/13 MGAR, ADC 089077 (without physician at Winslow, "[c]hart reviews have not been conducted and likely wouldn't be even if a full time physician started today as it would take the rest of the month to catch up on the backlog of inmates needing to be seen and the backlog of chart reviews.").

4. Intake Screening

54. Prompt intake screening is essential in a correctional setting to ensure, among other things, that patients receive timely medications for serious medical conditions, are screened for communicable diseases and are identified as requiring ongoing attention from specialty consultants.

55. The vast majority of intake screening in the ADC takes place at Phoenix (for men) and Perryville (for women), two prisons that I did not visit.

5. Timely Access to Medical Care

56. In order to ensure that prisoners are able to request medical care when they need it, prisons must have a system for prisoners to make their health care needs known, and for ensuring those requests are evaluated and addressed in a timely manner. For prisoners who suffer from chronic illnesses, the prison must have a system for tracking and scheduling appointments regularly to ensure continuity of care. For those who require care beyond the expertise of their primary care provider, the prison must have a system of referral to specialists.

a. Sick Call

57. The ADC has a "sick call process" that patients use by submitting a "health needs request" (HNR) for which they must pay $4 for each request, if they have funds. Under ADC's policies, HNRs are supposed to be collected every day, and for those requests listing symptoms, the patient should be seen by an RN within 24 hours (72 hours for weekends). Health Services Technical Manual**,** ADC 010827. If the patient needs further medical attention, he or she is supposed to be scheduled to see the provider (physician or mid-level) within seven days.

58. At the prisons I visited, it was clear these requirements are routinely ignored, causing patients to endure pain and suffering unnecessarily, as demonstrated

above in the [redacted] case, and in many other cases I reviewed. Among other prisoners who experienced harm because of delayed care was [redacted]. On 5/10/13, he submitted an HNR at Eyman complaining of a cyst in his armpit. He wrote: "Excruciating" "I can hardly move my arm. I think it has to drain. Emergency. Please see me ASAP. I can pay the $4 for this emergency visit. Thanks and God bless." On 5/13/13 he was told that he would be scheduled to the nurses' line. Six days later, he submitted a second HNR stating "Well now it is all infected. I have red streaks running down my arm." ADC 136482. On 5/24/13, two weeks after he submitted the HNR complaining of severe pain from his abscess, he was seen by an RN who confirmed that he had an abscess. Nurse Dorsica cleaned the wound, cultured it, and prescribed an antibiotic, clindamycin 150 mg three times a day and put bacitracin on the wound. Mr. [redacted]'s infection was cultured as methicillin resistant staph aureus. This is a very serious infection. Treatment of a serious painful bacterial infection should not be delayed for two weeks.

59. [redacted] a 40 year old man who has hypertension, asthma, epilepsy, and a history of a pituitary tumor, had his last chronic care visit a year before my July 2013 visit to Lewis. His April 20, 2013 HNR stated: "I'm losing my vision, difficulty seeing, experiencing pain and pressure and loss of peripheral vision." In the three months after submitting the HNR, Mr. [redacted] was not seen by an RN or an MD.

60. [redacted] right leg has been amputated. He submitted an HNR at Eyman for repair of his right prosthetic leg on May 1, 2012. On September 4, 2012, four months later, his HNR was reviewed, and an appointment with a physician's assistant was scheduled. ADC 136478. Mr. [redacted] was not seen by the physician's assistant about his broken prosthesis until April 9, 2013, eleven months after he placed his HNR.

61. Named plaintiff Stephen Swartz, 102486, reported that because of the shortage of medical staff at Lewis, it takes prisoners an average of three months to see the

doctor from the time they file a HNR. He reports that he submitted an HNR on January 13, 2013, requesting evaluation of a pigmented enlarging mass on his waist. He received no response and continued to submit HNR's. He was finally seen on June 26, 2013, more than five months later.

62. Named plaintiff Joseph Hefner at the Lewis-Barchey Unit, likewise reported he has encountered significant delays in care. When I interviewed him, he had recently had surgery on his left eye for glaucoma. However, following the surgery, he had not gotten the medications he needed or had a follow-up with the ophthalmologist, and he described symptoms that I found very troublesome and indicative of a possibly detached retina. He had pain behind the eyes, floaters, blurriness and spots. He had to file numerous HNRs (ADC 122325-28) but didn't see the prison doctor until July 12. According to Hefner, the prison doctor didn't do any sort of exam, not even pulling out the ophthalmoscope, and told Hefner his eye looked fine.

63. According to Mr. Hefner, nurses' line occurs only twice a week on the yard, and it takes eight weeks to be seen at the nurse's line from the time of filing a HNR. He said after nurses' line, it takes another 4 to 6 weeks to see the doctor. Other prisoners I spoke to at Lewis reported similar delays.

64. Prisoners housed in Eyman's SMU-I and Browning isolation units reported that custody staff will not give prisoners a blank HNR when they ask for them. The process is that the prisoner has to first write a "kite" (an informal letter) to the officers requesting blank HNR forms, and then a couple days later on the graveyard shift, they will be delivered blank forms. Once the prisoner fills out an HNR, they have to give them to custody officers and not the pill nurses or others coming in the unit. This type of custodial involvement is problematic because being forced to disclose medical information to custodial staff violates the prisoners' right to medical privacy.

65. ADC is aware of the failure of prisons to conduct nurse triage within 24 hours of reviewing the HNR, although it appears some staff may have tried to hide the

problem. ADC's compliance monitor Terry Allred documented on 5/22/13 that staff had found a backlog of HNRs dating back to December 2012. According to Allred, "it was clearly stated to [the person who discovered it] that the finding was not to be revealed to the audit team." AGA-Review_00017341.

66. MGAR reports likewise amply document the problem. 7/25/13 MGAR, ADC 137185 ("Of 40 medical charts reviewed [at Douglas] (10 at each unit), 18 were not seen within 24 hours of their respective HNR being triaged."); 7/31/13 MGAR, ADC 137201 (Of 50 charts reviewed[at Eyman (10 on each yard), 22 inmates were not seen on nurses line within 24 hours following the triage of their HNR.); 7/30/13 MGAR, ADC 137268 ("Of the 30 inmate medical charts audited (complex wide), only 3 of those noted patient encounters within the required 24 hour period. Of those same 30 inmate medical records, which included 7 '911' or emergent requests, 1 was seen on the same day of submission, while the other 6 were seen on average 6.2 days later."); 8/30/13 MGAR, ADC 137465-66 (Reporting that 32 out of 51 charts reviewed at Eyman indicated that sick call inmates were not being seen within 24 hours of HNR triage); 9/17/13 MGAR, ADC 154348 (Noting that Winslow had a 70% compliance rate with measure requiring inmates to be seen within 24 hours of HNR triage and requesting a corrective action plan); 9/27/13 MGAR, ADC 154050-51 (Reporting that 30 out of 50 charts reviewed at Eyman showed that sick call inmates were not being seen within 24 hours of HNR triage); 9/27/13 MGAR, ADC 154148 ("10 charts pulled from each unit [at Eyman] for the month. The percentage that were not seen within 24 hours of triage: Morey 80%, Stiner 40%, Buckley 50%, Barchey 60%, Rast 90%, Backman 70%, and Eagle Point/Sunrise 90% . . . Of those HNRs which were of the 911 variety: the standard wait time was 1-20 days after triage.")

67. Audits likewise demonstrate the long wait times for provider appointments, following nurse triage. For the month of July, 2013, Corizon reported wait times of up to six months for patients to see their Primary Care Provider (PCP) at Eyman, and up to six

weeks at Lewis. ADC 153838. For September, wait times at Eyman remain up to six months, while wait times at Lewis are up to a month. ADC 155093.

68. The ADC's monitoring reports also show regular delays in access to primary care provider clinicians. 4/16/13 MGAR, ADC 088816 ("In almost no cases are sick call referrals seen within 7 days. Rynning Unit [Eyman] has not had a provider for 6 weeks. No unit reported having a provider more than two days per week. Hundreds of HNR appointments/referrals are backlogged at every unit. The backlogged appointments go back to August. Hundreds of charts are on provider carts in the Complex, many at units without a provider to see the patients."); 4/30/13 MGAR, ADC 088893 ("A random audit of 20 nursing patients complex wide [at Lewis] reflected that only about 10% saw the provider within the 7 days period as required."); 4/16/13 MGAR, ADC 089062 ("Referrals to providers from sick call have not been seen within 7 days because Winslow has not had a provider this month."); 7/8/13 MGAR ADC 137403 (Requesting corrective action plan for the failure to have "referrals to providers from sick call being seen within seven (7) days" performance measure at Winslow). These consistent and widespread delays pose a threat of significant harm to the prisoner patients.

b. Chronic Care

69. A prison medical care system must provide adequate care to the most challenging of its patients. Those patients are often the sickest, have chronic multi-system diseases, and require close monitoring to keep their complicated diseases from spiraling out of control. Thus, a critical measure of the success, or lack of success, of a prison medical care delivery system is how well that system manages patients with serious diseases that require chronic care.

70. ADC has failed to implement a functioning tracking system that ensures that chronically ill prisoners see their providers on a regular basis. According to Kathy Campbell, the prisons use different systems at different prisons to schedule chronic care

appointments, including an electronic program called IHAS, and a system based on index cards. 9/11/13 Campbell Dep.171:20-172:11. Corizon's VP Vickie Bybee acknowledged that IHAS could generate some chronic care tracking report, "if used," but testified that most prisons were not using it. Bybee Dep. 107:7-17. Others testified that the IHAS program was not used consistently or was otherwise flawed. See Headstream Dep. 163:1-21; Dr. Crews Dep. 99:2-13; Mullenix Dep. 36:9-37:4; Fisher Dep. 23:1-15.

71. Without an effective tracking system, seriously ill patients cannot be effectively monitored and managed, and many will deteriorate. This is precisely what I found in the prisoners I interviewed and the files I reviewed.

72. At Eyman and Lewis, I routinely heard prisoners with chronic conditions complain that they were not scheduled for regular appointments. When I was able to review their medical charts, the records often documented these lapses. For example, [redacted] (Eyman) has Hepatitis C. He told me he sought follow-up for this chronic condition. On December 30, 2012, he placed an HNR in order to see a provider. On January 18, 2013, there was a response sent to Mr. [redacted] – "Appointment set." As of July 16th, when I reviewed his medical record, six and a half months later, the HNR was unanswered, and there was no documentation that he had seen a provider for a chronic care appointment.

73. Similarly, [redacted], Lewis, has HIV infection. Unfortunately his infection is not responding to prescribed treatment. Laboratory studies obtained on April 12, 2013 showed a low CD4 count of 230/mm3, and a high viral load of 3264. Importantly, three months before, on January 18, 2013, the viral load was undetectable. Although Dr. Merchant reviewed the laboratory studies on May 11, 2013, Mr. [redacted] had not been informed of the deterioration of his condition and no action has been taken to ameliorate it as of the date I reviewed the file.

74. When a person with HIV infection on treatment with previously undetectable viral loads develops a high viral load, this deterioration must be investigated

promptly. Resistance can develop to treatment, and can result in rapid deterioration of the patient's clinical status. Mr. [redacted] already has a very low CD4 count. Should it drop below 200, as is likely given his trend, he will be at high risk for opportunistic infections. It is extremely disturbing that Mr. [redacted]' deteriorating condition is not being addressed. Additional studies must be urgently obtained to determine if he is resistant to his current medications, appropriate treatment should be provided, and if T-cells have fallen further, appropriate medications must be provided to prevent opportunistic infections.

75. Diabetes mellitus likewise requires proper management. Without it, the patient's HgA1c levels (hereafter A1c levels)[6] will be elevated, as will his blood sugars. A prisoner-patient whose diabetes is not properly controlled runs the risk of blindness from diabetic retinopathy, and kidney failure from proteinuria (excessive protein in the urine, a complication of diabetes that tells medical staff that the diabetes patient runs the risk of kidney failure). Diabetics require regular eye exams to look for diabetic retinopathy as well as regular kidney function testing for proteinuria.

76. Medical charts that I reviewed for diabetic prisoners revealed a pattern of very poor care resulting in increased morbidity and an elevated risk of death in some cases. See, e.g., [redacted] (no change in insulin dosage despite persistently high A1c level); [redacted] (change to insulin dosage caused rise in A1c level, was prescribed wrong types of insulin for his condition); [redacted] (A1c over 12.9 for a year, no adjustment to insulin); [redacted] (A1c increases from February to May, but provider documents his control is improving); [redacted] (referred for

[6] The A1c test is a common blood test used to diagnose type 1 and type 2 diabetes and to gauge how well the condition is controlled. The A1c test result reflects the patient's average blood sugar level for the past two to three months. The higher the A1c level, the poorer the blood sugar control and the higher the patient's risk of diabetes complications. The goal for most diabetics is a level less than 7.

optometry check on 3/18/12, with no appointment at last chronic care follow up on 5/12/12), [redacted] (poorly controlled diabetic, incorrectly characterized by provider as "fair" control, with no recent eye exam or tests for proteinuria); [redacted] (no eye exam for last two years); [redacted] (no treatment for proteinuria). [7]

77. I found many other cases where chronic care patients were very poorly managed, whether or not they were regularly seen by their provider. [redacted] (critical lab studies for HIV delayed, and once done, not reviewed for weeks); [redacted] (no prescription changes for patient with persistently very high blood pressure values); [redacted] (on warfarin therapy, INR lab results were consistently reviewed 3-6 weeks after they were drawn.);[8] [redacted] (no chronic care appointment between 2/27/13 and 7/16/13, with INR levels dangerously out of range and abnormal A1c); [redacted] (failure to prescribe anti-seizure medications; patient has frequent seizures as a result); [redacted] (medications unchanged for patient with very high blood pressure; intervals too lengthy between visits).

78. ADC's monitoring reports document chronic care inmates often are not seen by the provider every three to six months, as specified in the inmate's treatment plan. 4/26/13 MGAR, ADC 088799 (Douglas inmate with hypertension was last seen in June 2012, was supposed to be seen in August 2012, but had not had a chronic care appointment as of 4/26/13. Douglas inmate with seizures was due to be seen in October 2012, but had not had a chronic care appointment as of 4/5/13. Douglas inmate with seizures was due to be seen in November 2012, but had not had a chronic care

[7] As noted above, I have attached as Appendix C my summary of my review of the medical charts for the patients discussed in my report.

[8] Warfarin is used to prevent clot formation. It is a drug which is safe only within a very narrow range, and ineffective or very dangerous outside of that range. The degree of anticoagulation is measured by the INR test. Patients on warfarin must have their INR measured frequently, with warfarin dosage adjusted immediately, based on the results of the test.

appointment as of 4/5/13); 4/14/13 MGAR, ADC 088982 (Inmate arrived at Safford on 1/19/12 but he did not receive chronic care appointment for his asthma, hypertension, and Hepatitis C until more than a year later on 3/6/13), 4/19/13, ADC 089065 (At Winslow "multiple [chronic care] charts noted out of compliance in being seen by Provider (every three (3) to six (6) months) as specified in the inmate's treatment plan."); MGAR, ADC 137472-73 (At Eyman in August, 25 out of 50 charts reviewed showed that chronic care patients were not being seen by the provider every three to six months as specified in the inmate's treatment plan), MGAR, ADC 137527-28 (At Lewis in August, 53 out of 76 charts reviewed showed that chronic care patients were not being seen by the provider every three to six months as specified in the inmate's treatment plan); 9/30/13 MGAR, ADC 154059-60 (At Eyman, 24 out of 50 charts reviewed showed that chronic care inmates were not being seen by the provider every three to six months as specified in the inmate's treatment plan); 9/30/13 MGAR, ADC 154059-60 (At Eyman, inmate with previous chronic care appointment on 3/15/12, seen 7/22/13. Inmate with previous chronic care appointment on 2/2/12, seen 9/24/13. Inmate with previous chronic care appointment on 6/11/12, not seen as of 9/16/13); 9/25/13 MGAR, ADC 154152-54 (At Lewis, 50 out of 71 charts reviewed showed that chronic care patients were not being seen by the provider every three to six months as specified in the inmate's treatment plan).

c. Specialty Care

79. In addition to primary care, some prisoners will require access to specialty providers. A sound prison medical care system must ensure that those prisoners are referred to a specialist on an urgent or routine basis, are timely seen, and then followed up by their provider so that any recommended treatment may be provided. ADC does not have an effective system for ensuring that prisoners receive specialty care when needed. Corizon Vice President Vickie Bybee and others documented this problem on May 10,

2012, in an email exchange indicating a backlog of almost 1000 specialty consult referrals that were more than three months old. "We continue to be made aware of consults not processed at the sites in loose filing, in medical records as we see patients." AGA_Review_00016658.

80. In my chart review, I discovered notable failures to refer prisoners for specialty services when they are clearly indicated. For example, [redacted], a diabetic, requires yearly eye exams to monitor for diabetic retinopathy, had not had an eye exam for two years. Mr. [redacted] has HIV infection, and entered the prison with a low T-cell level and a high viral load of 221,310, but was not referred to an HIV specialist until July 2, 2013, five months after his admission to the prison system. Mr. [redacted], was diagnosed with a three inch mass in his throat on 5/9/13. When I reviewed his chart more than two months later, I found a CT scan and ultrasound showing the mass, but no diagnosis or referral to a specialist, despite the fact that the mass may be cancerous.

81. Patient charts demonstrate that when ADC prisoners are referred for specialty care, the appointments can be delayed or never occur. A urology consult was ordered for Mr. [redacted], 67676, on January 1, 2012, because he had symptoms of a urethral stricture, but the consult had not taken place by my July 2013 visit. [redacted], was referred for an ophthalmology consultation on March 5, 2013, and again on July 17, 2013, both for monitoring diabetic retinopathy and for surgical correction of the ectropion, an eye condition which poses a serious risk of infection. In his July 17, 2013 consultation request to Corizon, his provider noted: "left eye pronounced ectropion, irritation of eye, injected sclera . . . This is [a] case which has been delayed approximately 2 years." ADC 136680. Mr. [redacted] with his failing pacemaker, had cardiology consult requests dating March 22, 2013 and April 29, 2013. ADC 136528. As of July 17, 2013 no consultation had been approved or provided.

82. [redacted], also suffered a delay in his specialty referral. Mr.

[redacted] injured his hand on August 13, 2012. Although medical staff saw him and advised that his hand was not broken, it remained extremely painful and swollen. An x-ray, taken four weeks after the injury on September 10, 2012, showed a boxer's fracture of the hand with distal angulation. The x-ray report was not reviewed by the prison physician, Dr. Merchant until September 21, 2012, ten days later. Dr. Merchant made note of the fracture and requested an orthopedic consultation as soon as possible. Mr. [redacted] was finally seen at an orthopedic consultation on November 14, 2012, three months after the injury.

83. As set forth above, Mr. [redacted] endured a seven week delay when waiting for his urgent appointment with the ENT to treat his cancer, a six week wait for an urgent CT scan, and a 33 day wait for a "stat" oncology appointment. Mr. [redacted] likewise suffered unconscionable delays in his care for cancer. He had complained for months of chest pain, but had received only Tums for indigestion. After several visits to the provider in May and June, 2013, he was sent to the hospital on 6/19/13 when he complained of chest pain and vomiting blood. Mr. [redacted] told me he was diagnosed with small cell lung cancer. The hospital recommended a PET scan and oncology consult. Both were ordered on 6/27/13, ASAP. However, when I interviewed Mr. [redacted] a month after his diagnosis, neither the PET scan nor the consult had happened. Small cell cancer is generally treated with chemotherapy, but Mr. [redacted] had received only pain medication since his diagnosis.

84. When patients do have a consult report, the prison often fails to schedule the necessary follow-up appointment with the providers so that the patient may receive the care recommended by the specialist. For example, named plaintiff Mr. Hefner reported in his Declaration dated November 1, 2012 a long history of eye pain and vision problems, eye surgeries, and delays in his medical care. Mr. Hefner had cataract surgery on June 13, 2013. He reported that following the surgery he developed flashing lights, floaters, and blurred vision. He submitted an HNR on June 19, 2013 complaining of pain

in his eye and difficulty seeing. Mr. Hefner has iritis, an inflammation of the external eye, which causes pain and blurred vision. The ophthalmologist Dr. Heller ordered steroid eye drops and antibiotic eye drops. Mr. Hefner received the steroid eye drops, but not the antibiotic drops. The medical record supports his statement because it shows that the antibiotic order was not acted on until July 15, 2013, the day his attorney and I met with him. That day, Mr. Hefner was still having difficulty seeing and was in pain. He has been unable to obtain follow-up care for his painful condition. I informed Dr. Winfred Williams, Corizon's regional medical director for Arizona, of my concerns regarding Mr. Hefner's medical problem.

85. Mr. [redacted] suffered an acute heart attack on 3/27/13. Management of an acute heart attack requires maintenance of anti-platelet therapy. When I reviewed his file at Lewis, I noted that, in the intervening three and a half months, there was no evidence that Mr. [redacted] has seen a provider during that period, or that he had had any follow-up cardiology consultations. There were also no MARs (medication administration records) for May or June, 2013. This failure to follow up with a patient after a major health event is shocking.

86. [redacted], a 47 year old man, was housed at ASPC-Winslow. Mr. [redacted] suffered severe pain for more than six months before receiving adequate pain medication, and his cancer treatment was deliberately delayed more than four months. Mr. [redacted] complained of back pain. He was scheduled for evaluation of this complaint on 1/23/13 but the appointment was cancelled because no practitioner was available. He was finally seen for his HNR on 2/21/13 by a nurse, and on 2/26/13 by a nurse practitioner. He failed to respond to treatment for his back pain. The x-ray of his lower spine taken on the 2/26/13 was not filed in the chart on 3/12/13 and the NP ordered another x-ray, which was taken six weeks later, on April 22, 2013. This film showed bony abnormalities consistent with cancer. Corizon denied requests by the Nurse Practitioner for an MRI scan. Mr. [redacted] suffered increasing pain and lost the ability to

bear weight on his right leg. He could not walk without crutches.

87. The plain x-ray film of the bones taken 4/22/13 was strongly suggestive of cancer. On 5/23/13 CT scans of the Abdomen and Pelvis were ordered to definitively identify the source of the cancer and evaluate its spread. On June 10, 2013, Dr. Moyse noted in the medical record that "Request for CT of Abdomen and Pelvis was denied. Inmate needs to be seen …for follow-up." Finally, almost two months later, on 7/23/13, a CT scan of the Pelvis and hip was performed which showed that Mr. [redacted] did have cancer, it had spread to both of his hips, and was so extensive that a fracture of his hip was impending. The CT scan of the abdomen was not performed at this time.

88. A CT scan of the abdomen was performed six weeks later on 9/3/13. It showed that Mr. [redacted] had cancer of the right kidney, with increasing metastatic bone involvement. It is frightening to read that Corizon denied the MRI scan ordered to determine the source of his cancer, and denied then delayed the critical CT scans for more than four months. During this period, Mr. [redacted]'s cancer spread, the delay of treatment worsened his chance of effective treatment, and left him to suffer severe cancer pain without treatment. He did not see an oncologist until after August 30, 2013. He was never provided with radiation therapy although radiation therapy has been shown to be effective for relieving bone pain from metastatic kidney cancer. It was not until August 21, 2013, four months after the x-ray showed that he had probable metastatic bone involvement causing his pain, that Mr. [redacted] was provided with appropriate pain medication.

89. Mr. [redacted]'s mistreatment demonstrates multiple failures in the Arizona Department of Corrections medical program: delays in responding to an HNR, delays in care because of staff unavailability, disorganized medical records with delays in access to reports, intentional prolonged delays in diagnosis and treatment of cancer by the Corizon specialty care coordinator. These failures were accompanied by severe untreated cancer pain, and according to Corizon medical staff, a terminal prognosis. A request to the

Board of Executive Clemency for early release due to imminent death was submitted by Dr. David Robertson on September 30, 2013. Dr. Robertson noted that Mr. [redacted]'s right kidney had been removed, and that he would "start chemotherapy in a few weeks." The decision by Corizon to deny the CT and deny the MRI requests when they were aware that Mr. [redacted] had bone changes indicative of metastatic cancer is terrifying to this reviewer, and demonstrates the grave danger to prisoners who are forced to live under Corizon's medical control.

90. ADC's monitoring reports show that prisoners who are referred for specialty care on an urgent basis, meaning they are supposed to be seen within 30 days of the consult's initiation, are often not seen within that timeframe. 9/30/13 MGAR, ADC 154056 (At Eyman, only 1 out of 12 charts reviewed showed that urgent consultations were being seen within 30 days of the consultation being initiated); 9/25/13 MGAR, ADC 154151 ("There is no urologist available to see inmates with approximately 10-12 inmates with urology consults pending."); 7/12/13 MGAR, ADC 137343 (Reporting that an urgent request to receive an echocardiogram was submitted for Safford inmate on 5/6/13 and the echocardiogram was performed on 7/2/13); 7/30/13 MGAR, ADC 137187 (Inmate received an urgent request for a urology consultation on 7/1/13 which was not approved as of 7/29/13. An unknown inmate received an urgent request for a cardiology consultation on 6/13/13 which was not approved as of 7/29/13); 7/31/13 MGAR ADC 137270 (Listing a sample of 22 urgent consultations requested for Lewis inmates that had not been scheduled within 30 days of the consultation being initiated).

91. The monitoring reports also show that consultation reports often are not timely reviewed by providers for patients returning from specialty care. 9/25/13 MGAR, ADC 154150 (Reporting that only 11 out of 20 charts reviewed showed that consultation reports were being reviewed by the provider within 7 days of receipt); 4/14/13 MGAR, ADC 088981 (Reporting that an outside consultation for a Safford inmate was dated 2/27/13 but was not reviewed by a provider as of 4/11/13), 9/30/13 MGAR, ADC

154056-57 (At Eyman, only 1 out of 12 charts reviewed showed that consultation reports were being reviewed by the provider within 7 days of receipt); 9/25/13 MGAR, ADC 154150 (At Lewis, only 11 out of 20 charts reviewed showed that consultation reports were being reviewed by the provider within 7 days of receipt)

6. Adequate Physical Space

92. Prison health care systems must allocate and equip sufficient space so that medical care can be delivered in a confidential and hygienic setting, and must either maintain sufficient medical beds on-site, or contract for medical beds for those patients requiring inpatient or infirmary level beds.

a. Clinic Space

93. The Eyman and Lewis prison complexes lack sufficient clinical space to provide constitutionally adequate medical care, given the number of prisoners housed at the prisons and the number of prisoners with chronic medical conditions who are at each prison. According to the most recent chronic care reports provided by Defendants, dated March 12, 2013, at Lewis, more than 20% of the total population had one or more chronic condition that needs regular monitoring: 1,187 chronic care patients out of a total population of 5,591.[9] ADC 095002-095052. At Eyman, chronic care patients account for an even higher percentage of the prison population: 2,173 out of 5,235 total prisoners, or 41.5%. ADC 094844-094931. (These numbers also show that it is physically and mathematically impossible for timely and minimally adequate chronic care to be provided, given the number of clinicians allocated to the two facilities).

94. As detailed below, the prisons appears to be making minimal use of the limited clinical space. In functioning correctional health care systems, the yard medical clinics are the busiest section of the prison. Nurses and doctors are examining and

[9] The daily populations for Lewis and Eyman prison on March 12, 2013 are available on ADC's website at http://www.azcorrections.gov/adc/PDF/count/03122013%20count%20sheet.pdf.

treating patients; prisoners are lined up inside and outside the clinics awaiting care. Correctional officers would be stationed outside and inside the clinics, escorting prisoners to and from appointments as needed, or providing supervision of the patients waiting at the clinics. Similarly, prison infirmaries, inpatient hospitals, and health care units should be busy places with medical staff on rounds, delivering medications and providing care and assistance with activities of daily living to the infirm and sick.

95. This was not the case at the two prisons I inspected: the unit clinics were eerily quiet shuttered and dark offices, medical equipment was nonfunctional or covered in dust, and there was no indication that any medical care was being delivered. Indeed, some clinics had the air of a Potemkin village, with clinics and equipment on display, but curiously, neither clinical staff nor patients. This observation has been similarly highlighted in Defendants' monitoring reports. See Eyman, August 2013, ADC 137465 ("it appeared that Meadows, Cook, and Rynning were not conducting NL five days a week.") Lewis, June 2013, ADC 117986 ("A true sick call is not occurring as defined in contract 5 days a week, Monday through Friday on all Lewis units"); Lewis, July 2013, ADC 137268 ("There is no dedicated nursing sick call line being offered on any unit."); 6/24/13 MGAR, ADC 117911 ("[At Douglas] [a]ccording to the FHA, due to the cutback of staff, primarily nurses and med techs, she has had to curtail daily nurse lines at both Mohave and Gila Units to 3 days only.")

96. On the first day of the Lewis tour, I began by inspecting the main medical facility referred to as "the hub," which contains an infirmary-like facility of 11 beds, dental space, and medical space. We were shown the offices designated for the medical providers, none of which had people in them – they were all dark and locked. We walked by the four holding cells for the prisoners awaiting medical care, they were concrete rooms that could probably hold 15-20 prisoners. They were all completely vacant. Similarly, outside the hub were five or six holding cells; each looked like they could seat

about 15 or 20 people. There were not any prisoners outside the hub waiting for medical care.

97. The medical hub does not have any negative pressure rooms, which are used to house patients suspected to have tuberculosis or other communicable diseases. Effective isolation of persons with suspected pulmonary tuberculosis, measles, or chickenpox requires that they are placed in airborne infection isolation room. This must be a private room with negative air pressure and a minimum of 6 to 12 air changes per hour. Doors to the isolation room must remain closed, and all persons entering must wear a respirator with a filtering capacity of 95% that allows a tight fit over the nose and mouth.[10] Even if a person with suspect tuberculosis is to be transferred to a hospital for treatment, while they are waiting to be transferred they must be housed in a negative pressure room. I later learned that no ADC prison facility has negative pressure rooms. Def's Resp. to Pltf Verduzco's First RFA's, # 179.

98. The Facility Health Administrator ("FHA") showed us two small rooms in the hub that used to be holding cells, but had been converted to private exam rooms. They were locked, dark, and empty. We went into one of these exam rooms and found that it had no exam tables or any other medical equipment in it, just a cabinet, a book shelf, and a sink.

99. In the maximum security Rast unit, we found the suite of medical offices empty, with all the offices dark and locked. The FHA said that the clinic was closed that day because there were no medical staff. He said, "this was designed to be a free standing full capability medical unit but we only use one exam room." When I asked him why this was the case, the attorney for ADC told him not to answer the question.

[10] General Principles of Infection Control, in UpToDate.com, accessed 11/2/13. UpToDate is an evidence-based, peer-reviewed online medical textbook, written and edited by leading medical experts, which is constantly updated. It is the standard textbook of medicine in the United States today.

100. I requested that they unlock the rooms. The FHA opened up a series of empty rooms he said were exam rooms, but there was no furniture or fixtures other than sinks and empty shelving units. There was an X-ray room, but no X-ray machine in it. The FHA stated that no X-rays were done. We finally got to the one exam room that is in use and had an exam table. There was no paper on the exam table, and there was no soap in the soap dispensers.

101. The medical area in Lewis's Barchey unit only had two offices, and one exam room. The exam table did not have paper on it, and when I asked the nurse on duty and the Director of Nursing where the paper was stored, counsel for Defendants told me I was "browbeating" the witness and threatened to terminate the tour if I asked a single other question of any other line staff. Counsel for Defendants told the Director of Nursing to not answer the question about where the paper is stored. It is very unsanitary for a health care clinic to not have paper on the exam tables that can be changed after each patient is examined.

102. On July 17-18, 2013, I toured the ASPC-Eyman prison. Unlike Lewis prison, Eyman does not have a central medical hub for the entire complex; each unit has medical space within it. I also inspected living units, interviewed prisoners, and reviewed medical charts. As in Lewis, there was little or no medical care being provided.[11]

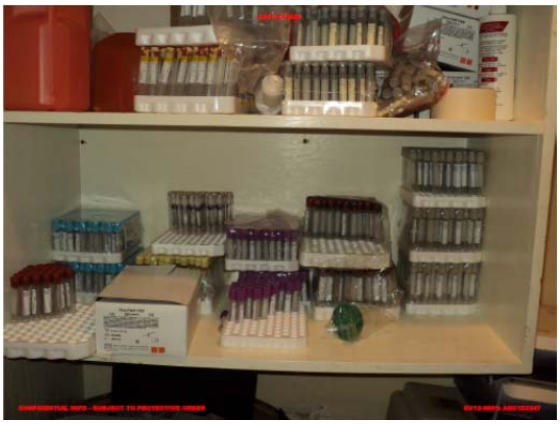
103. In the SMU-1 unit's medical area, we found a small exam room, which had an exam table set up with paper, an ophthalmoscope, and the blood pressure machine was on another wall, with no cuff attached. There was an x-ray viewer, and a sink. A larger exam room was locked, dark and not in use. In this larger room, there was a gurney, but

[11] Prisoners in the isolation units have their recreation on small concrete areas adjacent to the cell areas at Eyman complex. I asked to see the recreation area off the section of the 1-Delta pod where Named Plaintiff Smith was housed. It was about [redacted] by [redacted] feet, with [redacted] feet high walls and a grate overhead obstructing the view of the [redacted]ky. [redacted]bout [redacted] feet [redacted]he ground over the door, a swastika and the Nazi slogan "Sieg Heil" was pai[redacted]ted on the wall in large letters. It looked like it had been there for quite a while and had been painted there – it was worn.

no ophthalmoscope or blood pressure machine. There was a sink, and a door to the X-ray room.

104. Medical staff told me that the X-ray technician was on site daily, so I asked to go into the X-ray room that was off the exam room. The room was locked, dark, hot and stuffy. The x-ray machine was a very old model. The x-ray table and controls were covered with a thick layer of dust, as was the lead vest that was hanging on the wall. I found a notice on the machine that said it was last inspected on January 2001. Jim Taylor, a Corizon regional vice president, said that the room was not used and prisoners who need X-rays are transported to the Browning Unit.

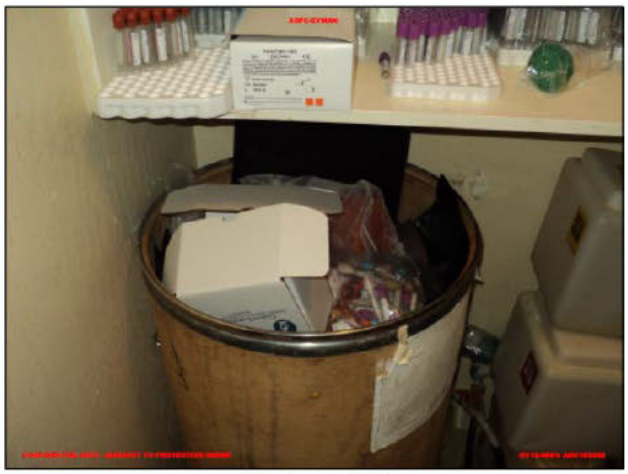
105. There was a door that said "Darkroom" that was inside the X-ray room. It was a closet approximately [redacted] feet by [redacted] feet. To the left against the wall were at least 7 or 8 bankers' boxes stacked up, with stacks of HNRs and other medical documents. To the right were shelves cluttered with half-opened boxes of the various equipment used for blood draws. [See Photograph 1]



Photograph 1

106. On the ground to the right, in front of the shelves were two or three five-gallon jugs half-full of brownish liquid. The opposite wall from the door had a crudely cut-out doorway/crawl space to the adjacent office; it was approximately [redacted] foot high. To the right of the crawl space, was a giant barrel approximately [redacted] feet high and [redacted] feet diameter, filled almost to the top with pipettes, blood bags, etc. The barrel was

sitting on top of an open rusty drain about [redacted] feet square. [See Photographs 2 and 3]



Photograph 3

Photograph 2

107. I asked to go into the medication room, but nobody on the tour had keys; only the pill nurses have keys to these rooms. I confirmed with the staff on the tour that this is the room where the "man down" bag for emergencies is stored.

108. In Eyman's Browning Unit, we again found the medical unit empty of prisoners. Most of the rooms were locked, dark and empty. The first exam room we went into looked like the others we had seen – the paper for the table was on the ground, no blood pressure cuff on the machine, sink, and minimal equipment.

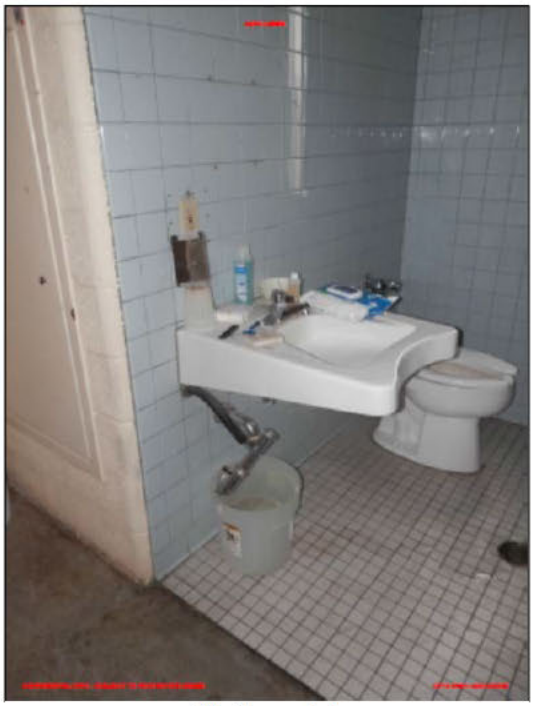
109. In Rynning unit's medical area, we found a few prisoners in the unit, and pill line was going on outside when we showed up. We were shown an exam room that didn't have an exam table in it, just an office and desk. It was dark and locked. The second exam room we were told was for "nurses' line" but again it had a desk but no exam table or equipment. The room was dark, locked, not in use.

110. The third exam room had an exam table in it. There was a nurse but no patients. There was no blood pressure machine on the wall. The fourth exam room was larger and a prisoner was being seen. It had two gurneys in it, an EKG machine, two large and one small oxygen tanks, two wheelchairs, one neck brace, and one back board.

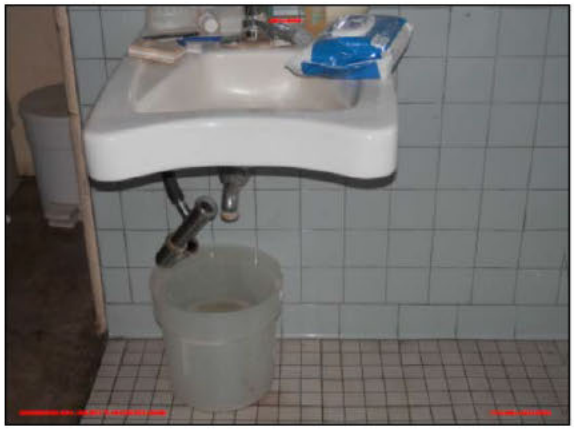
There was the blood pressure machine on the wall, but no cuff.

b. Medical Beds

111. Lewis's "L-11" unit appears to be a sheltered living unit set aside for patients who may be too medically fragile to return to the general population. The day that I visited, we found a unit that was dark, dirty and smelly. In the first cell that I entered, I found that the prisoner's sink had a broken drain pipe and was draining into a bucket that was three-quarters full of water. [See Photographs 4 and 5]



Photograph 4



Photograph 5

112. Such unsanitary conditions for a unit for medically fragile persons can lead to the spread of infectious disease. The prisoner housed in that room used a wheelchair due to multiple strokes, and he reported that he had developed multiple ulcers and pressure sores from sitting in a diaper in his wheelchair for long periods of time. Such unsanitary conditions in the same room with a prisoner with open wounds is a recipe for disaster.

113. In that unit, I interviewed [redacted] a 55-year-old man

who has had two strokes, and is disabled. He is unable to transfer independently from bed to wheelchair, and from wheelchair to toilet. He had been transferred in and out of L-11, where I interviewed him, and other sites at least five times in the two months prior to my visit. Each time he is sent back to L-11 because he requires nursing support for all activities, secondary to his left-sided paralysis. Because of the stroke, and inability to transfer, he is completely dependent on nursing staff. However, other medical staff at L-11 treat him as if he is lying, and can transfer, and do not provide him with the basic toileting services he needs. This results in Mr. [redacted] sitting for prolonged periods in his own urine and feces. Mr. [redacted] states that he has disciplinary write-ups for failure to put on his underpants, something he is physically unable to do because of his strokes. According to Mr. [redacted] his transfers to other living units at Lewis, including isolation cells, over the previous six weeks were all related to new prisoners requiring infirmary beds at L- 11.

114. In the same unit, I also interviewed [redacted]. Mr. [redacted] has a painful chronic skin condition called ectodermal dysplasia. Ectodermal dysplasia is a life-threatening condition characterized by a lack of sweat glands. Persons with this genetic disorder are at great risk from overheating and heat intolerance because they cannot sweat and get rid of excess heat. It is an understatement to say Arizona experiences excessive heat. Mr. [redacted] told me he spent one year in lockdown as punishment for seeking medical treatment. Because his body cannot easily get rid of excess heat, it is vital that Mr. [redacted] live in a climate controlled environment, such as L-11, without exposure to high temperatures. Mr. [redacted] was recently transferred out of L-11 to Buckley, and then transferred back. The reason he was transferred out was because there was a patient who was being transferred out of a hospital, and no infirmary level beds were available. This is one of multiple examples I have found of a patient being transferred in and out of L-11 because of the shortage of skilled nursing beds or sheltered housing in the Arizona system.

115. At Eyman, I reviewed the case of Mr. [redacted] who was housed in the general population despite his obvious need for nursing care that was unavailable in that setting. Mr. [redacted] is a 75-year-old man with multiple serious medical problems, including incontinence of bowel and bladder, diabetes mellitus, coronary artery disease, hypertension, and ADA/mobility issues. His medical conditions required a higher level of nursing care than is available at Eyman, but despite pleas from Dr. Rumsey, the medical director, and the nursing staff, he had not been transferred to a facility with appropriate clinical support. Instead, during the period from June 6, 2013 through July 14, 2013 he was hospitalized six times. Each time he was sent to the hospital because his complex medical problems required more intensive nursing care than was available at Eyman/Meadows, and each time the hospital sent him back because he required skilled nursing care, not hospitalization. ADC 136687-696. The last note in the medical record when I reviewed it was dated 7/16/13: "Security notified staff that I/M [redacted] was on his way back to Meadows unit from MVH [Mountain Valley Hospital]. MVH notified that Dr. Rumsey had given a written order the day he was sent out that the inmate was not appropriate to return to this yard due to non-compliance and in need of a higher level of care. Deborah from MVH ok'd for inmate to return to the hospital. Security notified. DON Bito'nn said he is taking care of finding a bed for inmate. Nursing supervisor Meyers notified of the above. /s Shahi, CPN." ADC 136696.

7. Access to Medication

116. Prisoners must be able to receive necessary medications for their serious medical needs. Defendants' practice and unwritten policy of failing to supervise, manage and support medication distribution has created a system that has been, and currently is, profoundly dysfunctional resulting in serious risk of harm to patients throughout the state.

a. Medication Delivery

117. I observed a dangerous medication distribution practice at a unit in the

Eyman prison complex. Medications are removed from blister packs in the medical area and placed in labeled small cups with prisoners' names written on a separate lid. These cups are then taken to a distribution site in the yard, or to cells of inmates in segregation. There is no way for prisoners to identify if they are receiving the right medications, nor can the nurse assure him/herself that they are dispensing the correct medication to the correct patient. Because generic forms of same medication can come in different shapes, sizes, and colors, it is never safe to "pre-pour" medications from a labeled container outside of the patient's presence.

118. An ADC pharmacy monitor discovered at Lewis "2 large trash bags full of medication being returned to PharmaCorr with both expired and adulterated medication cards …. The adulterated patient specific cards… are missing the original Pharmacy label and are being utilized for other patients." AGA_Review_00017096. This utter disregard for accepted medication distribution practices is shocking.

119. ADC also has a dangerous medication distribution practice of having custody officers deliver "Keep on Person," or "KOP" medications, to prisoners. 9/13 MGAR ADC 154168 (at Lewis, KOP delivered by security staff). Corizon staff confirmed during my tours, and in subsequent depositions, that this is still the delivery practice. Gross Dep. 63:22-64:1; Mielke-Fontaine Dep. 278:15 (at Florence). This practice is problematic: custodial officers are not trained health care staff and giving them access to and knowledge of prisoners' prescriptions violates health privacy law and creates an opportunity for that information to be used improperly.

120. ADC has a legacy of dangerous medication distribution practices. Last year at Lewis, more than 100 prisoners were exposed to Hepatitis C after a subcontracted nurse reused a syringe in a vial of insulin. September 21, 2012 letter from Joe Profiri to Karen Mullenix re: Written Cure Notification ADC 027855-856.

121. Named plaintiff Mr. Polson also told me about medication delivery problems. When I saw him at Lewis in July, 2013, he informed me that he has mania, is

supposed to receive lithium, but frequently is not provided with his medication due to staff shortages. In fact, he had not been given his lithium that morning, and he was acting manic during the interview. Mr. Polson reported in his Declaration dated November 1, 2012 that beginning in 2009 his lithium levels were not regularly checked. My review of his MARs demonstrated that he did not receive eight doses of lithium in April, 2013, and did not receive six doses of this medication in June, 2013. His lithium level was measured on June 13, 2013 and was low, at 0.3 meq/liter. The goal of treatment with lithium is to achieve a serum level of 0.8 to 1.2 meq/liter. No dosage adjustment was made in response to this non-therapeutic serum level. The low level is likely due to the missed doses, as Mr. Polson suggests. In a patient with known mania, on lithium treatment, inadequate dosage of prescribed lithium can precipitate a manic state. At the time I reviewed his file in mid-July, 2013, Mr. Polson has not seen a psychiatrist since December 2012, a delay of more than seven months.

122. While at Rast unit in Lewis complex, I spoke with named plaintiff Stephen Swartz, who reported that due to a shortage of security staff to escort the pill nurses, the insulin delivery has been late and the diabetic prisoners are having problems getting their shots and food on time. He said the morning pill run can occur anytime between 2 am and 8 am.

123. ADC's recent monitoring reports document widespread and continuing delays in delivering medication to patients. 9/30/13 MGAR, ADC 154085 (Noting that an Eyman inmate's Cymbalta was ordered on 7/29/13 but inmate did not receive the medication until 9/13/13); 9/25/13 MGAR, ADC 154171-73 (At Lewis, 43 out of 70 charts reviewed showed unreasonable delays in inmates receiving prescribed medications); 4/26/13 MGAR, ADC 088809 (Noting delays in inmates receiving keep on person medications at Douglas); 7/30/13 MGAR, ADC 137220 (Giving Eyman a "red" designation for unreasonable delays in inmates receiving prescribed medications); 7/24/13 MGAR, ADC 137207-08 ("Several issues are of concern with this location

[Eyman]. They include no response from existing D.O.N. on multiple medication issues that have been printed and sent from the online PharmaCorr/Corizon Patient profile. The patient continuity of care may be jeopardized.") 4/18/13 MGAR, AD C088908 (Reporting that, according to staff, medications that arrive at Lewis from the PharmaCorr[12] facility on Friday are not delivered to inmates until Tuesday); 4/29/13 MGAR, ADC 088841 (Reporting that none of the non-formulary medication requests found at Eyman were returned within 24 to 48 hours).

b. Medication Continuity

124. A sound prison health care system must have processes in place to ensure that prescriptions are timely renewed and refilled. ADC lacks an effective system to accomplish this.

125. In Rast unit, I spoke to several prisoners, chosen at random, at cellfront. Every single prisoner I spoke to reported gaps of up to six weeks in getting refills of chronic care and psychotropic medication.

126. Medication lapses are a problem for all patients, but can be particularly dangerous for patients with conditions like HIV, where lapses can cause the patient to develop drug-resistance. [redacted] for example, has HIV infection and requires daily anti-viral medications. His anti-viral therapy (Atripla) lapsed repeatedly during the first half of 2013. Predictably, the forced interruptions in his HIV therapy caused by failure to renew his medications resulted in the deterioration of his clinical condition. His viral load, the main measure of therapeutic success in HIV treatment, had been undetectable, measured as <20 copies/ml in December 2012 and April 2013. ADC 136705, 136706. However, by June 5, 2013 his viral load had increased more than ten times, to 231 copies/ml (ADC 136707) suggesting failure of treatment due to missed

[12] The PharmaCorr facility is located in Oklahoma, and prescriptions are faxed from the prisons to Oklahoma, and then a pharmacist fills the prescription and sends it out via overnight mail

doses, and possibly the development of resistance to the anti-viral medication. There was also a 15% drop in his T- cells from the March 18, 2013 laboratory studies. ADC 136708

127. Prisoners prescribed chronic care medications, like Mr. [redacted] have lapses because their medications are not timely renewed. 9/30/13 MGAR, ADC 154085-87 (At Eyman, 41 out of 50 charts reviewed showed that chronic care medication expirations dates were not being renewed prior to expiration); 8/15/13 MGAR, ADC 137548 (At Lewis, 29 out of 74 charts reviewed showed that chronic care medications were allowed to expire without renewal); 8/28/13 MGAR, ADC 137535 ("I continue to alert the site [Lewis] on expired chronic medications needing filled/refilled"); 7/30/13 MGAR, ADC 137282 (At Lewis, 50 out of 80 charts reviewed showed that chronic care medications were allowed to expire without renewal).

c. Poor Prescribing Practices

128. It is fundamental to primary care medicine to prescribe medications to patients based upon a clinical contact with the patient. In ADC, however, there appears to be a practice of changing patient's medication without first seeing or advising the patient. This is a harmful practice.

129. Mr. [redacted] was hospitalized when he suffered a heart attack on 3/27/13, and was started on standard medications for his condition, including clopridogel and aspirin, which prevent clotting of the coronary artery. ADC's Dr. Merchant ordered these medications on an emergency basis when Mr. [redacted] returned to Lewis complex on 3/30/13, but the order for clopridogel was crossed out with no explanation. Mr. [redacted] did not receive his aspirin, and the clopridogel was not provided until two days later, on 4/2/13.

130. Mr. [redacted], has peripheral neuropathy secondary to his diabetes mellitus. He had been receiving gabapentin at a dose of 1800 mg twice a day for this condition. On March 26, 2013 his practitioner decreased his dose by 2/3 to 600 mg twice

a day without seeing him or documenting a reason. Mr. [redacted] was forced to file multiple HNRs to have his gabapentin dose restored. Mr. [redacted], also had his gabapentin cut without documenting a reason, as did Mr. [redacted]

131. Mr. [redacted] was diagnosed with MRSA, and prescribed clindamycin by an RN. Unfortunately, the RN prescribed a dose that was much too low. Diagnosis and treatment of suspected MRSA requires a physician, physician's assistant, or nurse practitioner. MRSA diagnosis and treatment is a clinical decision not appropriate for RN level staff.

132. Mr. [redacted], has diabetes and proteinuria (protein in his urine). Treatment of proteinuria is required to decrease the risk of kidney failure for persons with diabetes. However, Mr. [redacted] received no treatment for this known complication of diabetes.

d. Delayed Non-Formulary Approvals

133. The medication problems include lapses in the approval process for non-formulary medications. Delays in gaining approval compound medication delivery delays. 9/30/13 MGAR, ADC 154158-59 ("Lewis continues to struggle with Corizon [pharmacy] policy/procedure. Upon a second visit to the facility, … the non-formulary pending file showed 94 requests that evidently needed follow up. According to nursing, they were not sure of any resolution of the 94 requests. ") 7/9/13 MGAR, ADC 137414 ("[At Winslow,] [p]roviders and the inventory coordinator are not being notified of denials or approvals [of non-formulary decisions].")

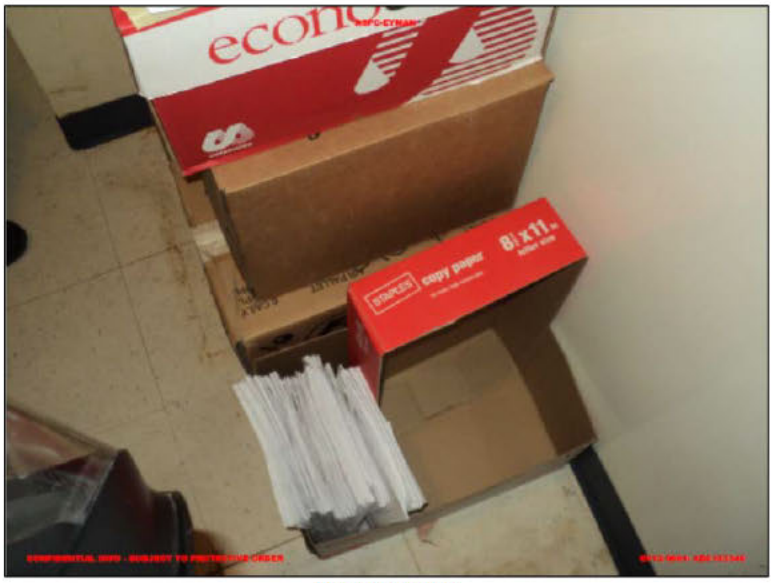
8. Medical Records

134. An accurate, organized and up-to-date medical record is an essential tool for delivering adequate health care.

135. In the medical records that I have reviewed, I found a pattern of patient care delays affecting, among other things, the timely and appropriate review of health needs

requests (HNRs), access to nurse triage and primary care providers, regular chronic care treatment appointments, timely access to medically necessary specialty care, and the prescription and delivery of necessary medications. The individual patient charts were completely disorganized and often lacked documents that would be critically important to a medical provider in delivering care.

136. The poor quality of the patient charts is in part due to a systemic failure to properly maintain and file medical records. For example, as noted above, when touring Eyman, I discovered in a closet off the X-ray room, six or seven bankers' boxes containing thousands of pages of unfiled medical records. [See Photograph 6] The records I observed on top were HNRs that were at least six months old.



Photograph 6

137. The situation I observed at Eyman was not anomalous. ADC's monitoring reports corroborate my findings that the records are often not current, accurate, consistent or chronologically maintained. 9/30/13 MGAR, ADC 154065-66 (Complex-wide at Eyman, in 32 out of 50 charts reviewed, medical records were not current, chronologically maintained with all documents filed in the designated location); 9/12/13 MGAR, ADC 154352 (Reporting that only 70% of medical records reviewed at Winslow

were current, accurate, and chronologically maintained with all documents filed in the designated location). 4/15/13 MGAR, ADC 088826 ("There is not consistency between the units either in the use of the [continuity of care/transfer summary] forms or the filing of them [at Eyman]."); 4/15/13 MGAR, ADC 088815 ("At Rynning, the receipt of HNRs is often not date-stamped."); 4/18/13 MGAR ADC 088897 ("[At Lewis] [t]here are volumes of loose filing piled up in the medical records room, including consult reports, hospital records, HNRs, lab results, etc."); 4/22/13 MGAR, ADC 088904 (at Lewis, "I can find no evidence that there is any consistency in no-show reporting among the noted disciplines of medical, dental, or mental health."); 4/18/13 MGAR, ADC 088897 ("MAR from Nov. 2012 to Mar. 2013 are piled on carts and shelves in the med records area."); 4/24/13 MGAR, ADC 088908 (A review of medication administration records for all units indicated records not completed in accordance with standard nursing practices; insulin and medication MARS document missing doses of medications, among other problems)**.**

9. Quality Assurance

138. Health care delivery systems, including prison medical systems, must have a system for evaluating the delivery of services and quality of care for patients. The elements of a program include the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.

a. Quality Improvement Program

139. The contract with Wexford required the company to submit a "Quality Management Program Description encompassing the Continuous Quality Improvement Program structure" within sixty days of the award of the contract. ADC Notice of Request for Proposal for Privatization of Health Care and Wexford Bid, ADC 14180. In

the absence of a structured program to examine health care quality in a health care delivery system of this size, life-threatening practitioner errors and systemic problems will be overlooked or ignored, creating a potentially dangerous situation for patients.

140. Although he testified that he is responsible for the quality of medical care, defendant Pratt indicated that he was not familiar with Wexford's quality management program, and had not received any of their quality improvement reports. Pratt Dep. 27:15-16, 113:17-114:10.

141. Dr. Winfred Williams, Corizon's Regional Medical Director, testified that Corizon collects internal data to measure contract compliance, and that Corizon shares that information with ADC, if ADC requests it through Vice President Vickie Bybee. Williams Dep. 21:11-24:22. ADC's Dr. Robertson testified that he does not have access to Corizon's proprietary software program for tracking prisoners' medical conditions. Robertson Dep. 80:3-11. Given the extreme dysfunction in the health care delivery system, this approach to monitoring quality is grossly inadequate.

b. Death Review

142. Adequate death reviews are an essential part of a minimally adequate correctional medical delivery system. Death reviews evaluate the quality of care provided to the deceased prisoner-patient. They not only should consider whether a death was preventable but also identify other correctable deficiencies, systemic or involving particular providers, regardless of whether those deficiencies affected the outcome. To be minimally adequate, death reviews must identify and address deficiencies and when appropriate result in referral for further investigation either by prison medical managers (so that identified systemic or personnel issues can be addressed) and/or peer review committees (when inappropriate clinical care is identified). Results of this process should be tracked.

143. The ADC death reviews are a sham because obvious and egregious

deficiencies in medical care are not identified, cases are not referred for further investigation and reviews, and the process involves no tracking. This includes cases in which a death was possibly preventable or in which inadequate care possibly resulted in the prisoner dying sooner than he otherwise would have, as well as cases in which gross deviations from basic standards of care, while not affecting the outcome, are ignored.

144. My opinion is based on review of the testimony regarding death reviews by the doctors who conduct those reviews at the Arizona Department of Corrections, certain death reviews and related documents such as autopsy reports (in this regard, I understand that the only death reviews provided to plaintiffs' counsel thus far were completed a year ago; I will supplement this report if and when more recent reviews are received), the ADC medical records of prisoner-patients who have died with physician reviews performed at my direction, and my experience as described above.

1. ADC Death Review Process

145. Final death reviews for the ADC have been done by Drs. Robertson and Rowe. Robertson Depo at 121:18-23. Dr. Rowe has done death reviews since at least March 2012, including some deaths that occurred in 2011. Rowe Dep. at 76:1-16, 79:1-15 (reviews in last six months) and 93:1-13 (reviewing 2011 deaths). Dr. Robertson has done reviews since July 2012. Robertson Dep. at 12:6-10 and 121:1-13. He testified that the reviews are conducted in order to identify systemic issues; but he has not yet identified any systemic issues. Robertson Dep. at 122:25-123:8. Dr. Robertson's qualifications as a reviewer are questionable, as he is neither board-certified nor board-eligible. Robertson Dep. at 14:25-15:2, 191:22-24.

146. That only the two doctors do the final death reviews violates ADC policy, which requires the reviews be completed by a committee that includes a nursing manager, a program monitor, and others. Department Order 1105, December 19, 2012, at pp. 2-5. http://www.azcorrections.gov/Policies/1100/1105.pdf. That the multi-disciplinary

requirement mandated by the policy is not observed renders the death reviews inadequate.

147. The most shocking and egregious fact regarding the ADC death reviews is the failure to identify even the most obvious deficiencies in care and thus take any action to further review or correct any problem. The doctors who do them say that they review "the appropriateness of care" (Rowe Depo at 76:23 - 77:4) and that the purpose is to "identify systemic issues." Robertson Depo at 122:25 - 123:2. But in fact, and again according to the doctors who do them, the actual reviews done have neither identified systemic problems nor trends or anything that "raised any flags" of concern, and have not resulted in referrals of any matter for further investigation. Rowe Depo at 164:2-21; Robertson Depo at 123:3-8.

148. As explained below through case examples, this failure to identify problems is appalling given that grossly substandard and inadequate care is obvious in the medical records of many prisoner deaths, and in some cases likely contributed to the death. The failure of death reviews to identify problems, or refer cases for investigation, is a certain sign of a completely inadequate medical delivery/quality assurance process and creates a substantial risk of harm to prisoner-patients.

2. Inadequate Care in Prisoner Deaths

149. I reviewed medical records and, in some cases, mortality reviews and autopsies, for patients who died in 2011 and 2012. I understand that plaintiffs have requested, but have not yet been provided the records for patients who have died more recently. Although the records that I reviewed reflect care that was provided over a year ago, I found that the patterns of significant delays, lapses and generally poor medical care evident in those records are consistent with the substantial problems I have identified that currently exist in Arizona.

150. [redacted] died on [redacted] at age 57. The autopsy report states that he

died from gastrointestinal hemorrhage due to his liver cirrhosis. It also states that Mr. [redacted]'s squamous cell carcinoma was a "factor which significantly contributed to death." ADC 061737. The ADC death review cause of death findings are in accord, listing the primary cause of death as acute GI hemorrhage, the secondary cause as hepatitis C with cirrhosis, and the tertiary cause was the metastatic cancer in the right arm. ADC 033639. The ADC death review determined that Mr. [redacted]'s care "met community standards without negative findings." ADC 033642. In fact, Mr. [redacted] received extremely poor care, including at a key juncture from a doctor (Robertson) who is one of the two physicians who conduct ADC death reviews.

151. On February 11, 2012, Mr. [redacted] was noted to have increasing abdominal swelling. ADC 041550. He was sent to the emergency department and had an abdominal computed tomography (CT) scan performed that showed multiple disturbing findings (ADC 041552) including "tortuous vessels consistent with varices noted paraesophageal region at GE junction" (Paraesophageal varices are dilated veins located next to the esophagus that can rupture and cause bleeding that can lead to death.) It also noted a "marked degree of ascites throughout the abdomen and pelvis" and a 2-cm lesion in the liver that was "suspicious for focal lesion." In advanced cirrhosis, the liver becomes increasing scarred. Blood has difficulty flowing through it and tends to flow through veins which surround the esophagus. These esophageal veins (varices) become enlarged and fragile due to the excess blood flow, and are at great risk for bleeding. Bleeding from esophageal varices is a frequent cause of death in persons with advanced cirrhosis. Another consequence of advanced cirrhosis is build-up of fluid in the abdomen. This fluid is called ascites. Patients with ascites are at increased risk of infection and death. There are no further records of what was done in the emergency department.

152. On February 22, 2012, Mr. [redacted]'s doctor at the prison, David Robertson, reviewed the CT scan results, initialing the report (ADC 041552) and writing a short progress note listing the findings, including "marked ascites." ADC 041466. Dr.

Robertson's "Plan" for care stated, "This is a sick man. Prognosis poor [without] dramatic intervention."

153. But there was no intervention at all, let alone "dramatic intervention" regarding the obvious alarming CT scan results, by Dr. Robertson or anyone else. The basic standard of care for patients with cirrhosis calls for: (1) removal of ascites fluid to improve comfort and to analyze fluid for infection with clinically apparent new-onset ascites; (2) treatment of patients with cirrhosis and ascites with sodium restriction and drugs to increase urine output (diuretics); and (3) in patients with cirrhosis and small varices that have not bled but have met criteria for increased risk for bleeding, medications to decrease the flow of blood into the portal vein are recommended to prevent the esophageal varices from bleeding. These medications are called non-selective beta blockers. Propranolol and nadolol are common drugs in this category which are routinely used as prophylaxis to prevent esophageal varices from bleeding. There is no evidence in the medical record that he was offered any of these standard treatments for patients with ascites and esophageal varices. The use of non-selective beta blockers for patients with esophageal varices is recommended in the published guidelines of the The American Association for the Study of Liver Diseases (AASLD).[13]

154. The ADC death review finding, prepared by Dr. Rowe, that care met community standards and that the review revealed no negative findings is incorrect. Mr. [redacted] should have received non-selective beta blockers to reduce his risk of variceal bleeding.

[13] Prevention and management of gastroesophageal varices and variceal hemorrhage in cirrhosis., Garcia-Tsao G, Sanyal AJ, Grace ND, Carey W, Practice Guidelines Committee of the American Association for the Study of Liver Diseases, Practice Parameters Committee of the American College of Gastroenterology, Hepatology. 2007;46(3):922.

155. Mr. [redacted] also did not receive adequate treatment of his malignancy (squamous cell carcinoma on right forearm). Specifically, when Mr. [redacted] was hospitalized from 7/12/11-7/18/11 for this condition, he was seen by an orthopedic surgeon and a general surgeon. Both recommended amputation of part of his arm and other interventions; both also suggested that cure of the malignancy was possible but his case was complicated. ADC 041740, ADC 041742. The hospital discharge report states that the surgeon "felt that [Mr. [redacted]'s condition] was too complicated and that it should be evaluated by an orthopedic oncologist for possible amputation or at least excision of an affected area." ADC 041729. In accord with the surgeon's determination, the hospital discharge instructions stated that Mr. [redacted] should "follow up with the orthopedic oncologist within 1 to 2 weeks." Id.

156. Upon return from the hospital to the prison Mr. [redacted] on 7/20/11 met with his primary care provider, Dr. Robertson. ADC 041624. The doctor's progress note states that the hospital specialist assessment and recommendations were discussed, and that Mr. [redacted] at that time refused treatment until he spoke with his wife and received what the doctor termed a "second opinion." *Id.* The patient's position was reasonable, and his prison doctor in fact agreed with it, since on 7/19/11, he (the doctor) submitted an urgent request for the orthopedic oncology specialist consult recommend by the hospital specialists. ADC 041727.

157. However, from the date of Mr. [redacted]'s discharge from the hospital (7/18/11) until the time of his death [redacted] he was never sent to or seen by an orthopedic oncologist. This was despite urgent, repeated requests for this consultation made by primary care providers on 7/19/11, 1/31/12 and 3/6/12. ADC 041727, ADC 041565, and ADC 041465. Mr. [redacted] died less than a week after the last request. The failure over many months to provide the recommended and repeatedly requested urgent consult strongly suggests a systemic problem in obtaining specialty services, which is consistent with my observations in more recent cases. It is also an obvious instance of

very poor care.

158. The only post-7/18/11 hospital discharge specialty consult received by Mr. [redacted] was on 8/25/11, when he saw an oncologist (unclear whether an orthopedic oncologist). ADC 041657. This oncologist recommended further consultation with a hand surgeon and an MRI. *Id.* Again, neither a hand surgeon consult nor an MRI were ever received by Mr. [redacted], even though a provider made repeated urgent requests for them. ADC 041567-ADC 041568. That neither this consult nor the MRI were provided despite repeated urgent provider requests once again suggests a systemic problem in obtaining specialty services, which is consistent with my observations regarding specialty referrals in general. And again, it represents poor care.

159. Given the inadequate care for Mr. [redacted]'s liver condition and failure to obtain a specialty consultation for his cancer, as described above, which likely hastened his death, it is disturbing that the ADC death review found no problems, determined that his care met community standards, and took no action to further review, investigate, or correct problems. The Mortality Review Committee Final Report requires the reviewer to codify their findings. Mr. [redacted] failed to receive indicated preventive measures for his esophageal varices, and failed to receive repeatedly ordered surgical oncology consultation. The Review Committee selected: "Meets community standards without negative findings." That conclusion is inconsistent with the identified failures of care.

160. Mr. [redacted] died on [redacted] at age 52. [redacted]. He had a history of chronic obstructive lung disease, a heart attack, and hepatitis C, and he died at University Physicians Hospital on [redacted] of a cardiac arrest. His death was due to severe septic shock, a complication of overwhelming infection (sepsis) and multi-organ failure (renal, hepatic and pulmonary failure). ADC 042749-755. Autopsy confirmed this diagnosis (ADC 032613) and final blood cultures revealed Staph Aureus. ADC 032614.

161. The ADC death review concluded that Mr. [redacted]'s care met community standards and the review included no negative findings. ADC 033659 – ADC 033662. It

also did not identify any contributing cause, including any medical delivery system or clinical failure or issue. ADC 033659. However, the ADC mortality review regarding Mr. [redacted]'s death was totally inadequate. As explained below, it failed to identify numerous points at which basic medical intervention might have averted his death. The review is also at points materially inaccurate or misleading.

162. Mr. [redacted] appears to have been in his usual state of health until 3/7/11 at which time he developed severe back pain. He was seen by providers on 3/7/11, 3/10/11 (twice) and 3/11/11 for continued symptoms. ADC 042742-746. Until the last visit, providers failed to recognize the severity of his symptoms and signs of sepsis. On 3/7/11 he had a high temperature of 102.6. ADC 042746. At each visit he had low levels of oxygen (hypoxic) and rapid heart rate (tachycardia) which were ignored by the medical staff. There are numerous points of contact with health care providers where Mr. [redacted] s serious symptoms should have prompted investigation as to their origin. Had basic lab tests been ordered or had he been referred to the emergency room (ER) at any of these visits, his death almost certainly could have been avoided.

163. Mr. [redacted] was finally sent to the ER on 3/11/11, at which time, it was too late. The ADC death review calls his death "natural" and "unavoidable" but this is inaccurate. Sepsis (widespread infection) is almost always treatable with antibiotics and fluids if caught early enough. Delay in treatment is often fatal. Had Mr. [redacted] been referred to the ER when he first developed symptoms his death almost certainly could have been averted.

164. In addition, the death review states that the "[r]ecord showed that the inmate was afebrile [without fever] when sent to the hospital." ADC 033661. This appears to suggest that the diagnosis of sepsis was not clear. What the reviewer fails to include in his report was that Mr. [redacted] had a fever to 102.6 on 3/7/11, the first day he had symptoms of back pain which was never worked up or acted upon and was the first sign of underlying infection. ADC 042746. There were in fact numerous alarm signs

that should have prompted a more thorough and earlier work-up by health care providers. It is unclear why the death review is silent on these matters.

165. On 3/7/11, an ICS ("Incident Command System," ADC's code for emergency) was called (ADC 024331) by officers because Mr. [redacted] was out of breath which was attributed to a back injury. The medical record is not entirely clear, but it appears that Mr. [redacted] was not seen by a clinician or registered nurse but only a licensed practical nurse (LPN), who then obtained a telephone order from a Nurse Practitioner. ADC 042746. The note documented a temperature of 102.6, an elevated heart rate of 140, normal blood pressure, and an oxygen saturation of 88%. Mr. [redacted] complained of injuring his back during a softball game on Saturday and also complained of a sore throat and cough. On exam the provider documented wheezing in all of his lung fields. He gave him albuterol after which time his oxygen saturation improved to 90%, ordered antibiotics (apparently for the sore throat) and sent him back to housing.

166. The care provided on 3/7/11 was inadequate. Wheezing in a patient with a history of chronic obstructive pulmonary disease and low oxygen levels is consistent with a COPD exacerbation and merits either close monitoring with frequent albuterol and steroids or referral to an emergency room. The progress note assessment includes no mention of the severe tachycardia (elevated heart rate) and fever, both of which are signs of an infection. None of these ancillary symptoms or vital signs are explained by his back sprain alone. The basic standard of care given the patient's presentation would have been to at least obtain basic labs and an x-ray to identify the source of the fever or referral to the emergency room. None of this was done.

167. On the morning of 3/10/11, another ICS was called because Mr. [redacted] was unable to get out of bed or walk. ADC 042746. He was evaluated at medical at which time he was again noted to be tachycardic (heart rate 105) and hypoxic (oxygen 88% on room air). ADC 042746. Both of these findings again point to some type of pulmonary process; the hypoxia (low oxygen level) is not explained by his back injury. On

examination he was noted to have burns on his lower back from the heating pad he was using. *Id.* The physician was called and Mr. [redacted] was again given albuterol (his oxygen improved to 91%), cyclobenzaprine, a muscle relaxant, for muscle spasms, and counseled to drink more fluids. ADC 042743. At this point, Mr. [redacted]'s severe pain and disability, and continued hypoxia should have prompted clinical investigation. The standard of care would be to order an x-ray, carefully examine the patient, and attempt to identify the reason for worsening back pain. None of this was done.

168. On 3/10/11 at 7:36 p.m., another ICS was called after Mr. [redacted] fell in the bathroom. ADC 024337. He was evaluated again in medical where he complained that "I've been throwing up all day. I can't move, my back is all seized up. I can't do anything and the pain is driving me crazy." ADC 042743. The provider noted that Mr. [redacted] was on the gurney "writhing in pain" and "grimacing" and vomiting into the wastebasket. *Id.* He was still tachycardic (heart rate 112), with a low oxygen level (94%). The nurse practitioner on call recommended rest, a nausea medication and continued heat and cyclobenzaprine for muscle spasms. *Id.* No physical examination was performed, and no laboratory tests were ordered. At this point, Mr. [redacted]'s health was clearly deteriorating. He had been seen three times in the previous few days, twice for emergencies on 3/10/13. Although it was not certain that he was septic (he was afebrile, blood pressure was normal), the basic standard of care required investigation into why his pain was clearly worsening days after an injury, and why he had hypoxia and was vomiting. Again, basic lab tests and imaging of his back should have been done, or if not available at the prison, Mr. [redacted] should have been referred to an emergency room. None of this was done. Mr. [redacted] was not a young healthy man. He had chronic lung disease and had already had a heart attack. His deteriorating condition required careful clinical investigation and monitoring. He received neither.

169. On [redacted] at 11:10 a.m., another ICS was called when Mr. [redacted] was found in bed screaming and grabbing his back and his head "and talking nonsense

phrases." ADC 024340. He was taken to medical where a nurse (unclear if a RN or LPN) evaluated him. ADC 042742. The medical staff documented the security staff who referred Mr. [redacted] indicated he "had been crying about pain all night," raising serious questions about whether security staff should have brought him to medical sooner (it was at that point close to 11 a.m.). *Id.* At this point, Mr. [redacted] was still hypoxic (oxygen 88%), tachycardic (heart rate 135), tachypneic (respiratory rate 34, normal is usually 18 breaths/minute), and had a dry mouth. Mr. [redacted] was crying about back pain and yelling "I can't breathe." *Id.*

170. A nurse practitioner was contacted who appropriately referred him to the local ER and gave him albuterol. *Id.* IV fluids were not begun, which is significant because such fluids are a cornerstone therapy in septic shock, and might have saved Mr. [redacted] s life if started earlier. Even without knowing he was septic, the basic standard of care calls for fluids to be started on a patient with a heart rate of 135 and dry mucous membranes while waiting for emergency medical responders to arrive and transport the patient. The medical note only states, "Attempted IV unsuccessful." *Id.*

171. Mr. [redacted] was initially evaluated and treated at South Eastern Arizona Medical Center, but was transferred to UPH, where he died less than 24 hours later of septic shock and multi-organ failure. ADC 042749.

172. As stated above, the ADC death review found no problems with care or any issue. This is shocking. As explained, the review should have found a failure to recognize symptoms or signs and a delay in access to care. It should also have investigated the poor note regarding attempted IV fluids and the substantive reason an IV was unsuccessful.

173. The death review's conclusion "Unavoidable" is also inadequate. For the reasons stated, Mr. [redacted]'s demise was at the least possibly preventable and almost certainly would have been averted with timely medical intervention. At the least, the death review should have identified the problems discussed above and taken action to

minimize the risk of recurrence, so as to reduce a substantial risk to prisoner-patients. Multiple practitioners failed to correctly interpret the signs of early sepsis. The death review process should have identified this failure, and developed training for nursing and provider staff regarding the diagnosis and treatment of early sepsis. Instead, the death review under "Lessons Learned" simply stated, "None." ADC 033661. Unfortunately, this was true. Mr. [redacted]'s death was preventable had the signs of early sepsis, in a man with multiple medical problems, been addressed with the seriousness his situation deserved.

174. [redacted] died on [redacted], at age 57. The care he received while at ASPC likely resulted in a hastened death and was woefully inadequate. However, the ADC death review, while cryptically indicating there were medication delivery, medical prescribing, and patient non-adherence issues, concluded that there were no negative findings and that care met community standards. ADC 033694-0033697.

175. Mr. [redacted] had a past medical history of end-stage liver disease, presumably from hepatitis C, with known esophageal varices and prior hepatic encephalopathy (confusion and altered level of consciousness as a result of liver failure). He was admitted to the hospital twice in the year preceding his death with complications related to his liver disease. ADC 046783, ADC 046799. Mr. [redacted] was pronounced dead on [redacted] in his cell after being found disoriented, actively vomiting blood and with a pool of blood around him on the floor. ADC 046780. The autopsy confirmed the likely cause of death to be bleeding to death from esophageal varices (varicose veins of the esophagus – enlarged, tortuous, and fragile) associated with his underlying liver disease. ADC 040266. Persons with end-stage liver disease often have developed fragile swollen veins around the esophagus, because their scarred liver blocks blood from its normal path, and blood backs up into the esophageal veins. The walls of these swollen veins become thin and break, causing severe and often fatal bleeding. Although patients with end-stage liver disease are at medical risk, there were several factors in this case,

relating both to acute and long-term mismanagement that likely resulted in a hastened death.

176. Mr. [redacted] had multiple serious complications of his liver disease while he was in prison in 2011. On 5/28/2011 staff responded when Mr. [redacted] was found to be confused, feverish and with a heart rate in the 130s. ADC 046793. On exam, he was noted to be oriented only to name, have 4+ pitting edema (massive swelling of his legs), and a bloated abdomen. *Id.* He was evaluated by an RN and a nurse practitioner, given fluids and Tylenol, and released to the yard.

177. This was grossly inadequate care. When a patient with end-stage liver disease, with a past history of hepatic encephalopathy presents with abnormal mental status, a fever and evidence of ascites (swollen abdomen due to fluid accumulation), the basic standard of care requires evaluation for spontaneous bacterial peritonitis (SBP). This is a life threatening but easily treatable infection of the abdomen. Diagnosis requires obtaining a sample of fluid from the abdomen by placing a needle into the belly (paracentesis), examining the fluid under a microscope, performing tests on the ascitic fluid, and, if appropriate, promptly starting antibiotics. The risk of recurrence of spontaneous bacterial peritonitis (SBP) is increased in patients who have had prior SBP, as Mr. [redacted] did.

178. Mr. [redacted] was known to have severe liver disease. The development of confusion, fever, and rapid heart rate in the setting of severe liver disease is ominous, and requires prompt evaluation and treatment in a hospital setting. Mr. [redacted] should have been sent directly to an emergency room for assessment and treatment of his hepatic encephalopathy and probable SBP.

179. Mr. [redacted] was hospitalized from 10/29/11 through 11/5/11. ADC 046817. It was a complex hospitalization: he was treated for SBP, a gastrointestinal bleed and sepsis. *Id.* On 11/28/2011 Mr. [redacted] saw a provider. ADC 046782. At that time, Mr. [redacted] said he had worsening shortness of breath and leg edema. *Id.* His heart rate was

115 and he was noted to be in respiratory distress. He was given an increased dose of furosemide, a diuretic, and scheduled to be seen in one week.

180. The increase in furosemide was an appropriate response to his increasing shortness of breath, and increased leg swelling (edema). However, the presentation of new symptoms of increasing shortness of breath, leg swelling, and rapid heart rate in a man with advanced liver disease who was recently hospitalized for internal bleeding and severe infection, is ominous. Mr. [redacted]'s medical condition at this point required close monitoring, with vital sign measurement several times a day, in a clinical setting. If this type of setting were not available at the prison, he required hospitalization.

181. This was not done, and rather predictably, his condition deteriorated and another emergency response was called two days later, on 11/30/11, because of Mr. [redacted]'s persistent shortness of breath and abdominal pain. ADC 046781. His heart rate had now increased to over 120 with worsening leg edema. He was re-instructed how to properly use his medications and was told to contact medical if his symptoms worsened.

182. This too was grossly inadequate. Mr. [redacted]'s persistent tachycardia, respiratory distress and worsening edema are all indications that he should have been moved to the emergency department. Had he been referred to the emergency department during either episode on 11/28/11 or 11/30/11, when he was clearly decompensating, treatment might have prevented the massive esophageal bleeding which occurred on 12/2/11.

183. In addition to the severe deficiencies of care for acute conditions, there were several gross deviations from the standard of chronic care for patients with liver cirrhosis. Patients with liver cirrhosis must be screened every 6 months with imaging and blood tests because of the increased incidence for cancer of the liver. During Mr. [redacted]'s hospitalization in late October/early November 2011, a CT scan of his abdomen was done showing a "hypodense lesion in the right lobe of the liver" (ADC 046829), which may have been HCC (liver cancer). I cannot say whether this contributed to his

death, but he did not receive the standard of care in terms of HCC monitoring.

184. Mr. [redacted] had esophageal varices. The basic standard of care for patients with varices is to provide medication (a beta blocker) to reduce the chance of future bleeding. Mr. [redacted] was started on nadolol (a type of beta blocker) during his hospitalization in late October/early November 2011, but for unclear reasons this medication was not ordered or continued after he left the hospital and returned to ADC. The failure to provide this basic medication is another example of very poor care.

185. Finally, patients with esophageal varices, gastrointestinal bleeding, and a history of spontaneous bacterial peritonitis (ADC 046805) should be started and continued on antibiotic prophylaxis for SBP. This is a practice guideline recommendation of the American Association for the Study of Liver Disease.[14] This was not done in Mr. [redacted]'s case.

186. When Mr. [redacted] was found in his cell vomiting blood on [redacted] the emergency response care was adequate. However, had Mr. [redacted] been appropriately managed, especially with regard to the days leading up to the date of his demise, he likely would have been in the hospital and able to receive more appropriate medical care potentially ending with a more favorable outcome. It is shocking that the ADC death review found no problems with the care in this case, and required no further review or corrective action.

187. [redacted] was a prisoner at Arizona State Prison Complex in Florence. He died [redacted] at age 41. There was a significant delay of diagnosis and initiation of chemotherapy.

188. Mr. [redacted] had a swollen right testicle. He was taken to the Florence Hospital Emergency Room on 5/3/2011 and treated for an infection. The chart does not contain any records from Florence Hospital. One week after the ER visit, Mr. [redacted]

[14] http://www.aasld.org/practiceguidelines/Documents/ascitesupdate2013.pdf (Accessed on April 23, 2013)

filed an HNR, inquiring: "5/3/2011 Florence Hospital ER…can I please know the results of tests…still in a lot of pain." ADC 045315. It is standard of care to request an urgent testicular ultrasound for a man of this age with an enlarged tender testicle that has not responded to treatment for infection. Persistent swelling of the testicle strongly suggests cancer or other serious condition. An urgent ultrasound was mandatory. No testicular ultrasound was ordered. On 5/24/2011 in another Health Needs Request (ADC 045314), Mr. [redacted] complained that the antibiotics he had been given had not worked. On 5/25/2011, Mr. [redacted] was seen by a physician's assistant and prescribed more antibiotics for presumed orchitis (infection of testicle). ADC 045352 Medical staff again failed to obtain an ultrasound.

189. On 6/7/2011, [redacted] was seen by an acute care physician at the prison (ADC 045348) who noted continued right testicle swelling and sent him to the hospital. On 6/13/2011, Mr. [redacted] underwent removal of his right testicle (ADC 045349), which was sent for pathology testing. His diagnosis of cancer (specifically, extra nodal NK/T cell lymphoma, nasal type, of the right testicle), an aggressive form of the disease, was made a few days later, approximately six weeks after his initial complaint. ADC 045346. Had a testicular ultrasound been performed when Mr. [redacted] initially presented with the complaint of testicular swelling, the malignancy would have been detected much more rapidly, and treatment could have been started in a timely fashion. Rapid initiation of treatment is paramount in the case of aggressive malignancy; NK/T cell lymphoma is an aggressive malignancy.

190. On 3/6/12, notes from 21st Century Oncology of Arizona document "lump of about 2 cm diameter on the medial aspect of his left thigh…will follow closely." ADC 045238. This issue in fact received no follow-up based on review of the available medical records. It appears likely that this lesion was spread of the lymphoma to Mr. [redacted]' thigh, but this was not further assessed or diagnosed until more than three months later.

191. A biopsy was done of thigh lesions on 6/21/2012 at St. Luke's Hospital during Mr. [redacted] hospitalization. Per the pathology report (ADC 045088), this lesion was consistent with cutaneous lymphoma, which means Mr. [redacted] either had lymphoma that was refractory to the initial chemotherapy regimen (did not respond) or a relapse of lymphoma. Regardless of whether the thigh lesions represented relapse or remission, Mr. [redacted] did not receive timely treatment with alternative chemotherapy agents or an intensification of his regime that could have improved his outcome once it was clear his cancer was more advanced than previously thought.

192. There is little documentation leading up to what I believe was Mr. [redacted]' final hospitalization (the last medical records available are date 6/22/2012 at which point Mr. [redacted] was critically ill, and he passed away on [redacted]). The documentation that is available, however, includes vital signs documented on 5/28/2012, which show inadequate care. ADC 045051. Mr. [redacted] requested discharge from the medical ward back to his normal prison unit since he stated he had completed chemotherapy. On that date, he had abnormal vital signs: a temperature of 95.5 degrees and pulse of 108. *Id.* These vital signs indicated that Mr. [redacted] met the criteria for the Systemic Inflammatory Response Syndrome, a physiologic state that is often the body's response to an infectious insult. While these vital sign abnormalities are not specific for one particular condition, they always warrant further investigation since they may be the first sign that a serious illness is present. However, ADC medical staff did no further investigation into these abnormal vital signs. Generally it is the standard of care to take a further history, review of systems, perform a physical exam and potentially order diagnostic testing. Rather than doing any of these things, the medical staff at the prison approved Mr. [redacted]'s request to go back to his normal prison unit that day without any further medical care. Since Mr. [redacted] had just completed a cycle of chemotherapy, the possibility that he had developed sepsis, an overwhelming infection, from a low white count had to be considered seriously, but was not.

193. Four days later, on 6/1/2012 at 15:50, a registered nurse noted that Mr. [redacted] was "defecating on self," "scared to eat due to vomiting" and demonstrating "slow cognition," and was given a "verbal order from Dr. Rowe -- send inmate back…for closer observation." ADC 045050. There are no further notes in the medical chart until 6/1/2012 at 22:00, when Mr. [redacted] was again found to have abnormal vital signs and was administered intravenous fluids. ADC 045049. He was not sent to a hospital until 23:56 that day, nearly 8 hours after he presented with symptoms of a serious illness.

194. The fact that Mr. [redacted] was admitted to a hospital four days after he was discharged from the prison medical ward (on the morning of 6/2/2012) further indicates that he was already falling ill on 5/28/2012, and the medical providers in the prison at that time failed to recognize the warning signs of sepsis. ADC 045058. At the hospital, he was found to have neutropenic (low white blood cell count, due to effects of chemotherapy) sepsis, pneumonia, and small bowel obstruction. ADC 045058-64. Delay in the diagnosis of these serious medical conditions very likely contributed to Mr. [redacted] death.

195. Mr. [redacted], who died on [redacted] at age 60, experienced inappropriate delays in care while in custody, including inadequate follow-up for obvious skin lesions. Without an autopsy report or mortality review (not yet provided to plaintiffs, I am informed), I cannot determine whether these lapses may have contributed to his death. I will supplement this report as necessary if additional documents are received.

196. On 6/5/11, Mr. [redacted] submitted a health needs request, stating "I have skin cancer in 3 locations on my neck and back that need attention." ADC 043967. On 6/14/11, he was seen by a registered nurse who stated he would be seen by a medical provider, indicating that the appointment should take place on 6/23/11. ADC 043896. No such appointment took place.

197. On 7/5/11, a continuity of care transfer summary was prepared regarding

Mr. [redacted]. ADC 043895. It failed to document the need for a provider exam regarding the skin cancer, as ordered by nurse on 6/14/11. On 7/11/11, apparently after a transfer, a new arrival record review was done regarding Mr. [redacted] but it did not note the need for the exam. ADC 043894.

198. On 7/15/11, Mr. [redacted] submitted a second HNR regarding his skin lesions, stating, "I have skin cancer on my neck and shoulder. Please schedule me for treatment." ADC 043965. A handwritten note on the request, presumably done by staff, states "schedule [health care provider] for follow-up." *Id.* No such appointment happened, and he did not have the required nurse triage assessment.

199. On 8/31/11, Mr. [redacted] submitted a third HNR regarding his skin, stating, "I have skin cancer on my neck – It bleeds. Please schedule me for treatment." ADC 043964. In response, a registered nurse wrote on the form, "[healthcare provider follow-up] schedule." *Id*. No such appointment happened, and again, he had no nursing assessment.

200. On 9/7/11, a medical provider reviewed Mr. [redacted]'s records, without seeing him. The provider's note states that two HNRs re skin cancer with bleeding had been received from Mr. [redacted] and orders, "Please schedule [doctor line] visit to evaluate." ADC 043893. No such appointment took place.

201. On 12/17/11, Mr. [redacted] submitted a fourth HNR regarding his skin conditions, stating, "[m]y skin cancer is progressing. It's likely that surgery is necessary now! Please schedule me." ADC 043963. He was not seen.

202. On 1/11/12, a doctor wrote a note in the medical record, based apparently only on a review of documents, stating that Mr. [redacted] needs to be scheduled to see a doctor as soon as possible regarding, among other things, the concern and requests about skin cancer. ADC 043891.

203. On 2/17/12, eight months after his first request, after multiple nurse and provider orders, Mr. [redacted] finally saw a medical provider about his skin cancer. ADC

043891. The provider noted Mr. [redacted]'s history of skin cancer, documented multiple lesions and wrote "may be cancerous [and] needs attention." ADC 043889, ADC 043904. The medical provider requested a dermatology consult. ADC 043904.

204. On 4/24/12, Mr. [redacted] again saw a medical provider, who noted the continuing need to see a dermatologist. ADC 043886. The provider submitted another dermatology consult, pointing out that the consult had been previously requested in mid-February. ADC 043900. The provider described the need for the consult as "semi-urgent" and wrote the word "EXPEDITE" in capital letters near the top of the request form. *Id*.

205. On 5/29/12, Mr. [redacted] was seen by a registered nurse, who noted his skin lesions, stated that a doctor should evaluate them, and indicated that Mr. [redacted] will be seen by a doctor on 7/10/12. ADC 043885. He was not.

206. On 6/11/12, Mr. [redacted] submitted a formal letter regarding his skin cancer. Among other things, he wrote, "These spots are painful and they bleed through my shirt and occasionally on my bed sheet." ADC 043956. A handwritten statement on the letter, presumably by medical staff, indicated that Mr. [redacted] would be scheduled to see a nurse. *Id.* There is no record of any such appointment.

207. On 7/31/12, Mr. [redacted] submitted yet another letter about his condition. "This is my 5th or 6th request to get my skin cancer removed. It's painful and it bleeds." ADC 043952. A medical provider writes on the letter, "will set up [appointment]." *Id.*

208. On 8/3/12, a medical provider entered an order in the chart to set up an appointment regarding Mr. [redacted] s skin lesions. ADC 043884. No such appointment ever happened. On [redacted] Mr. [redacted] died, fifteen months after he told staff of his skin cancer, and eight months after his referral to a dermatologist.

209. There were in this case multiple instances delay, multiple instances of a lack of follow-up, and a failure to provide necessary (and repeatedly ordered) specialty services in response to Mr. [redacted]'s obviously very troubling skin lesions. These

failures exposed Mr. [redacted] to a substantial risk of harm.

210. Mr. [redacted], at the time of his death on [redacted] was 33 years old. Mr. [redacted] had advanced liver disease/cirrhosis, a condition known to ADC medical staff at least as early as 1/5/11, when a Physician Assistant (PA) documented that Mr. [redacted] stated that in October and November 2010 he was diagnosed with the condition by a specific doctor after specific tests. ADC 043021. The PA asked to get medical records from previous doctor at Maricopa Medical Center (MMC) and ordered a GI (gastro-intestinal) consult. Id.

211. The PA saw him again a week later, on 1/12/11. ADC 043020. The PA noted abdominal ascites (an accumulation of fluid) and lower extremity edema (swelling), assessing the condition as consistent with end stage liver disease. Id. The next day, Mr. [redacted] was observed as being pale and jaundiced, with swelling of the lower extremities. ADC ADC 043019. He was seen by a doctor, who upon assessment of him and just-received lab results, diagnosed End-Stage Liver Disease and wrote, "no cure, only comfort measures." ADC43018. However, no medication was ordered.

212. On 1/23/11, Mr. [redacted] submitted an HNR, asking to get medication for his liver condition and mentioning he had been on it at the county jail. ADC 043199. He complained of "real bad" swelling of his feet. Id. On 1/25/11, he was seen by medical staff. ADC43016. The note for this encounter includes no objective section or assessment and the only plan is to request records from MMC. Id.

213. However, just as was the case earlier in January 2011, no medication was prescribed on 1/25/11 – or in the subsequent days or weeks. While it was appropriate to request previous medical records, Mr. [redacted] s medical conditions alone, as empirically known and observed at the time, required restarting medication – the standard set of medication for liver cirrhosis patients - upon his arrival to the ADC without waiting for the jail medication list. Failure to order medication in these circumstances is a gross

example of poor care.

214. On 3/3/11, Mr. [redacted] again filled out a health needs request, stating he had liver cirrhosis, "can't take the pain anymore," and that he had not seen a doctor for two months, as well as noting where his previous medical records could be accessed and asking for medication. ADC42951. After seeing a provider, Mr. [redacted] was transferred to the hospital for swelling. ADC 043014. This hospitalization likely could have been avoided if the patient had been receiving his medications since the time of transfer.

215. On 3/7/11, when Mr. [redacted] was seen by a provider back at the prison, he still was not on any medication except Tylenol #3; the provider noted that they were "still awaiting med list" from the previous provider and finally ordered medications for end-stage liver disease symptoms that day. ADC 043011. Again, there was a long unnecessary delay in ordering medication for this patient, which resulted in needless suffering and likely caused an unnecessary hospitalization.

216. The medical records are replete with additional examples of Mr. [redacted] receiving very poor medical care. For example, on 3/28/11 he was seen by a nurse and complained of dizziness. ADC 042996. No vital signs were recorded, even though doing so is a basic requirement of a minimally adequate nursing assessment. Mr. [redacted] was not referred to a provider, and his dizziness was dismissed as a complication of one of his medications, propranolol. *Id.* However, there are many other possible and far more serious diagnoses that must be considered in any patient with Mr. [redacted] s serious condition; he should have been referred to a doctor. The very next day, on 3/29/11, he was found unresponsive on the floor by a guard and taken to hospital where he was treated for hepatic encephalopathy; he remained there for approximately 10 days. ADC 042995, ADC 042992-ADC 042993.

217. On 6/8/11, Mr. [redacted] was hospitalized for hepatic encephalopathy. ADC 042960. Upon return to prison on 6/14/11, Mr. [redacted] was hospitalized

again almost immediately with confusion and other symptoms. ADC 042959. In the 6/21/11 discharge summary, hospital doctors recommended follow-up with a gastroenterology specialist within one week. ADC 043084. The specialist follow-up did not occur until 9/14/11. ADC 042887. This is a totally inappropriate delay in care.

218. The specialist on 9/14/11 recommended a diagnostic procedure, endoscopy of the esophagus, stomach, and duodenum (EGD) with possible banding if esophageal varices were seen. ADC 042887. Varices are dilated blood vessels; esophageal varices that are left untreated can lead to life-threatening internal bleeding, which can be fatal. Mr. [redacted] s EGD was performed on 9/28/11, and demonstrated 3 large varices. Banding, a procedure which compresses the weakened veins to prevent them from bleeding, was performed. ADC 042888. As such, the three month delay in providing the urgent gastroenterological consultation created a significant risk of harm to the patient.

219. At the time the banding was done, the GI specialist recommended a repeat EGD in three to six months. ADC 042888. Yet in the following nine months prior to Mr. [redacted] s death no further EGDs are documented. This is substandard care and created a significant risk of harm.

220. On 1/26/12, Mr. [redacted] was seen because results from a lab test based on a sample taken on 12/29/11 showed abnormal low white blood cell count and low platelets, which can contribute to increased risk for infection and life-threatening bleed, respectively. ADC 042828. He was sent for a STAT (emergency) lab draw and an order made that he be seen again by a doctor by February 1st (within five days). *Id.* However, his next visit did not take place until 3/16/12 – six weeks later. *Id.* This shows non-existent mechanisms for follow-up, failure to act on physician orders, and very poor primary care.

221. When Mr. [redacted] was seen by a doctor on 3/16/12, the labs ordered on 1/26/12 were re-ordered, suggesting the previously ordered tests were never done.

ADC 042828. The newly re-ordered lab tests were never done by prison staff. On 4/10/12, Mr. [redacted] had an emergency department visit for confusion (hepatic encephalopathy). AD C042827. When seen back at the prison on 4/12/12, the labs were ordered yet again, and lab tests were ordered every two weeks to check electrolyte levels. ADC 042827. Despite that order, in the three months that remained until death, only a single lab test was done. ADC 042899–902. This failure to follow doctor's orders for a basic diagnostic procedure again shows grossly substandard care.

222. On 5/1/12, Mr. [redacted] had the only set of labs drawn in response to the order that such labs be done every two weeks. ADC 042899 – ADC 042902. The results were reported on 5/3/12 but not reviewed by a provider until 5/9/13. Id. The results among other things showed low potassium, which requires repletion that same day. Id. Low potassium in a patient with advanced liver disease can cause hepatic encephalopathy. However, potassium was not provided and Mr. [redacted] was not seen by a provider for follow-up on those lab results until 5/22/12. ADC 042827. This was an inappropriate delay in following up abnormal labs.

223. At the 5/22/12 visit, Mr. [redacted] was noted to be jaundiced and to have 4+ pitting edema (severe swelling), suggestive of worsening liver failure and increased edema. ADC 042827. He was ordered TED hose (compression stockings). Id. Such stockings help prevent blood clots in his legs but do little for the swelling. This was inappropriate treatment of his edema. His diuretics should have been increased to help decrease the edema, and he should have been on a sodium-restricted diet.

224. Mr. [redacted]'s final admission to Tempe hospital occurred on 7/10/12. ADC 042871, ADC 042839. He was admitted to the hospital for an infection of his leg. *Id.* He died on [redacted] Cause of death was determined to be complications of severe left lower extremity cellulitis, and he was also determined to have hepatic cirrhosis secondary to chronic alcohol abuse with acute renal failure and hypertension. ADC 062594. Mr. [redacted] had advanced liver disease. This is a complex medical

problem, requiring coordinated treatment, which Mr. [redacted] did not receive.

225. [redacted] was a 52 year old woman with a history of hypertension, asthma and a prior heart attack in 2009 who died while in custody on [redacted]. She was found dead in her cell and the cause of death is unclear from the medical records provided (I will supplement this report if the death review, autopsy, or other records are received). However, Ms. [redacted] received poor care in the months preceding her death; in particular, she had a history of a serious cardiac condition that was not addressed and an episode of seizure activity and associated problems that were not adequately addressed by health care providers.

226. On 2/21/12, during an initial facility intake assessment, Ms. [redacted] was noted to have a history of, among other conditions, a myocardial infarction (heart attack) in 2009. ADC 041306. On 4/2/12, staff was called to see Ms. [redacted] when she suffered seizure-like activity that occurred while she was sitting at a table. ADC 041325. A licensed professional nurse (LPN), not a registered nurse, assessed Ms. [redacted]. The LPN note indicates that Ms. [redacted] did not remember all of what had just happened to her. The LPN told her to "increase water intake. Stop smoking and picking up buds off ground." *Id.* Nothing else was done. This is entirely inappropriate management. Ms. [redacted] has no history of seizure disorder and it is unclear if this episode was truly a seizure or some other neurologic or cardiac event; the patient should have been seen by a doctor that day. The LPN was acting outside the scope of her training.

227. On 4/4/12, Ms. [redacted] was seen by a nurse practitioner (NP) for "multiple complaints." ADC 041324. Ms. [redacted] had submitted a request for care, received 4/3/12, stating, "on 4/2/12, I passed out two times. I have a past history including 2 strokes [and] a heart attack. I am having problems remembering anything that has happened since 4/2/12. I don't remember passing out . . . ." ACD041429. The NP performed a physical exam which was normal except for some mild abdominal pain and

diagnosed her with "dehydration" and "anxiety." ADC 041324. She also ordered an EKG, abdominal ultrasound, a chest x-ray and labs to assess for pancreatitis--which were all normal. *Id*. The NP also referred her for psychiatry counseling due to the recent death of her spouse. *Id.* Although the labs ordered were reasonable as was the psychiatry referral, attributing episodes of "blacking out" to dehydration and anxiety is inappropriate (especially because Ms. [redacted]'s blood pressure was high (160/85), arguing somewhat against dehydration).

228. The basic standard of care given Ms. [redacted]'s history of heart attack and stroke and multiple episodes of blacking out, calls for a provider to obtain a more detailed history to determine if this was due to a neurologic problem or cardiac problem-especially given her history of having a heart attack. Generally, patients who have suffered a heart attack are treated with multiple medications which have been shown to decrease the risk of another heart attack. These medications include: beta blockers, ACE inhibitors, and statins (drugs which lower cholesterol). Ms. [redacted] was not provided the benefit of any of these medications besides aspirin.

229. This failure to provide standard treatment to prevent another heart attack was not addressed anywhere in her primary care visits. Although she had a history of a heart attack and two strokes, no laboratory evaluation of her cholesterol was ever measured. Her multiple episodes of unexplained loss of consciousness required thorough cardiac evaluation. She needed an echocardiogram, an ambulatory cardiac monitor (to monitor the heart rhythm for a twenty four hour period), and complete ultrasound evaluation of the arteries supplying her brain. None of these tests were ordered.

230. [redacted] was found dead in his cell on [redacted] with the cause of death unclear from the medical records (I was not provided an autopsy report or death review, and will supplement this report if such documents are hereafter received). Mr. [redacted] was a 55 year old male with a history of untreated high cholesterol and pre-diabetes. He did not receive treatment for either condition. One month prior to his death he

complained of chest pain on multiple occasions. He was treated with antacids only. He received no evaluation for possible coronary artery disease. Given his age, his elevated cholesterol and triglycerides (another fat which predisposes to heart attacks), his family history of early heart attacks and his pre-diabetic state, he was at significant risk for a heart attack.

231. Mr. [redacted] was transferred from ASPC-T/Winchester to Eyman/Meadows on 7/13/11; at that time he was documented to have a history of high cholesterol and a history of basal cell skin cancer but was not on any medications. ADC 043278. He had a new arrival medical review on 7/18/11, which noted his history of skin cancer, and he was referred to a health care provider. ADC 043277. He was not seen until 1/13/12, six months later. ADC 043276. This was a completely inappropriate length of time to wait to see a provider for follow-up. He was not provided any diagnostic evaluation for elevated cholesterol, and received no treatment for it.

232. At his chronic condition visit on 1/13/12, Mr. [redacted] was noted to be on no medications and have no complaints except being worried about diabetes because of a history of diabetes in his family. ADC 043276. The provider documented that he had a history of high cholesterol, but no recent laboratory tests. Basic lab tests including tests for diabetes and high cholesterol were ordered. *Id.* These tests were never performed, and no further testing was obtained.

233. On July 12, 2012, Mr. [redacted] was seen again for chronic care follow-up. He complained of on-and-off chest tightness at night which was relieved with sitting up. ADC 043274. The provider note clearly documents that Mr. [redacted] had a strong family history of early coronary artery disease/heart attacks (a brother had a heart attack before he was 50 years old) and other risk factors including obesity and a history of high cholesterol. *Id.* The provider ordered a cholesterol test, advised "lifestyle modifications" and tried famotidine (an antacid type medication) to see if the chest pain was due to esophageal reflux, caused by acid from the stomach irritating the esophagus, or

heartburn. ADC 043274. This is inappropriate and dangerous. Although Mr. [redacted]'s symptoms certainly could be due to heartburn, chest tightness in a middle-aged obese male with high cholesterol and a strong family history of heart attacks always requires a cardiac work-up. The basic standard of care required obtaining labs and referring Mr. [redacted] for a stress test to see if his symptoms were due to coronary artery disease. This was not done. Starting an antacid alone was completely inappropriate.

234. Mr. [redacted] did get labs done on 8/9/12 which showed a markedly elevated total cholesterol of 280 mg/dL and triglycerides of 407 mg/dL (ADC 043289) -- these most certainly should have been checked when he was first transferred in 2011 and he should have been started on medication for his cholesterol. His untreated high cholesterol and elevated triglyceride put him at high risk for a heart attack.

235. On [redacted] at 6:30 am, an emergency was called after Mr. [redacted] was found in his dorm, unresponsive. ADC 043273. Staff on site started CPR. They applied the AED which did not advise a shock. Emergency services arrived and the patient was pronounced dead at the scene at 6:53 am. Given that Mr. [redacted] was already cold and stiff when he was found, he was likely dead for some time prior to being discovered.

236. No autopsy is available, but a heart attack is the most likely cause of death. Mr. [redacted] should have received treatment directed towards lowering cholesterol and triglyceride levels in his blood. When he complained of recurrent episodes of chest pain, he should have received urgent cardiology consultation, specifically a stress test, to identify and treat probable coronary artery disease. His sudden death was most likely due to coronary artery disease. This was a definite failure of preventive care which was probably contributory to his death.

237. [redacted] was a 66 year old male with a history of hepatitis C cirrhosis, diabetes (on insulin) and hypertension who died on [redacted] – approximately two weeks after being received in custody – while receiving care at a hospital for gastrointestinal bleeding, hepatic coma, sepsis, and other conditions, likely due to his

underlying cirrhosis. Similar to other cases, Mr. [redacted] received extremely poor care for his liver disease.

238. During his reception center screening on 8/2/12, medical staff recorded that Mr. [redacted] stated he had coughed up blood on 7/15/12, and that he was supposed to have had banding of his esophageal varices. ADC 042654. This information was not followed up. The standard of care in such a situation would be an immediate referral to a doctor or emergency room, and/or an expedited endoscopy in the next few days.

239. Mr. [redacted] also had a psychiatric assessment on 8/2/12 which documented severe episodes of depression a few weeks prior and also documented depressed mood, flat affect, confusion and slowed speech and concluded that there were no emergent mental health needs. ADC 042652. All of these findings can also be symptoms of worsening liver function and hepatic encephalopathy (an antecedent to hepatic coma)--but this was not addressed.

240. Mr. [redacted] was seen by a provider on 8/4/12 for chronic care follow-up where he was noted to have "prob[able] impending liver failure" and noted to have shortness of breath, edema and ascites. ADC 042660. The assessment stated that he had diabetes, hypertension, coronary artery disease, Hepatitis C with abnormal liver function tests. *Id.* However, instead of obtaining urgent consultation and follow-up, the physician ordered routine labs, a chest x-ray, and an albuterol inhaler. No changes in medication were ordered, and no urgent follow-ups for management of his liver failure were initiated. This was outrageously poor care. In a patient that was clearly assessed to have "impending liver failure," the swelling in his legs and abdomen (ascites) were due to his liver disease. The basic standard of care calls for adding diuretics to treat the swelling and an assessment for other signs of liver decompensation, such as confusion and mental slowness that could be consistent with hepatic encephalopathy. Given the symptoms note on 8/2/12, Mr. [redacted] likely should have been started on lactulose, a medication used to prevent hepatic encephalopathy and coma.

241. In addition, the physician should have addressed the previous report of coughing up blood and either referred the patient to the ER or for urgent outpatient endoscopy as described above. Patients with ascites need to be evaluated for possible infection of the abdomen, spontaneous bacterial peritonitis. Patients with a history of variceal bleeding should be treated with a beta blocker, such as nadolol. None of these urgent actions were taken.

242. Five days later, on 8/7/12, Mr. [redacted] was seen by a doctor for follow-up for his lab results, but again none of the treatments he needed were ordered. ADC 042658. Later that same day, Mr. [redacted] threw up two cups of bright red fluid consistent with blood. He was evaluated by the nurse and noted to be "confused and lethargic." The doctor on call was telephoned and Mr. [redacted] was sent to the emergency room. ADC 042657. The hospital diagnosed him with a massive upper gastrointestinal bleed. ADC 042672-673.

243. Had physicians addressed his complaints of bleeding at the time of intake on 8/2/12, this might have been addressed earlier, and his death possibly averted. Mr. [redacted] had multiple serious medical problems on admission to prison, and was in an unstable condition. He received shockingly inadequate care.

244. [redacted] was a 50 year old male who died on [redacted] of a spontaneous subarachnoid hemorrhage, bleeding in the brain cause by the spontaneous rupture of an aneurysm. ADC 065591. Ruptured aneurysms are spontaneous and not preventable. However, Mr. [redacted] received extremely inadequate care while in ADC.

245. On 3/16/11 Mr. [redacted] was seen by a doctor who noted that he had a history of a heart attack in 2010, for which he was taking appropriate medications (a beta blocker, plavix, aspirin, ace-inhibitor and lovastatin); the doctor continued these medications for 180 days and ordered a follow-up visit for September 2011. ADC 046928-929, ADC 046933. The doctor also reviewed labs from January 2011 which

were largely normal and appropriately ordered repeat lab tests. An echocardiogram performed on 6/27/11 was mildly abnormal, demonstrating low normal global contractility, and mildly enlarged left ventricle. (ADC046932) These are signs that the heart has sustained mild injury, probably from the heart attack that had occurred in 2010.

246. Mr. [redacted] was next seen by the doctor after he passed out in the yard on 8/22/11. He was noted to have a low blood pressure (BP 80/50) and to be sweating profusely. He was given fluids and sent back to the yard; health care providers believed he had passed out due to the heat. ADC 046927. The note from this episode is only a few sentences and lacks a full history and physical. Because Mr. [redacted]'s has had a heart attack, and as well as abnormalities on his 6/27/11 echocardiogram, serious heart disease should have been at the top of the list of possible explanations for his passing out. He was at significant risk for developing an arrhythmia (abnormal heart beat) which can cause loss of consciousness. The standard of care for evaluating loss of consciousness in a 50 year old man with a prior heart attack mandated a detailed history and basic tests, including an immediate EKG, urgent laboratory studies, and possibly cardiac stress testing, none of which were obtained.

247. Mr. [redacted] was seen briefly by a nurse on 3/24/12 for a twisted ankle, but did not have a chronic care follow-up until 6/6/12, when he was seen by a nurse practitioner. ADC 046923, ADC 046921. In other words, the chronic care follow-up appointment that the doctor in March 2011 ordered to take place in September 2011 did not take place, and no such appointment took place for another additional eight months. This is a fifteen month interval between chronic care visits, completely inappropriate and dangerous.

248. At the 6/6/12 visit, the nurse practitioner documented that Mr. [redacted] had a history of a heart attack and had previously been on plavix, aspirin (both blood thinners), a beta blocker, ace inhibitor (blood pressure medications also used in people with a history of heart attacks) and lovastatin (a cholesterol medication) but that all of his

medications expired in October 2011. ADC046921. The fact that Mr. T[redacted]'s medications expired and he was neither seen by a physician nor had his medications renewed for approximately eight months is a gross deviation from minimal standards of care. It is also predictable given the failure to assure timely chronic care clinic visits.

249. The nurse practitioner documented a normal exam, normal blood pressure. *Id.* She appropriately ordered basic lab tests, but only prescribed aspirin and failed to re-start any of Mr. [redacted]'s previous medications. This was totally inadequate care. Almost all patients with a documented history of coronary artery disease, which Mr. [redacted] clearly had, should be maintained on aspirin, a beta blocker, ace-inhibitor and a cholesterol medication. The standard of care required re-starting Mr. [redacted]'s previous medications while also obtaining laboratory tests. The failure to do so raises concerns about the medical knowledge of mid-level providers (nurse practitioners, etc.) in ADC and the degree of physician oversight of those providers.

III. CONCLUSION

250. The health care system in recent years, whether run by the ADC, Wexford or Corizon, clearly lacks the capacity to address the needs of the many ADC prisoners with serious medical needs. As a result, prisoners are denied basic and necessary health care for their serious medical needs, and they are suffering substantial harm as a result.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct.

Executed this 8th day of November, 2013 at New York City, New York.

Robert L. Cohen, M.D.

APPENDIX A

Robert L. Cohen, MD

314 West 14th Street (W) 212-620-0144
New York, NY 10014 (F) 212-691-8588
BobbyCohen@aol.com

EDUCATION

A.B., Princeton University, 1970
M.D., Rush Medical College, 1975

POSTGRADUATE TRAINING

Residency, Medicine, Cook County Hospital, 1978
Chief Residency, Cook County Hospital, 1979
Board Certification, Internal Medicine - 1978

PROFESSIONAL EMPLOYMENT

Clinical Practice in General Internal Medicine
New York City, 1988 –

Medical Director
Cicatelli Associates
New York, NY, 2007 --

Attending Physician
Department of Medicine
Langone Medical Center
New York University School of Medicine, 2010 –

Attending Physician
St. Vincent's Hospital and Medical Center
New Yorkl, NY 1988-2010

Medical Director
AIDS Center
St. Vincent's Hospital and Medical Center, NYC
January 1989 - October 1990.Robert L. Cohen, MD

Vice President for Medical Operations
New York City Health and Hospitals Corporation
1986-1988

Director
Montefiore Medical Center
Rikers Island Health Services
1982 - 1986

Associate Medical Director
Rikers Island Health Servi
1981 - 1982

Attending Physician
Department of Medicine
Cook County Hospital
1979 - 1981

FACULTY APPOINTMENTS

Clinical Assistant Professor
Department of Social Medicine and Clinical Epidemiology
Albert Einstein College of Medicine
1985 – 2008

Clinical Instructor
Department of Medicine
New York University School of Medicine
2010 –

INSTITUTIONAL REVIEW BOARD MEMBERSHIP

Vice Chairman
Institutional Review Board
Montefiore Medical Center
1984 - 1986

Member
Institutional Review Board
City University of New York
2000 –

TESTIMONY OVER LAST FOUR YEARS

- Martin Hernandez Banderas v. United States, CV 08-6594 PSG (CTx)
- Baires v. United States Case No.: CV 09-5171 CRB
- Lin Li Qu, et.al v. Cornell Companies, Inc. et al, USDC C.A. No. 09-53-S-DLM

- Castaneda v. US, Central Dist. Of California, CV07-07241 DDP (JCx)
- Jennings v. Hart - Case No. 3:08cv0028, Western District of VA

MEDICAL EXPERT -- PRISON HEALTH

Federal Court Appointed Monitoring of Health Care in Prisons and Jails

Michigan, Hadix v. Johnson, 2003 – present
Court Appointed monitor for oversight of medical care of in several Michigan Prisons

Ohio, Austin v. Wilkinson, 2002 -- 2005
Member of two person Medical Monitoring Team to monitor compliance with settlement agreement regarding medical care in Ohio State Penitentiary

Connecticut, Doe v. Meachum, 1990 -- present
Medical expert at trial and court appointed monitor of compliance with settlement agreement covering care of all HIV infected prisoners in Connecticut.

New York State, Milburn v. Coughlin, 1989 -- present
Continuing review of compliance with health care consent agreement

Washington, D.C. 1986 - 2000
Court appointed medical expert involved in monitoring compliance with several consent agreements regarding medical care at the DC Jail as well as DC prisons at Lorton (VA)

Florida, Costello v. Wainwright, 1983 through 1988
Review of compliance with settlement agreement in all Florida Prisons
State Court Appointed Monitor

Philadelphia, PA, Jackson v. Hendricks, 1991 -- 1999
Review of compliance with consent agreement on medical care within Philadelphia jails

Department of Justice Appointed Medical Expert

Cook County Jail, 1982 (Chicago, IL)
Essex County Youth House, 1995 – 1999

RECENT PRESENTATIONS

"Inhumane and Ineffective: Solitary Confinement in Michigan and Beyond." University of Michigan Journal of Race and Law, February 2, 2013

"The Impact of Solitary Confinement on Prisoner Health", WHO Health in Prison Project, Copenhagen, Denmark, October 12, 2012

Dialogues on Detention: "Applying Lessons from Criminal Justice Reform to the Immigration Detention System", Human Rights First, University of Texas, Austin, TX, September 12, 2012

"Health Care for Detained Immigrants US and Europe", Health in Prison and Throughcare: Provision and continuity of care for those in the criminal Justice System, Abano Terme - Italy, October 7, 2011

Prisoners' Human Rights and Day to Day Correctional Health, 4th Academic and Health Policy Conference on Correctional Health, March 10, 2011, , Boston, MA

Mass Incarceration and Correctional Medicine: The Dialectics of Caring for Prisoners, Albert Einstein College of Medicine , February 16, 2011

Strategies for assuring the civil rights of detained persons: U.S. and International Perspectives; American Public Health Association, Denver, November 8, 2010

Why the United States Should Adopt the Optional Protocol to the Convention Against Torture; International Conference on Prison Health Care/WHO Health in Prison Project, Madrid, Spain, November, 2009

What is the Physician's Responsibility in an era of Mass Incarceration, Offender Health Research Network, Manchester, England, May 2009

Health Care for Immigration Detainees: What Should Be The Standard? Panel of the ABA Council on Immigration, February 13, 2009, Boston, MA

Medical Consequences of Mass Incarceration, 2ème Université d'Eté de Médecine en Milieu Pénitentiaire, Association of French Correctional Medicine Physicians, Perpignan France, May 21, 2008

American Exceptionalism: The Health Consequences of Mass Incarceration 2nd Annual Conference of the International Journal of Prison Health Care, Varna, Bulgaria, October 21, 2007

HIV/AIDS in Custody: Advocacy for Prevention, Care and Treatment In Correctional Settings and on Reentry, NYC Bar Association January 10, 2007

PUBLICATIONS

Allen-S, Wakeman-S, Cohen-R, Rich-J, Doctors in US Prisons in the Era of Mass Incarceration, International Journal of Prisoner Health, 6(3):99–106, 2010

Cohen-R., "Health and Public Health Advocacy for Prisoners" in Puisis-M, et.al, *Clinical Practice in Correctional Medicine*, Elsevier, 2006.

deLone-M, Cohen-R, et.al, Standards for Health Services in Correctional Institutions, 3rd edition, American Public Heatlh Association 2003

Cohen-R., The Medical Intake Examination, in Puisis-M, Cohen-R, et al, *Textbook of Correctional Medicine, Mosby, St. Louis, 1998.*

Frickhofen-N, Abkowitz-JL, Safford-M, Berry-M, Antunez-De-Mayolo-J., Astrow-A, Cohen-RL, King-LN,et.al., Persistent B19 Parvovirus Infection in Patients Infected with HIV-1, Annals of Internal Medicine, Vol. 113, No. 12, 926-933, Dec. 15, 1990.

Laudicina, S., Goldfield, N., Cohen, R., Financing for AIDS Care, The Journal of Ambulatory Care Management,Vol. II, No. 2, 55-66, May 1988.

Selwyn, Peter A., Feiner, Cheryl, Cox, Charles P., Lipshutz, Carl & Cohen, Robert L., Knowledge about AIDS and High-Risk Behavior Among Intravenous Drug Users in New York City, AIDS, Vol. 1, No. 4, 247-254, 1987.

Cohen, Robert L., Case Studies: A Prisoner in Need of a Bone Marrow Transplant, Hastings Center Report, Vol. 17, No. 5, 26-27, 1987.

Bayer, Ronald, Carol Levine, Susan M. Wolf et. al. HIV Anti-body Screening: An Ethical Framework for Evaluating Proposed Programs. JAMA Vol. 256, No. 3: 1768-1774, 1986.

Cohen, Robert L., Oliver Dennis, Pollard-Sigwanz, Cathy, Leukopenia and Anergy as Predictors of AIDS, JAMA, Vol. 255, No. 10, 1289, 1986.

Whitman S, King L, Cohen R, Epilepsy and Violence: A Scientific and Social Analysis. In: Whitman S, and Hermann B, ed. The Social Dimensions of Psychopathology. Oxford University Press, 1986.

Cohen, R., AIDS: The Impending Quarantine, Bulletin of the Health Policy Advisory Committee, Vol. 17, No. 3, 9-14, 1985.

Whitman S, Coleman T, Patron C, Desi B, Cohen R, King L, Epilepsy in Prison: Elevated Prevalence and No Relationship to Violence. Neurology, Vol. 34, No. 6, June, 1984.

Cohen, Robert L., Imprisoned Plasma Donors: A Medical-Ethical Case and Comment, Journal of Prison & Jail Health, Vol. 2, No. 1, 41-46, 1982

APPENDIX B

Depositions

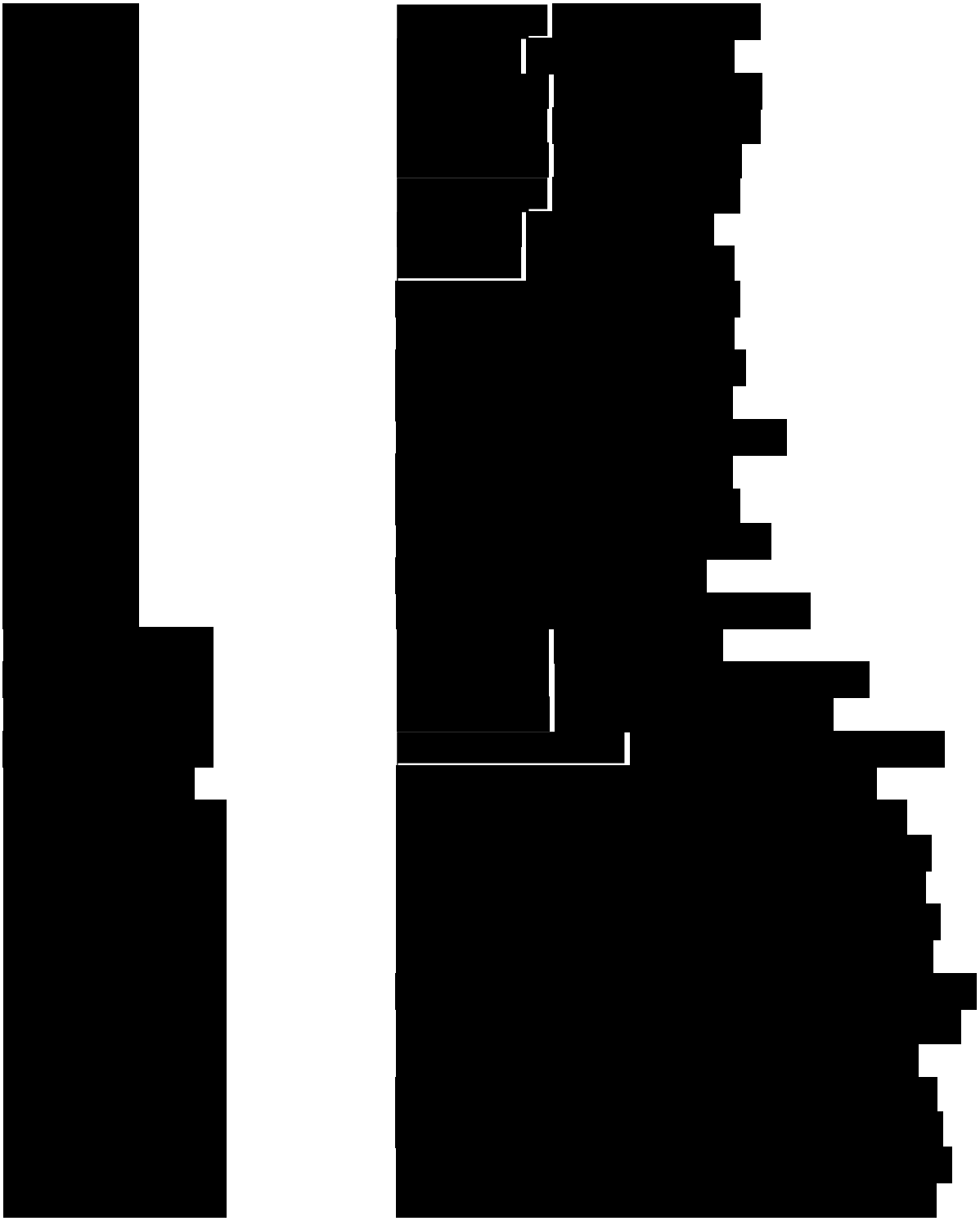
13.09.13	Mark Haldane Deposition
13.09.20	Jenny Mielke-Fontaine Deposition
13.10.08	Neil A. Fisher, M.D. Deposition
13.10.13	Winfred D. Williams, M.D. Deposition
13.05.21	Karen D. Mullenix Deposition
12.09.19	Richard H. Rowe, M.D. Deposition
12.10.03	Tracy Crews, M.D. Deposition
12.10.03	Ben L. Shaw, Ph.D Deposition
12.10.04	Richard Pratt Deposition
13.08.26	David W. Robertson, D.O. Deposition
13.09.09	Arthur Gross Deposition
13.09.11	Kathleen Campbell, RN Deposition
13.10.10	Vickie Bybee Deposition
13.08.27	Vanessa Headstream, RN

Documents

ADC010648-011231	Health Services Technical Manual
ADC094844	Monitored Conditions Report, Eyman – 13.03.12
ADC095001	Monitored Conditions Report, Lewis – 13.03.12
ADC137741-137753	Compliance Quarterly Report, Douglas – June 2013
ADC137741-137753	Compliance Quarterly Report, Eyman – June 2013
ADC137780-137792	Compliance Quarterly Report, Lewis – June 2013
ADC137819-137831	Compliance Quarterly Report, Safford – June 2013
ADC137845-137857	Compliance Quarterly Report, Winslow – June 2013
ADC153777-153793	Arizona Contract Staffing Percentage Report – 13.07.29
ADC153838	Inmate Wait Times Report – July 2013
ADC 155093	Inmate Wait Times Report – September 2013
ADC155099	Arizona Monthly Staffing Report – September 2013
AGA Review 00006402-6412	Arizona Staffing Comparison Roll-Up
AGA Review 00007226	Email
AGA Review 00013126-13127	Email
AGA Review 00015752-15755	Email
AGA Review 00016658	Email
AGA Review 00017095-17096	Email
AGA Review 00017341	Email
AGA Review 00037462-37466	Email
ADC088796	Compliance Report, Douglas – April 2013
ADC088814	Compliance Report, Eyman – April 2013

ADC088892	Compliance Report, Lewis – April 2013
ADC088979	Compliance Report, Safford – April 2013
ADC089060	Compliance Report, Winslow – April 2013
ADC117910-117926	Compliance Report, Douglas – June 2013
ADC117985-118002	Compliance Report, Lewis – June 2013
ADC137359	Compliance Report, Safford – June 2013
ADC137185-137200	Compliance Report, Douglas – July 2013
ADC137201-137228	Compliance Report, Eyman – July 2013
ADC137268-137288	Compliance Report, Lewis – July 2013
ADC137402-137418	Compliance Report, Winslow – July 2013
ADC137465-137496	Compliance Report, Eyman – August 2013
ADC137525-137554	Compliance Report, Lewis – August 2013
ADC137610-137625	Compliance Report, Safford – August 2013
ADC154049-154094	Compliance Report, Eyman – September 2013
ADC154147-154181	Compliance Report, Lewis – September 2013
ADC154347-154368	Compliance Report, Winslow – September 2013
ADC014403-014248	RFP
No Bates Number	[redacted] Death Narrative – [redacted]
No Bates Number	[redacted] Review – [redacted]
No Bates Number	[redacted] Review – [redacted]
No Bates Number	[redacted] Review – [redacted]
No Bates Number	[redacted] Death Review – [redacted]
No Bates Number	[redacted] Death Narrative – [redacted]
No Bates Number	[redacted] Death Review – [redacted]
No Bates Number	[redacted] Report – [redacted]
No Bates Number	[redacted] Addendum – [redacted]
No Bates Number	[redacted] Report – [redacted]
No Bates Number	[redacted] Report – [redacted]
No Bates Number	[redacted] Report – [redacted]
No Bates Number	[redacted] Report – [redacted]
[redacted]	[redacted]
ADC122290-122321	Joseph Hefner Medical Records – 13.03.01 to 13.07.15
ADC122322-122337	Joseph Hefner Medical Records – 13.03.01 to 13.07.15
ADC122338-122354	Joshua Polson Medical Records – 13.03.01 to 13.07.15
ADC122355-122370	Joshua Polson Medical Records – 13.03.01 to 13.07.15
ADC130287-130308	Joshua Polson Medical Records – ORC and Rxs
ADC131368-131405	Joshua Polson Medical Records – 12.03.08 to 12.10.23
ADC122465-122490	Stephen Swartz Medical Records – 13.03.01 to 13.07.15
ADC122491-122510	Stephen Swartz Medical Records – 13.03.01 to 13.07.15
ADC122511-122527	Stephen Swartz Medical Records – 13.03.01 to 13.07.15

ADC122528-122551 Stephen Swartz Medical Records – 13.03.01 to 13.07.15
ADC122552-122565 Stephen Swartz Medical Records – 13.03.01 to 13.07.15
ADC133730-133866 Stephen Swartz Medical Records – 95.07.11 to 97.12.09
ADC133867-134306 Stephen Swartz Medical Records – 09.11.18 to 11.06.29
ADC134307-134801 Stephen Swartz Medical Records – 11.10.05 to 12.10.23



[redacted]

[redacted]

ADC 027855-856

September 21, 2012 letter from Joe Profiri to Karen Mullenix re. Written Cure Notification

[redacted]

[redacted]

APPENDIX C

APPENDIX C

1. Diabetic Care

1. If diabetes mellitus is not managed properly, the patient's HgA1c levels (hereafter A1c levels) will be elevated, as will his blood sugars. A prisoner-patient whose diabetes is not properly controlled runs the risk of blindness from diabetic retinopathy, and kidney failure from proteinuria (excessive protein in the urine, a complication of diabetes that tells medical staff that the diabetes patient runs the risk of kidney failure). He or she may also suffer from peripheral neuropathy, an intensely painful condition if not managed properly with appropriate pain medication. Proper treatment of diabetes therefore absolutely requires regular eye exams to look for diabetic retinopathy as well as regular kidney function testing for proteinuria.

2. Medical charts that I reviewed for diabetic prisoners revealed a pattern of very poor care resulting in increased morbidity and an elevated risk of death in some cases.

3. [redacted] (Eyman; [redacted]). Mr. [redacted] has multiple serious medical problems, including uncontrolled diabetes, diabetic retinopathy with prior laser treatment, high cholesterol, and coronary artery disease with a prior heart attack. In addition, he is disabled, requiring a wheelchair. Review of his medical record shows a chaotic chart. The only recent laboratory study available in the chart demonstrated uncontrolled diabetes with an A1c level of 9.6 on November 29, 2012. Mr. [redacted] apparently trying himself to manage his diabetic retinopathy, had been requesting to see an ophthalmologist since November 4, 2012. He was informed that he would be "placed on the eye list" on December 4, 2012, but as of July 17, 2013 he had not been seen. Dr. Rumsey, the medical director at Eyman, had asked for a consultation with the retina specialist on May 30, 2013, but there has been no ophthalmology consultation for at least a year. This lack of access to ophthalmology for Mr. [redacted] who has diabetic retinopathy, is dangerous and can lead to blindness.

4. The insulin regimen prescribed for Mr. [redacted] is chaotic. He is being treated with a hazardous combination of multiple types of insulin: regular insulin, NPH, and Levemir, at a combined dosage of 170 units per day. These should not be used together because their interaction cannot be predicted. It is not recommended to use two long acting insulin preparations (NPH and Levemir). It is also the case that the current treatment is not controlling Mr. [redacted]'s diabetes. Mr. [redacted] needs access to an endocrinologist to manage his diabetes since staff and Eyman are unable to treat him effectively.

5. Mr. [redacted]'s treatment presents multiple serious failures: lack of access to proper medical care, failure to appropriately manage his chronic disease, lack of adequate medical records, lack of access to specialty consults outside the prison, and failure to deliver proper medication.

6. [redacted] (Eyman; [redacted]). Mr. [redacted] has diabetes, chronic obstructive pulmonary disease (COPD), hypertension, and neuropathy. I reviewed the status of Mr. [redacted]'s medical care during my visit to Eyman prison on July 18, 2013. His A1c level, a measure of how well his diabetes is controlled, had been elevated for the eight months prior to my visit. Ideally, a patient's A1c level should be below 7.0. Mr. [redacted]'s level on December 13, 2012 was 8.7; his level on May 13, 2013 was also 8.7 (ADC 136574). In addition, his daily finger stick blood sugar readings are always high, frequently over 300 and often over 400 mg %. He is receiving a mixture of 70/30 NPH and regular insulin twice a day, in addition to supplemental regular insulin. There has been no change in his insulin treatment since at least October, 2012, which indicates to me that there is insufficient review of the status of chronic care patients with diabetes. In addition, Mr. [redacted] complained that he receives insulin at irregular times.

7. Mr. [redacted]'s treatment for his diabetes demonstrates lack of access to care, failure of timely delivery of necessary medications, and very poor management of his chronic disease, diabetes mellitus. He is at serious risk for diabetic retinopathy, loss of

kidney function, and already suffers from peripheral neuropathy.

8. [redacted] (Eyman; [redacted]). Mr. [redacted] is a 35-year-old man with insulin-dependent diabetes that was diagnosed when he was 25 years old. His diabetes has been poorly controlled, with inadequate follow-up. His A1c level has been elevated since January, 2013. He placed Health Needs Requests (HNRs) on April 30, May 2, and May 5, 2013 indicating that his blood sugar levels had been high for the last few months after his insulin was changed to NPH 70/30. When his labs were drawn on July 5, 2013, his A1c was 8.8, indicating poorly controlled diabetes. There was no evidence in the medical record I reviewed that the laboratory studies obtained on Mr. [redacted] had in fact been reviewed by the medical provider. In addition, Mr. [redacted] is receiving an inappropriate combination of three different kinds of insulin for his diabetes: Lantus, a long acting insulin, NPH 70/30 a combination of a medium acting insulin with regular insulin, as well as regular insulin on a sliding scale basis. The use of premixed insulins is not recommended for patients with type 1 diabetes, as intensive regimens require frequent adjustments of the pre-meal injection of short-acting or rapid-acting insulin.

9. In addition, he is receiving two different kinds of long acting insulin, Lantus and NPH 70/30 NPH has an intermediate duration of action (2 hours after injection for onset of action, i.e., begins to reduce blood sugar); regular insulin has an onset of action within 30 minutes; and Lantus has a slower onset (70 minutes) and a longer duration (24 hours). Giving three types of insulin preparations at the same time will make it difficult to achieve appropriate glucose levels, as Mr. [redacted] has experienced. Use of two different long acting preparations is not recommended. Appropriate care would be to provide Lantus once a day at a fixed dosage, with sliding scale regular insulin before each meal and evening snack.

10. Mr. [redacted] treatment for his diabetes demonstrates lack of access to care, very poor management of his chronic disease, and mismanagement of his medications. In addition, if there was proper review of his medical records, particularly his medication

administration records (MARs), a knowledgeable practitioner would see that his diabetes medications are being mismanaged.

11. [redacted] (Lewis; [redacted]). Mr. [redacted] has diabetes, peripheral neuropathy secondary to diabetes, diabetic retinopathy, hypertension, and hepatitis C. On December 20, 2012 he received 48 units of regular insulin, instead of 48 units of combined 70/30 NPH insulin at 3:20 a.m. This was three times the usual dose of regular insulin, and could have caused a severe hypoglycemic reaction any time in the next 4 to 6 hours. He was kept in the nursing station until 5:00 AM and then sent back to his yard. There was no follow-up of his blood sugar for the rest of that day. Mr. [redacted]' diabetes is very poorly controlled. His A1c level was 9.9 on April 30, 2013. This was the second consecutive time that his A1 C level was over 9.6. However, despite these laboratory results, which demonstrated very poor control of his diabetes, at his chronic care visit on May 22, 2013 the practitioner characterized his diabetes control as "fair." A1c levels greater than 7.0 are very poor, not fair, and are associated with increased rates of progression of diabetic neuropathy and diabetic retinopathy, an irreversible and debilitating complication of diabetes that can lead to blindness. Mr. [redacted] has not had a recent eye exam, which is essential in his situation, and there was no recent monitoring of his urinary protein, also required for prevention of kidney disease in persons with diabetes.

12. Mr. [redacted] also has peripheral neuropathy secondary to his diabetes mellitus. He had been receiving gabapentin at a dose of 1800 mg twice a day for this condition. On March 26, 2013 his gabapentin dose was decreased by 2/3 to 600 mg B. I. D. There was no reason given in his medical chart for decreasing the dose, and Mr. [redacted] was not informed by any practitioner that his pain medication was going to be drastically decreased. He was forced to file multiple HNRs to have his gabapentin dose restored.

13. My review showed multiple failures to provide Mr. [redacted] necessary

medical care. These failures are characteristic of my review of medical care at Lewis and Eyman. He received the wrong dose of medication for his diabetes. His pain medication, prescribed to control a painful complication of his diabetes, namely peripheral neuropathy, was decreased dramatically without reason, and without informing him in advance. His chronic medical condition, diabetes mellitus, is not being treated effectively and despite recurrent laboratory confirmation that his diabetes is out of control, medical staff ignore this information and write in the medical record that his care is adequate.

14. [redacted] (Lewis [redacted]). Mr. [redacted] suffers from diabetes, painful diabetic peripheral neuropathy, hypertension, and hepatitis C. Hepatitis C is not included in his problem list. The problem list is the one-page summary of all of a patient's chronic conditions, so that medical providers can see the information at a glance. The failure to document a disease such as hepatitis C on a problem list can lead to delays in treatment or no treatment at all. Mr. [redacted] has had persistent elevations of his blood sugar. On November 20, 2012 his A1c was 8.8, and on February 26, 2013, it was 8.0. This February 26, 2013 laboratory was not noted until his chronic care visit of June 18, 2013, four months later, when his insulin dose was increased. Mr. [redacted] also has painful peripheral neuropathy caused by his diabetes, and was treated with gabapentin 1200 mg, twice a day. Without informing him, this dosage was cut by one third, to 800 mg twice a day. Mr. [redacted]'s blood pressure has been consistently elevated since October 23, 2012 when it was 152/92. On February 7, 2013 it was 166/99, and on March 14, 2013 his blood pressure was 170/104. On April 22, 2013, when he was finally treated for hypertension, his blood pressure was 164/100. Inappropriately, he was treated with atenolol, a drug which is potentially dangerous in a person with diabetes because it blocks the response to low blood sugar (hypoglycemia), and can prevent the patient from seeking treatment.

15. Mr. [redacted]'s chronic medical problems were ignored and untreated. Laboratory and radiology results were obtained but not reviewed, and though abnormal, not followed up. His treatment for painful neuropathy due to his diabetes was

significantly reduced without reason and without informing him. This practice of cutting pain medication without reason or discussion was described as routine practice by many men I interviewed at Lewis prison.

16. The poor medical care given to Mr. [redacted] demonstrates lack of access to care, failure of timely delivery of the appropriate medications, and failure to manage his chronic diseases.

17. [redacted] (Eyman; [redacted]). Mr. [redacted] is another prisoner housed at Eyman who has diabetes. As explained above, patients with diabetes are at risk for loss of sight because of diabetic retinopathy. Mr. [redacted] has not had an eye examination for the past two years. Diabetes management requires annual ophthalmology examinations. These have not been provided to Mr. [redacted]. Mr. [redacted]'s case indicates that prisoners requiring regular chronic care are being lost in the system because of poor medical review practices and poor recordkeeping.

18. Mr. [redacted]'s case demonstrates lack of access to care, failure to appropriately manage his chronic disease, lack of adequate medical records, and lack of access to specialty consults.

19. [redacted] (Eyman; [redacted]). Mr. [redacted] is a patient with uncontrolled diabetes and poorly controlled thyroid function following a thyroidectomy (removal of his thyroid) for thyroid cancer. At his last chronic care clinic, on July 16, 2013, none of his laboratory studies was available. Although his A1c level has been significantly abnormal for the past year, never less than 12.9, there was no indication that his insulin dosage had been adjusted. This suggests extremely poor management and control of Mr. [redacted]'s diabetes.

20. Mr. [redacted]'s case demonstrates failure of access to care, failure to provide appropriate medications for his chronic serious disease, failure to appropriately manage his chronic disease, and failure to maintain adequate medical records.

21. [redacted] (Eyman; [redacted]). Mr. [redacted] suffers from diabetes

mellitus. He has proteinuria as indicated by his elevated micro-albumin levels. Treatment of proteinuria is required to decrease the risk of kidney failure for persons with diabetes. However, Mr. [redacted] is not receiving any treatment for this known complication of diabetes. Also, Mr. [redacted] has filed multiple HNRs complaining about the irregularity of his insulin administration. He wrote that he received medication irregularly between the hours of 3:00 AM and 8:00 AM. His insulin administration needs to be at fixed times relative to his meals.

22. The poor care provided to Mr. [redacted] for his diabetes demonstrates failure of access to appropriate care, failure to timely deliver appropriate medications, and failure to manage the known and serious consequences of his chronic disease.

23. [redacted] (Eyman; [redacted]). Mr. [redacted] has multiple serious medical problems including diabetes and hypertension. There are no medication administration records (MARs) in his chart for March, May, and June 2013. Mr. [redacted] s diabetes is poorly controlled; his A1c level has increased from 8.1 on February 21, 2013 to 8.8 on May 17, 2013. Despite this deterioration in control, Dr. Rumsey noted that control of his diabetes had improved. This is another example of poor chronic care for a man with diabetes. Also, a urology specialty consult was ordered for Mr. [redacted] on January 1, 2012 for symptoms of a urethral stricture, but no consult has taken place.

24. Mr. [redacted]'s case demonstrates failure of access to appropriate care, failure to appropriately manage his chronic disease, failure to maintain adequate medical records, and failure to provide access to specialty consults.

25. [redacted] (Eyman; [redacted]). Mr. [redacted] has diabetes mellitus. His last chronic care appointment was on May 10, 2012, more than a year ago. Mr. [redacted] placed an HNR to see an optometrist on March 18, 2011. ADC 135452. At the time of his last chronic condition follow-up, on May 10, 2012 he was still waiting for the in-house optometry clinic. ADC136451.

26. Mr. [redacted]'s care demonstrates failure of access to care, failure to

appropriately manage his chronic disease, and failure to provide a specialty consult, to an optometry clinic, inside prison.

27. [redacted] (Eyman; [redacted]). Mr. [redacted] has diabetes, hypertension, and hypothyroidism. He also has severe left ectropion, an outward turning of the lower eyelid which increases exposure of the ocular surface and sensitive mucous membrane of the inner lid, and disrupts normal tear drainage patterns. Surgical correction was first recommended on January 31, 2012. A partial procedure was performed to correct the ectropion but never completed. ADC 136678. He has been waiting 18 months for the surgery. Dr. Rumsey, the medical director at Eyman, requested an ophthalmology consultation on March 5, 2013, and again on July 17, 2013, both for monitoring diabetic retinopathy and for surgical correction of the ectropion, which poses a serious risk of infection. Dr. Rumsey, in his July 17, 2013 consultation request to Corizon, noted: "left eye pronounced ectropion, irritation of eye, injected sclera . . . This is [a] case which has been delayed approximately 2 years." ADC 136680. The delays experienced by Mr. [redacted] in obtaining the necessary ophthalmology consultation for his diabetic retinopathy evaluation and severe ectropion demonstrate serious problems in access to specialty consultation. Failure to detect asymptomatic diabetic retinopathy can result in blindness. Dr. Rumsey has demonstrated extreme frustration with the failure of the consultation process with Corizon.

28. The poor medical care provided to Mr. [redacted] demonstrates failure of access to necessary care, failure to appropriately manage his chronic disease, and failure to provide him with access to specialty consults outside the prison.

29. [redacted] is a 60 year old man with diabetes, hypertension, hepatitis C and elevated cholesterol. His medical record is disorganized and laboratory slips are in the chart but unfiled. He has painful diabetic neuropathy. In May, 2013 he was receiving gabapentin 1200 mg twice a day for painful diabetic neuropathy. In June, 2013, his dosage was suddenly decreased 75% to 300 mg of gabapentin, twice a day.

There is no chart entry by the provider explaining the reason for the dramatic reduction in the dose of the medication, and Mr. [redacted] was not informed of the fact of the dosage reduction or the reason. This is one of many cases described to me in interviews and confirmed by chart review that men with chronic painful conditions are being denied their pain medication.

2. HIV Care

30. HIV disease, another chronic disease, can be managed with proper medication and is no longer regarded as a necessarily fatal disease. When properly managed and treated, an HIV patient's viral load will decrease, and remain low and stable. Also, a prisoner's T-cell count, the measure of a partially restored and functioning immune system, will remain elevated and stable if HIV disease is properly managed. Proper management absolutely requires timely delivery of the appropriate medications. If delivery of these medications is interrupted by failure of the medical delivery system to get the necessary medications to the prisoner-patient on time, HIV disease can spiral out of control with the viral load increasing dramatically while at the same time T-cell counts plunge.

31. Below, I evaluated several cases of ADC prisoners with HIV. As is true for diabetic care, I found that treatment of prisoners with HIV disease has been characterized by lack of access to care, failure of timely delivery of the appropriate medications, and failure of appropriate management of a serious chronic disease.

32. [redacted] (Eyman; [redacted]). Mr. [redacted] has HIV infection and is supposed to be on treatment with daily anti-viral medications. He has consistently had his anti-viral therapy (Atripla) interrupted by failure to renew his ordered medications. It is extremely dangerous if an HIV positive patient has any interruptions or delays in receiving his medications, because he can develop drug-resistant HIV or AIDS. There are no MARs in the medical record for February or March, 2013. A MAR from January 2013 shows that no Atripla was dispensed. ADC 136713. Once again, in April 2013, no

Atripla was dispensed. Mr. [redacted] ran out of Atripla on May 23, 2013, and did not receive any medication until June 4, 2013. ADC 136713.

33. On May 24, 2013, after his medication was not refilled, Mr. [redacted] wrote an "informal complaint" to the health unit supervisor. In it, Mr. [redacted] predicted that these missed doses of his HIV medication would have significant adverse consequences: "This is a major issue and significant concern for me, as each time doses are missed, it creates an opportunity for resistance to current meds, decreasing the rate of survival. This is not the first time this is happened under the current contractors [i.e., Corizon]."

34. The response to Mr. [redacted]'s complaint confirmed that his medications were not provided from May 24, 2013 through June 3, 2013. ADC 136713. As Mr. [redacted] had predicted, the forced interruptions in his HIV therapy caused by failure to renew his medications resulted in the deterioration of his clinical condition. His viral load, the main measure of therapeutic success in HIV treatment, had been undetectable, measured as <20 copies/ml in December 2012 and April 2013. ADC 136705,136706. However, by June 5, 2013 his viral load had increased more than ten times, to 231 copies/ml suggesting failure of treatment due to missed doses, and possibly the development of resistance to the anti-viral medication. There was also a 15% drop in his T- cells from the March 18, 2013 laboratory studies.

35. Disturbingly, the clinical care accompanying the failure to provide medication was also very deficient. Laboratory studies obtained on March 8, 2013, were not reviewed by a provider until June 6, 2013, and there is no indication that Mr. [redacted] was examined. On June 13, 2013 the laboratory results from June 6, 2013 were reviewed, and the again showed a significant jump in viral load and a decrease in T-cells. Again, Mr. [redacted] was not examined. The physician's assistant, Mr. Ainslie, misinterpreted the June 6, 2013 results as showing "HIV in remission." This false information was communicated to Mr. [redacted].

36. This serious failure to provide timely medications to a patient with HIV

disease resulted in development of significant viral load, which had previously been undetectable, as well as a significant decrease in T-cells. The physician's assistant demonstrated a fundamental failure to understand the significance of the abnormal laboratory tests, and did not undertake any action to address this therapeutic failure.

37. Mr. [redacted]'s case demonstrates failure to provide appropriate management of a serious chronic disease, failure to timely deliver his essential HIV disease medication, failure to maintain adequate medical records, and failure to provide timely access to care.

38. [redacted] (Lewis; [redacted]). Mr. [redacted] has HIV infection, hepatitis C, asthma, and epilepsy. Prior to his admission into the Arizona prison system on January 31, 2013, Mr. [redacted] was receiving antiviral therapy for his HIV disease. However, his HIV medications were not re-ordered until February 7, 2013, one week after his admission to the prison system. Such a delay is symptomatic of a broken health care intake and assessment process. No HIV laboratory studies on Mr. [redacted] were obtained until March 4, 2013. Those studies showed a low T-cell level and a high viral load of 221,310 copies two and a half months after they were ordered. These lab results were not reviewed by a provider until April 26, 2013. Mr. [redacted] did not have his first chronic care appointment until June 3, 2013, more than four months after his incarceration. He was not referred to an HIV specialist until July 2, 2013, five months after his admission.

39. This is another example of the failure to provide minimal chronic care for men with serious medical conditions requiring regular follow-up. Mr. [redacted]'s case demonstrates the consequences of that failure. The laboratory studies obtained on March 4, 2013 suggested that Mr. [redacted]'s HIV disease had become resistant to his medications. Failure to maintain continuity of medication causes resistance. These results also mandated that resistance testing be ordered and that an effective anti-viral therapy be provided. As of my review of Mr. [redacted]'s case four months later, no resistance testing, no modification of anti-viral therapy, and no specialty consultation had taken place.

During this period, Mr. [redacted]'s HIV infection is likely to have deteriorated dramatically.

40. Mr. [redacted]'s case demonstrates failure of access to care, failure of timely delivery of the appropriate medications, gross failure of the appropriate management of a serious chronic disease, failure to review and understand medical records, and failure to provide timely access to a specialist in HIV disease.

41. [redacted] (Eyman; [redacted]). Mr. [redacted] has HIV infection, although this serious chronic medical condition is not on any problem list, nor is he included on the monitored conditions report. On May 10, 2013 he submitted an HNR complaining of a cyst in his armpit. He wrote: "Excruciating" "I can hardly move my arm. I think it has to drain. Emergency. Please see me ASAP. I can pay the $4 for this emergency visit. Thanks and God bless." On May 13, 2013 he was told that he would be scheduled to the nurses' line. He submitted a second HNR on May 19, 2013 stating "Well now it is all infected. I have red streaks running down my arm." ADC 136482. On May 24, 2013, two weeks after he submitted the HNR complaining of severe pain from his abscess, he was seen by A. Dorsica, an RN. RN Dorsica confirmed that he had an abscess, and that although it had burst, it was still firm, suggesting a persistent abscess. Nurse Dorsica cleaned the wound, cultured it, and prescribed an antibiotic, clindamycin 150 mg three times a day and put bacitracin on the wound. The wound tested positive for methicillin resistant staph aureus (MRSA), a serious infection.

42. There were many medical failures with respect to Mr. [redacted]'s care. Medical staff failed to include this man with HIV infection on a chronic medical condition report, and failed to include HIV infection on the problem list. A fourteen day delay for a painful infection in anyone, but particularly a person with HIV infection, is a dangerous lapse that could have fatal consequences. Delayed treatment of MRSA or sepsis, an overwhelming infection of a painful abscess, in an HIV positive person is dangerous given the patient's suppressed immunity. Proper treatment of suspected

MRSA infection should be drainage of any abscess, and antibiotic treatment. The recommended dosage for clindamycin should be 300 to 450 mg q8h or q6h. The dosage chosen by the RN was much too low. Diagnosis and treatment of suspected MRSA requires a physician, physician's assistant, or nurse practitioner. MRSA diagnosis and treatment is a clinical decision not appropriate for RN level staff.

43. Mr. [redacted]'s care demonstrates failure of access to appropriate care, failure to provide the timely delivery of appropriate medications, and failure to appropriately manage a serious infection in a person with a significant chronic disease.

3. Hypertension

44. Hypertension is a common illness. Untreated hypertension is the major cause of stroke, renal failure, a major risk factor for heart attacks, and a major contributor to the development of heart failure. Very mild hypertension can be treated with diet and lifestyle modification, but chronic moderate and severe hypertension require lifelong treatment with medications. Failure to receive these medications regularly can cause spikes in blood pressure which can cause a stroke or heart attack.

45. Patients being treated for hypertension require regular monitoring of their blood pressure, regular chronic care visits, scheduled based upon the severity of the hypertension and its response to therapy. They also need regular laboratory monitoring to prevent the development of medication side effects. They require regular electrocardiograms, and routine evaluation for congestive heart failure, and occasionally cardiology consultation. Most important is regular monitoring of blood pressure, and uninterrupted treatment with appropriate effective medication.

46. Patient with heart disease require chronic care monitoring. Heart disease can result from inadequate blood supply to the heart, from diabetes, from hypertension, from infection, and from mechanical problems such as heart valve disease, heart muscle disease, and irregular rhythms. Treatment can be extremely complicated, and often requires specialized diagnostic testing, specialty consultation, and frequent monitoring.

Inadequately treated heart disease can cause severe pain, great difficulty breathing, swelling of the legs, as well as sudden death.

47. Patients with heart disease generally require multiple daily medications, many of which, such as anti-coagulant medications, require constant monitoring. Systems for monitoring of chronic heart disease require frequent chronic care visits, with intervals determined by the severity of the illness, and the response to therapy. Frequent laboratory testing is required, and results must be reviewed promptly. It is often necessary to carry out a carefully organized sequence of testing in a short period of time. Absent a carefully designed and monitored system of access to specialty consultation, patients with significant heart disease can suffer unnecessary but significant, sometimes fatal, consequences.

48. [redacted] (Lewis, [redacted]). Mr. [redacted] is a 40 year old man who has hypertension, asthma, and epilepsy, and has had a pituitary tumor. His medical record is grossly disorganized, with misfiled records. The last chronic care visit occurred one year ago, on July 24, 2012. Mr. [redacted] placed an HNR on April 20, 2013 stating: "I'm losing my vision, difficulty seeing, experiencing pain and pressure and loss of peripheral vision. In the three months since submitting the HNR, Mr. [redacted] was never seen by an RN or an MD. His chronic medical problems are not being monitored.

49. Mr. [redacted] filed an HNR on May 4, 2013, alerting staff that he had run out of medications. This patient with asthma, epilepsy, and hypertension requires regular chronic care monitoring, including routine blood tests, and physical examination to determine if his blood pressure is controlled, if he having any complication of his epilepsy and blood pressure medications. These are basic components of medical care not being provided to Mr. [redacted]

50. [redacted] (Lewis, [redacted]). Mr. [redacted] has renal failure. When I interviewed him at Lewis, his blood pressure has been uncontrolled for the previous month. He told me that his blood pressure was "through the roof" and that he

only saw a nephrologist every 90 days. A review of the 15 blood pressure measurements taken in June and July confirmed his statement. 40% of his blood pressure readings had a systolic pressure greater than 180.

51. This is extremely dangerous. Management of blood pressure in a patient with chronic renal failure is not simple, but there were no demonstrated medication changes to address this very high blood pressure, which is putting Mr. [redacted] at great risk for a stroke.

52. [redacted] (Eyman; [redacted]). Mr. [redacted] is a 46-year-old man with hypertension, diabetes, hyperlipidemia, and neuropathy. His hypertension has been poorly managed over the last two months. During the period May 14, 2013 through July 9, 2013 his blood pressure was measured on five occasions and never fell below 172/92, a dangerously high level. On July 9, 2013, the week before my visit to Eyman prison, his blood pressure was measured at 184/88. This patient with hypertension, diabetes, and hyperlipidemia has had uncontrolled blood pressure for over two months. He should be referred to a specialist because clinical staff at Eyman are unable to treat him effectively, but no consultation has been sought.

53. Mr. [redacted]'s care demonstrates failure of access to appropriate care, failure to provide access to specialty consultation outside the prison, and failure to appropriately manage a serious chronic disease.

54. [redacted] (Eyman; [redacted]). Mr. [redacted] has hypertension. He was sent to the emergency room in early February 2013 for atrial fibrillation. He was hospitalized on March 5, 2013. The hospital doctor said he required continued hospitalization, but a SOAP note showed that he was returned to the prison that same day. He refused his anticoagulation medicine on May 29, 2013. His previous INR level (a measurement of the amount of anti-coagulation being achieved) from February 28, 2013 was at 10.6, dangerously high, putting him at risk for excessive bleeding, including major hemorrhage. Others of his INR's were all too low: April 3, 2013 - 1.12; April 25, 2013 -

1.07; May 7, 2013 - 1.13; May 14, 2013 - 1.11, putting him at risk for developing dangerous blood clots. Mr. [redacted] also has poorly controlled diabetes mellitus; his A1c level is abnormal but he has not been seen and any recent chronic care clinic. In fact, his last visit to a chronic care clinic was February 27, 2013. He was not given a physical examination at that time.

55. Mr. [redacted]'s case demonstrates a failure of chronic care. He was not seen in a chronic care clinic for five months, although his labs showed INR/anticoagulation problems and diabetes as both uncontrolled. Mr. [redacted]'s case demonstrates failure of access to appropriate care, failure to timely deliver appropriate medications, failure of appropriate management of two chronic diseases, and failure to utilize emergency care at an outside hospital.

56. [redacted] (Eyman, [redacted]). Mr. [redacted] has hypertension, Marfan's syndrome, and a mechanical aortic valve. He has to take warfarin and aspirin to prevent the valve from clotting; any such clotting has potentially fatal consequences. During 2013, he had to file HNRs on February 12, April 3, April 23, and May 2 because the medical service failed to renew his warfarin medication. ADC 136457-459. My review of his medical record also demonstrates that when the laboratory results for INR, the gauge of success of his anti-coagulation medications, were received, there were consistent and dangerous delays of three to six weeks before the labs were reviewed. ADC 136455-456. Mr. [redacted]'s anticoagulation medications were consistently not provided, and his HNR responses were delayed. Critical laboratory values were not reviewed in a timely manner. This is another demonstration of extremely poor care for a patient with complicated multisystem diseases.

57. Mr. [redacted]'s case demonstrates failure of access to care, failure of timely delivery of appropriate medications, and failure to appropriately manage his chronic diseases.

58. [redacted] (Eyman; [redacted]). Mr. [redacted] has diabetes, hypertension,

and epilepsy. Mr. [redacted] also suffered a stroke which has resulted in significant limitation to his ambulation. Problem one: he is dependent on a walker. His anti-seizure medications were only available as directly observed therapy ("watch swallow"), which required him to spend 40 minutes each day using his walker to get to the medical distribution area. Mr. [redacted] reported that he was not going to meals because he couldn't safely use his walker. On June 13, 2013 he collapsed in front of the Meadows Housing Unit. Problem 2: Mr. [redacted] developed blood in his urine on April 11, 2013. He was sent to the hospital and a urinary catheter was placed. A urology consultation was requested from Corizon on April 13, 2013 and approved by Dr. Rumsey on April 15, 2013. The consultation request was re-faxed on April 18, 2013. It was re-faxed and called in on May 13, 2013. A note on June 14, 2013 indicates that the urology consult was still pending. There was no report of a consultation in the medical record. Although Mr. [redacted] was so disabled that it took him 40 minutes to get his medication, he was not evaluated for a wheelchair until he collapsed on the yard. Additionally, despite hospitalization for unexplained blood in his urine, multiple requests for urology consultation were ignored by the Corizon consultation system for more than three months. The care provided to Mr. [redacted] demonstrates failure of access to care, failure to provide access to outside specialty consultations, and failure to provide appropriate management of his chronic diseases.

59. [redacted] (Eyman; [redacted]). Mr. [redacted] has multiple serious medical problems including COPD, hypertension, schizophrenia, and ischemic cardiomyopathy (a condition in which the heart can no longer pump enough blood to the rest of the body because of serious coronary artery disease), and has a defibrillating pacemaker in place. This pacemaker failed on March 19, 2013. The cardiologist requested that the patient be followed up to have his pacemaker checked in two weeks. A consult was directed to Corizon requesting the consultation on March 22, 2013. It was faxed again to Corizon on April 29, 2013. As of July 17, 2013 no consultation had been approved or provided.

(ADC 136528) Mr. [redacted] also has severe mobility issues, has had a hip replacement, and falls frequently. This is of great concern because of his prosthetic hip. On March 18, 2013 Mr. [redacted] requested a shower chair, but the request was denied. He fell on April 29, 2013 because he could not maneuver with the crutches he was given when his wheelchair was taken away. He requested a shower chair again following a fall on May 19, 2013. No wheelchair was provided to him because "there was no consensus between Corizon Health and corrections on medical chairs yet." ADC 136526-527. On June 10, 2013 it was noted in Mr. [redacted]'s medical chart that he had fallen eight times in the preceding six months.

60. Mr. [redacted]'s case illustrates lack of access to necessary specialty consultation, demonstrated by the failure to provide a cardiology consultation after his pacemaker failed. It also demonstrates lack of access to necessary support for severe motor disability: Mr. [redacted] needs both a wheelchair and a shower chair.

4. Cancer

61. Patients with cancer require careful monitoring, in consultation with surgical and medical sub-specialists. Therapies for cancer include surgery, radiation, and medication, and, frequently two or three of these treatment modalities in carefully organized sequence. Frequent diagnostic scans are essential to diagnosis and treatment, and these scans – nuclear medicine, MRI, CT – need to be done expeditiously, prior to initiation of definitive therapy. Because delays in diagnosis can result in metastatic spread of localized cancer, time is of the essence in access to diagnostic and therapeutic resources for patients with cancer. All patients with treatable cancer will require frequent specialty consultation off site, and must be accommodated without delay. Patients with cancer that is no longer amenable to curative treatment will still require complex palliative care which can include surgical, medical, and radiation treatment. Effective referral systems, transportation to multiple off-site visits, and close monitoring by physicians within the prison are essential to basic care of prisoners with cancer.

62. [redacted] (Lewis; [redacted]). I interviewed Mr. [redacted] in his room on L-11, Lewis's medical hub. Mr. [redacted] reported to me that he had complained repeatedly for months about chest pain, but each time was told by LVN's that he had indigestion or acid reflux, and was given Tums. He was seen by a clinician on May 10, 2013, for his chronic care. He has hypertension and elevated cholesterol. Although his blood pressure was 160/90, this was considered "fair" control and no change in his medications was made. An EKG was ordered. On June 1, 2013, he complained of heartburn, headache, and a cough for two days. His blood pressure was extremely high, 185/112. His blood pressure medications were changed, and he was scheduled to be followed up in three days.

63. One week later, on June 9, 2013 he complained of burning chest pain. His blood pressure was still elevated at 160/112. He was sent to the emergency room for treatment of a possible heart attack. On June 19, 2013 he again complained of chest pain, and had nausea and was vomiting for three days, including vomiting blood. He was sent to the ER at West Valley Hospital where, according to Mr. [redacted], he was diagnosed with small cell lung cancer. The hospital recommended two consultations: a PET scan to determine if there was spread of the cancer, and an oncology consultation for treatment. On June 27, 2013 the PET scan and oncology consultation were both ordered ASAP.

64. One month after his diagnosis, when I interviewed Mr. [redacted] and reviewed his medical record, he had not received a PET scan nor had he received an oncology consultation to determine therapeutic options. Small cell lung cancer is generally treated with chemotherapy. The only treatment that Mr. [redacted] had received was pain medication.

65. This is an extraordinary situation, and symptomatic of the many failings of the medical care treatment provided by the Arizona Department of Corrections and its medical care contractors. Mr. [redacted] had a newly diagnosed lung cancer without the benefit of biopsy, a PET scan, or an oncology consultation. Mr. [redacted]'s case

demonstrates failure of access to timely care, failure to diagnose and appropriately manage a serious disease, and failure of access to specialty consultation outside the prison.

66. [redacted] (Eyman [redacted]). Mr. [redacted] developed severe throat pain. He was treated on June 5, 2012 with amoxicillin for his sore throat. Seven weeks later, on July 20, following seven weeks of severe pain, he was treated with clindamycin 500 mg b.i.d., with a referral to an ear nose and throat (ENT) specialist. Four days later he suffered a spontaneous rupture of a peri-tonsillar abscess. A CT scan of his neck, done with contrast on July 24, 2012, showed cervical adenopathy. He was seen two months later, on September 19, 2012 by a Dr. Joel Cohen, an ENT specialist, who recommended surgery. The surgery was performed on November 20, 2012. The biopsy report to the ENT on November 21, 2012, showed "moderate to poorly differentiated squamous cell carcinoma, involving full thickness of tumor, tumor extensive." No follow-up was scheduled for Mr. [redacted]. An ENT follow-up was requested on March 28, 2013 because of adhesions of the left base of Mr. [redacted]'s tongue to his tonsillar fossa. Dr. Cohen, the ENT, saw Mr. [redacted] on May 14, 2013. He ordered a PET scan. Two months later, at the time of my visit, Mr. [redacted] had not received any treatment for the cancer diagnosed in November 2012, nine months earlier.

67. The denial of basic care to Mr. [redacted] is inexcusable. His cancer was left untreated for nine months. Even after his diagnosis was "rediscovered," by Dr. Cohen on May 14, 2013, after the original failure to follow up on the cancer of his tonsil diagnosed back in November 21, 2012, Mr. [redacted] waited two months for the beginning of a plan to treat his cancer. Mr. [redacted]'s lack of treatment for his tonsillar cancer for over eight months demonstrates failure of access to medical care, failure to appropriately manage a serious disease, failure of timely access to specialty consultations, and failure to follow and treat a patient with a life-threatening illness.

68. It is particularly distressing to see the same lackadaisical response to Mr.

[redacted]'s untreated cancer when the medical staff, including Drs. Cohen and Williams, are aware that they injured Mr. [redacted], perhaps irreparably, by failing to follow-up on his diagnosis last November. I would have expected to have his consultations and scans done immediately, and definitive treatment initiated, rather than have to plead with the Regional Medical Director, two months after "rediscovery," to provide Mr. [redacted] the care that he desperately needs.

69. [redacted] (ASPC Winslow, [redacted]). Mr. [redacted] is a forty seven year old man who complained of back pain sometime prior to January 23, 2013. No response to his complaint was provided by the medical staff. On February 21, 2013, he again complained of back pain and right groin pain. He reported on that date that he had been told he had degenerative joint disease of his spine in 2009.

70. Mr. [redacted] was scheduled to be seen by medical staff on January 24, 2013, but he was not seen because, according to the note written by Vickie Anne Johnson on January 23, 2013: "No HCP (Health Care Practitioner) on 1/24/13, R/s (reschedule) to 1/29/13. On January 29, 2013 there is a one line note by Nurse Practitioner Daniel Gallegos, stating; "IM (inmate) complains of LBP (low back pain) secondary (to) degenerative disk disease." There is no record of any examination of the patient, or discussion with the patient by Mr. Gallegos. On February 14, 2013, two weeks later, Nurse Julie Lucek noted Mr. Gallegos entry.

71. On February 20, 2013, Mr. [redacted]'s HNR was scheduled for the Nurses line. He was seen on February 21, 2013 by Michal Boyd, RN. Nurse Boyd listened to Mr. [redacted]'s complaint of severe back pain and referred him to see an HCP. He was examined on February 26, 2013, by Mr. Gallegos. Mr. Gallegos noted that Mr. [redacted] has back pain radiating to his right groin. The pain increased with walking. Mr. Gallegos diagnosed sciatica, back and leg pain secondary to compression of nerves leaving the spinal cord, ordered an x-ray of the lumbo-sacral (lower) spine, and ordered an intramuscular injection of 80 mg of triamcinolone, a steroid medication, to address the

back pain. He also ordered 50 mg amitryptilline, a medication which sometimes relieves pain of nerve origin (neuropathy).

72. A lumbar spine x-ray was obtained on February 26, 2013. The findings were: "Alignment is satisfactory with djd [degenerative disk disease] and slight disc space narrowing evident at L3-4 and L5-S1 suggests djd. Lumbar MRI or CT may be helpful in view of radicular symptoms." Unfortunately the x-ray report was not read by any clinical staff until it was seen, three months later, on May 28, 2013, by Nurse Practitioner Hamilton.

73. On March 12, 2013, Mr. Gallegos saw Mr. [redacted] again, noted that the pain was not resolved, and again ordered an x-ray of his spine. On March 26 he saw Mr. [redacted] and was unable to find any x-ray report. He wrote: "Why has X-ray not been done yet." On April 22, 2013, Dr. Steven Ward, a radiologist at Little Colorado Medical Center, reviewed the x-ray ordered by Mr. Gallegos. Dr. Ward wrote: "Multilobulated lucent lesion involving the right acetabulum (bone which adjoins the hip and the pelvis) raising the suspicion of a cystic or lytic lesion. Further evaluation with CT should be considered." The radiologist recommended the CT scan because this type of lesion strongly suggests metastatic cancer.

74. On May 6, 2013, Mr. [redacted] was seen by an RN. Mr. [redacted] explained that he had been in pain for three months, that his pain was very severe whenever he tried to stand up, that he was using large amounts of ibuprofen, and that he would like to have crutches. He was observed to have an uneven and unsteady gait, was unable to perform a straight leg lift, and had difficulty bending at the waist. Dr. Williams was notified. One week later Mr. [redacted] was given an injection of toradol, a pain medication, was issued crutches, and the x-ray results were faxed to Dr. Williams. Dr. Williams did not see Mr. [redacted] but gave telephone approval for the pain medication, the crutches, and a follow-up appointment. On May 13 Mr. [redacted] was seen by Julie Lucek, an RN. On May 22 Mr. [redacted] was seen by NP Hamilton, who ordered additional pain medication,

meloxicam, and a CT scan was ordered.

75. On May 23, 2013 Nurse Practitioner Hamilton filled out the form requesting Corizon to approve a CT scan of the abdomen and pelvis. NP Hamilton noted the following reasons for justifying the CT scans: Mr. [redacted] was unable to bear weight on his right leg, he had significant decreased strength in his right leg, and the multi-lobulated lucent lesion (cystic/lytic) in the right acetabulum. There was no response by Corizon for the requested CT scan. On June 10, 2013, Dr. Moyse noted that Corizon had denied the request for the CT of the Abdomen and Pelvis. A request for an MRI was made; the request was also denied by Corizon.

76. Mr. [redacted] was not seen again until June 21, 2013, one month later. He stated he was waiting for his MRI, and that the pain medications were not helping him and the pain was now radiating down to his right hip. He stated that he could not put pressure on his right hip to walk. This inability to walk was confirmed by NP Hamilton, who again noted that there was an acetabular lesion. Physical therapy was ordered.

77. He was scheduled for follow up with a health care provider on July 22, 2013, but again, no Health Care Provider was available. A CAT scan of the pelvis was finally obtained on July 23rd, three months after the cystic/lytic multi-lobulated acetabular lesion was identified. As expected, it showed cancer: "Large expansile lytic lesion of R lower ilium involves acetabulum w/ ST mass highly suspicious for metastatic disease such as renal cell CA (cancer), needs f/u & possible biopsy. Increase in size since lumbar spine radiographs of 4/22/13. Also, lytic lesion of L(eft) femoral neck suspicious for met(astasis), concerning for impending pathologic fx (fracture)."

78. This report was seen by NP Hamilton on July 25. A repeat plain film of the right hip obtained on July 24 also showed the lytic lesion of the right hip. The comment about an impending pathologic fracture was made to advise the clinicians responsible for Mr. [redacted]'s care that he was at risk for a hip fracture because he had an undiagnosed cancer which had spread to his right and left hips, and the left hip metastasis

was likely to cause the hip to break. One week later, on August 1, 2013, NP Hamilton reviewed the results of the CT scan with Mr. [redacted] and informed him that he probably had cancer, that he was at high risk for a broken hip because of the spread of the cancer, and that he would be transferred to a "corridor facility" for biopsy and oncology consultation.

79. On August 10, 2013 he was transferred to APCT-Tucson. On August 21 he was finally prescribed morphine for the severe pain of cancer which had metastasized to his bones six months earlier. An oncology consultation was requested on August 12, 2013. As of August 30, 2013, oncology consultation was still pending, and Mr. [redacted] had received no treatment for his spreading cancer.

80. A request to the Board of Executive Clemency for early release due to imminent death was submitted by Dr. David Robertson on September 30, 2013. Dr. Robertson noted that Mr. [redacted]'s right kidney had been removed, and that he would "start chemotherapy in a few weeks."

81. This tragic situation demonstrates a complete breakdown of medical care for a patient with painful metastatic cancer. He waited a month before there was any response to his initial HNR. On several occasions scheduled appointments with health care practitioners were cancelled, because no health care practitioner was available. Serious pain from cancer was treated with ibuprofen. Ordered x-rays with critical findings were not acted on, allowing the cancer to spread. Corizon refused to allow Mr. [redacted] to have an MRI. They denied the initial request for absolutely critical CT scans while they were aware that his plain x-ray showed a likely cancer which absolutely required these studies in order to identify and treat the cancer. After cancer was demonstrated on a CT scan on July 23, two more months passed before surgical removal of the kidney allowed for pathological analysis and formulation of a cancer treatment plan, which as of September 30, 2013, five months after it was presumed that he had cancer, had not begun.

82. The decision by Corizon to deny the CT and MRI requests when they were aware that Mr. [redacted] had bone changes extremely suggestive of metastatic cancer is terrifying to this reviewer, and underscores the grave danger faced by prisoners who are forced to live under Corizon's medical control in Arizona's prisons.

5. Other Access to Care Cases

83. In addition to finding serious problems with treatment for prisoners with chronic health conditions, I also found significant health care delivery problems in the charts of some prisoners with non-chronic medical care conditions.

84. Stephen Swartz, (Lewis,102486). I interviewed Mr. Swartz, a named plaintiff, at the Lewis facility. He reported that because of the shortage of medical staff at Lewis, it takes prisoners an average of three months to see the doctor from the time they file a HNR. He reports that he submitted an HNR on January 13, 2013, requesting evaluation of a pigmented enlarging mass on his waist. He received no response and continued to submit HNR's. He also told me that he had chronic disturbing facial pain and numbness secondary to prior surgery, which had been treated effectively with tramadol, but that medication had since been discontinued.

85. He was finally seen on June 26, 2013, more than five months later. Dr. Merchant recommended an ultrasound of the testicle and a general surgery consultation for the mass on his waist. He also noted that Mr. Swartz had facial numbness secondary to the surgery which required treatment. None of these consultations had occurred as of the time of my review.

86. Joshua Polson (Lewis, 187716). I interviewed named plaintiff Mr. Polson at the Lewis facility. Mr. Polson told me about medication delivery problems. He informed me that he has mania, is supposed to receive lithium, but frequently is not provided with his medication due to staff shortages. In fact, he had not been given his lithium that morning, and he was acting manic during the interview.

87. Mr. Polson reported in his Declaration dated November 1, 2012 that

beginning in 2009 his lithium levels were not regularly checked. My review of his MARs demonstrated that he did not receive eight doses of lithium in April, 2013, and did not receive six doses of this medication in June, 2013. His lithium level was measured on June 13, 2013 and was low, at 0.3 meq/liter. The goal of treatment with lithium is to achieve a serum level of 0.8 to 1.2 meq/liter. No dosage adjustment was made in response to this non-therapeutic serum level. The low level is likely due to the missed doses, as Mr. Polson suggests. In a patient with known mania, on lithium treatment, inadequate dosage of prescribed lithium can precipitate a manic state. At the time I reviewed his file in mid-July, 2013, Mr. Polson has not seen a psychiatrist since December 2012, a delay of more than seven months.

88. Joseph Hefner (Lewis, 203653). Named plaintiff Joseph Hefner at the Lewis-Barchey Unit, reported he has encountered significant delays in care. When I interviewed him, he had recently had surgery on his left eye for glaucoma. However, following the surgery, he had not gotten the medications he needed or had a follow-up with the ophthalmologist, and he described symptoms that I found very troublesome and indicative of a possibly detached retina. He had pain behind the eyes, floaters, blurriness and spots. He had to file numerous HNRs (ADC 122325-28) but didn't see the prison doctor until July 12. According to Hefner, the prison doctor didn't do any sort of exam, not even pulling out the ophthalmoscope, and told Hefner his eye looked fine.

89. According to Mr. Hefner, nurse's line occurs only twice a week on the yard, and it takes eight weeks to be seen at the nurse's line from the time of filing an HNR. He said after nurse's line, it's another 4 to 6 weeks to see the doctor. Other prisoners I spoke to at Lewis reported similar delays.

90. [redacted] (Eyman; [redacted]). Mr. [redacted]'s right leg has been amputated. He suffered a broken prosthesis. He requested, by HNR, repair of his right prosthetic leg on May 1, 2012. On September 4, 2012, five months later, his HNR was reviewed, and an appointment with a physician's assistant was scheduled. ADC 136478.

Mr. [redacted] was not seen by the physician's assistant until April 9, 2013, eleven months after he placed his HNR. Mr. [redacted]'s case demonstrates failure to treat prisoners with disabilities, and provide them with the necessary durable medical equipment. The eleven month failure to respond to his HNR is inexcusable.

91. [redacted] (Lewis, [redacted]). Mr. [redacted] is a 55-year-old man who has had two strokes, and is disabled. He is unable to transfer independently from bed to wheelchair, and from wheelchair to toilet. He had been transferred in and out of L-11, the infirmary where I interviewed him, and other sites at least five times in the two months prior to my visit. Each time he is sent back to L-11 because he requires nursing support for all activities, secondary to his left-sided paralysis. Because of the stroke, and inability to transfer, he is completely dependent on nursing staff. (Nurse practitioner Ende documented on May 17, 2013 that Mr. [redacted] is unable to transfer.) However, other medical staff at L-11 treat him as if he is lying, and can transfer, and do not provide him with the basic toileting services he needs. This results in Mr. [redacted] sitting for prolonged periods in his own urine and feces. Mr. [redacted] states that he has disciplinary write-ups for failure to put on his underpants, something he is physically unable to do because of his strokes. According to Mr. [redacted] his transfers to other units at Lewis, including isolation cells, over the previous six weeks were all related to new prisoners requiring infirmary beds at L- 11.

92. [redacted] (Eyman; [redacted]). Mr. [redacted] has multiple medical problems including hepatitis C, chronic obstructive lung disease, hypertension, neuropathy secondary to vertebral compression fractures, and a dense cataract in his left eye. He was being treated with gabapentin 900 mg three times a day for his documented neuropathy, due to spinal fractures he sustained while a soldier in Vietnam. However, his medication dose was arbitrarily decreased to 800 mg twice a day, a 40% decrease, without explanation and without a physician telling Mr. [redacted] about the reduction. Mr. [redacted] was able to get the proper dose re-established, but he suffered unnecessary but

predictable pain when his medication dose was dramatically decreased.

93. Mr. [redacted] has also been diagnosed with a cataract of his left lens which requires removal and lens replacement. He has been waiting for cataract surgery since September 23, 2012.

94. This arbitrary reduction of Mr. [redacted]'s pain medication for a painful neuropathy from spinal fractures sustained while on military service in Vietnam is incomprehensible. Also, there has been a delay in the scheduled cataract surgery for nine months. Mr. [redacted]'s case demonstrates failure of access to care, failure of timely delivery of the appropriate medications, and denial of access to specialty consults outside the prison.

95. [redacted] (Lewis; [redacted]). Mr. [redacted] has hepatitis C, osteomyelitis (chronic bone infection), and epilepsy. He had his initial intake physical at ASPC-Phoenix. At that time, Mr. [redacted] was noted to be on depakote, clonazepam, and gabapentin for control of his epilepsy. These medications were not prescribed. On May 22, again, the Lewis medical staff failed to continue his anti-seizure medications. Beginning on June 30, 2013 he began to have frequent seizures. At that time, Mr. [redacted] was housed on L-11. Mr. [redacted]'s case demonstrates failure of access to care, failure of timely delivery of appropriate medications, and failure to provide continuity of care. The consequences were sadly predictable. If medical staff are not competent to continue a patient's anti-seizure medications, that patient's condition will deteriorate and frequent seizures will be the result.

96. [redacted] (Eyman; [redacted]) Mr. [redacted] has multiple medical problems including: colon cancer, prostate cancer, and hypertension. My review of his medical record demonstrated that management of his hypertension is inadequate. On October 1, 2012 his blood pressure was measured at 198/120. This is an extremely dangerous level, placing him at great risk for stroke or kidney failure. No treatment was recommended. He was next seen three and a half months later, at a chronic care review. At that time his

blood pressure was 174/110, still extremely high. Despite this out of control reading, follow-up was scheduled to take place six months later, rather than in two weeks, which would have been appropriate. On May 26, 2013 Mr. [redacted] was diagnosed by an RN with MRSA cellulitis, which was treated by a telephone order. Diagnosis and treatment of cellulitis should be performed by a clinician (i.e., a medical doctor, a physician's assistant, or a nurse practitioner).

97. Mr. [redacted]'s case illustrates once again serious problems with the Arizona Department of Corrections chronic care system: serious problems were ignored, there were long delays between appointments, all secondary to there being an insufficient number of doctors during 2012 and 2013 as described repeatedly in the MGAR reports. Once again, as shown in the case of Mr. [redacted], above, MRSA was inappropriately treated by an RN when Mr. [redacted] should have been seen and followed by a clinician. Mr. [redacted]'s case demonstrates failure of access to care, and failure to appropriately manage his chronic disease.

98. [redacted] (Lewis; [redacted]). Mr. [redacted] is being treated for breast cancer. Secondary to his cancer, and its surgical treatment, he has lymphedema, chronic swelling of his left arm. On May 2, 2013 he had increased swelling of his left arm. He was sent to the emergency room and returned with treatment recommendation for MRSA cellulitis. After his return from the hospital, he had no further follow-up to make sure that the treatment was effective.

99. MRSA cellulitis and a patient with lymphedema requires careful follow-up to assure adequate treatment. The lymphedema decreases circulation to the infected area, and oral antibiotics may not reach the infection in adequate dosage to cure the cellulitis, therefore clinical follow-up including physical examination is required to assure that healing of the infection has occurred. Follow-up for treatment of Mr. [redacted]'s cellulitis was mandatory, but was neither scheduled nor provided. Mr. [redacted]'s case demonstrates failure of access to care, failure of timely delivery of the appropriate medications, and

failure to appropriately manage a chronic disease.

100. [redacted] (Lewis; [redacted]). Mr. [redacted] is 55 years old. On March 27, 2013 he experienced severe chest pain. He was seen by an LPN, not an RN or physician. He had to wait 30 minutes for an EKG to be taken because of staff shortages at the Lewis medical hub. He had three EKGs, all of which showed he was having an acute heart attack. He was taken to West Valley Hospital (WVH) and returned on March 30, 2013. At WVH Mr. [redacted] was started on clopridogel (Plavix), metoprolol, aspirin, and lisinopril, all standard treatment for an acute myocardial infarction (MI). The most important elements of this treatment are the clopridogel and aspirin, because they prevent clotting of the coronary artery. Medical staff were aware of the importance of continuing this medication, and Dr. Merchant placed an emergency (STAT) order for clopridogel, metoprolol, lisinopril, and atenolol on March 30, 2013, but the emergency order for clopridogel was crossed out without explanation. Mr. [redacted] did not receive that medication until April 2, 2013, two days later. He also did not receive aspirin, another critical component of management of an acute heart attack. Mr. [redacted]'s medical record was disorganized, recent cardiology consultations were not present in the medical records, and the MARs for May and June, 2013, were not present in his chart. There were no further clinical notes in Mr. [redacted]'s chart since his return from WVH three and a half months earlier.

101. Management of an acute heart attack requires maintenance of anti-platelet therapy. Although medical staff were aware that this was a medical emergency, necessary medications were not obtained for two days. There was no evidence of follow-up cardiology consultations present in the chart, and no further clinical follow-up was provided to this man with an acute heart attack. Furthermore, an LPN should not be the person evaluating and treating an individual with severe chest pain, as this is outside their scope of practice. This lack of care provided to Mr. [redacted] is extremely disturbing, but unfortunately consistent with other failures rooted in the lack of a health-care staff

necessary to provide urgent care, to prescribe and deliver ordered medications in a timely manner, to provide proper care for chronic conditions, and to address the disorganized state of the medical records.

102. [redacted] (Eyman; 165447). Mr. [redacted] is a 75-year-old man with multiple serious medical problems, including incontinence of bowel and bladder, diabetes mellitus, coronary artery disease, hypertension, and ADA/mobility issues. He has received very poor care at Eyman. His medical conditions require a higher level of nursing care than is available at Eyman, but despite pleas from Dr. Rumsey, the medical director, and the nursing staff, he has not been transferred to a facility with appropriate clinical support. Instead, during the period from June 6, 2013 through July 14, 2013 he was hospitalized six times. Each time he was sent to the hospital because his complex medical problems required more intensive nursing care than was available at Eyman/Meadows, and each time the hospital sent him back because he required skilled nursing care, not hospitalization. ADC 136687-696. The last note in the medical record when I reviewed it was dated July 16, 2013: "Security notified staff that I/M [redacted] was on his way back to Meadows unit from Mountain Valley Hospital (MVH). MVH notified that Dr. Rumsey had given a written order the day he was sent out that the inmate was not appropriate to return to this yard due to non-compliance and in need of a higher level of care. Deborah from MVH okayed the inmate to return to the hospital. Security was notified. DON Bito'nn said he is taking care of finding a bed for the inmate. Nursing supervisor Meyers notified of the above. /s Shahi, CRN."

103. Mr. [redacted]'s case demonstrates a lack of adequate skilled nursing home level beds. He was transferred out six times in five weeks and returned each time. There is no coordination between medical and security, and there has historically been a lack of necessary medical infirmary beds in the Arizona system to care for an elderly, ill, disabled, incontinent patient like Mr. [redacted].

104. [redacted] (Lewis; [redacted]). Mr. [redacted] injured his hand on August 13,

2012. He was seen by the medical staff who told him that his hand was not broken. His injury remained extremely painful, and his hand swelled up. An x-ray of the hand was ordered on August 24, 2012. He submitted an HNR on August 25, 2012. The x-ray of his hand was not taken until September 10, 2012. The x-ray showed a boxer's fracture of the hand with distal angulation. On September 11, 2012, Mr. [redacted] submitted another HNR requesting to be advised of the results of his x-ray. The x-ray report was not reviewed by Dr. Merchant until September 21, 2012, ten days later. Dr. Merchant made note of the fracture and scheduled an appointment to see Mr. [redacted] on September 25, 2012. On that same day he requested an orthopedic consultation as soon as possible. Mr. [redacted] was finally seen at an orthopedic consultation on November 14, 2012, three months after the injury. Mr. [redacted] never received surgical treatment. He now has a persistent hand deformity, has decreased grip strength and healed fractures of the 4th and 5th metacarpal bones.

105. This case represents an all too common confluence of the multiple failures of the medical care system in Arizona prisons to provide minimal care for a serious painful condition with potentially serious consequences. There was a delay in follow-up, a delay in ordering x-ray, a delay in noting the results of the x-ray, a delay in requesting the consultation, and a delay in obtaining the consultation. The victim here was Mr. [redacted] who now has a deformed hand with decreased grip strength.

106. [redacted] (Lewis; [redacted]). On April 21, 2013 Mr. [redacted] placed an HNR stating: "Knot on the lower left side of the middle of my throat. It's a little painful and I don't know what it is." On May 9, Mr. [redacted] was seen on the nurses' line, and referred to nurse practitioner Ende, who noted a three inch mass, possible thyroid in origin. Nurse practitioner Ende ordered laboratory studies, an urgent ultrasound of the neck, and a follow-up appointment in four weeks. There is no follow-up note in the chart. Laboratory studies obtained on May 22, 2013 showed an elevated LDH of 421. An ultrasound was obtained on May 21, 2013 but not read until June 13, 2013. It showed a solid cystic

enlarged mass, left side of neck. A CT scan with IV contrast was ordered by Dr. Merchant, approved on June 13, 2013, and performed two weeks later on June 27, 2013. As of July 16, 2013 there was no report of the results of the CT scan or any other follow-up notes in Mr. [redacted]'s chart. There was no diagnosis of the cystic mass, and no follow-up had been scheduled.

107. Mr. [redacted]'s case demonstrates failure to obtain a timely consultation, and failure to follow up with a necessary radiology examination. Almost three months have passed since Mr. [redacted] discovered a possible cancerous lump in his neck. The results of a critical test performed weeks ago have not been obtained.

108. [redacted] (Eyman; [redacted]7). This 80-year-old man was a chronic care patient who had diabetes mellitus, hepatitis C, and hypertension. Mr. [redacted] complained of chest pain and lung pain on May 18, 2013. On May 21, 2013 he complained of itching, which he attributed to his NPH insulin. He was seen in the chronic care clinic on May 28, 2013 and a new insulin formulation, levemir (insulin deternir), was started. On June 4, 2013, he complained of chills and sweats and chest discomfort. A chest x-ray showed bilateral pneumonia with right-sided effusion. He was seen on June 5, 2013 and started on levaquin, 750 mg a day for ten days. His white blood cell count, a measure of the seriousness of his infection, was 16,000 /mcL. On June 7, 2013, his oxygen saturation was low at 94%, his respiratory rate was high at 20/minute. No rash was noted on examination by the nurse practitioner, Janet Houdeshel. Mr. [redacted] was not seen again by the medical staff after June 7, 2013. On June 11, a repeat chest x-ray was requested by Dr. Ramsey. The film was not reviewed by the medical staff until June 13, 2013. On June 13, 2013 Dr. Ramsey told the nursing staff to send Mr. [redacted] to the hospital. There had been no nursing or medical evaluations for the prior six days of this 80-year old man with bilateral pneumonia and diabetes. No follow-up evaluation was scheduled. Mr. [redacted] was sent urgently to Florence Medical Center in Anthem, Arizona, and then transferred to Tempe St. Luke's Hospital. His condition deteriorated, and he died at

Tempe St. Luke's Hospital. The final diagnosis was primary coccidioidomycosis.

109. There was a delay in diagnosis for this man complaining of chest pain and lung pain, who was incarcerated in Arizona, a state with the highest incidence of Valley Fever in the country. Had his significant complaint of chest and lung pain on May 18, 2013 been urgently addressed, with an EKG and chest x-ray as required for an 80 year old man with diabetes, he would likely have been diagnosed, and treatment begun , four weeks earlier. Had his complaint been responded to urgently, as required his chances of recovery would have been dramatically improved.

110. Instead, Mr. [redacted] waited two and a half weeks to be seen for his extremely serious complaints of chest and lung pain. When the chest x-ray showed a pleural effusion, and infiltrates in both lungs, in an 80-year-old man with diabetes mellitus and hypertension, he was clearly much too sick for general population and required immediate hospitalization. Instead, he was placed in general population, and not examined again for six days. Mr. [redacted] received extremely poor care from the Arizona Department of Corrections. The delays in diagnosis and failure to provide emergency care and hospitalization when required contributed to his death. This case demonstrates failure of access to timely care, failure to appropriately diagnose and manage chronic diseases, failure to provide access to specialty consultation outside the prison, and failure to provide timely access to emergency care.

111. [redacted] (Lewis [redacted]). Mr. [redacted] has HIV infection. Unfortunately his infection is not responding to prescribed treatment. Laboratory studies obtained on April 12, 2013 showed a low CD4 count of 230/mm3, and a high viral load of 3264. Importantly, three months before, on January 18, 2013, the viral load was undetectable. Although Dr. Merchant reviewed the laboratory studies on May 11, 2013, Mr. [redacted] has not been informed of the deterioration of his condition and no action has been taken to ameliorate. When a person with HIV infection who treatment with previously undetectable viral loads develops a high viral load, this deterioration must be

investigated promptly. Resistance can develop to treatment, and can result in rapid deterioration of the patient's clinical status. Mr. [redacted] already has a very low CD4 count. Should it drop below 200, as is likely given his trend, he will be at high risk for opportunistic infections. It is extremely disturbing that Mr. [redacted]' deteriorating condition is not being addressed. Additional studies must be urgently obtained to determine if he resistant to his current medications, appropriate treatment should be provided, and if T-cells have fallen further, appropriate medications must be provided to prevent opportunistic infections.

112. [redacted] (Lewis, [redacted]. I interviewed Mr. [redacted] in his room in L-11, the infirmary unit at Lewis. Mr. [redacted] has a painful chronic skin condition called ectodermal dysplasia. Ectodermal dysplasia is a life-threatening condition characterized by a lack of sweat glands. Persons with this genetic disorder are at great risk from overheating and heat intolerance because they cannot sweat and get rid of excess heat. It is an understatement to say Arizona experiences excessive heat. Mr. [redacted] told me he spent one year in lockdown as punishment for seeking medical treatment. Because his body cannot easily get rid of excess heat, it is vital that Mr. [redacted] live in a climate controlled environment, such as L-11, without exposure to high temperatures. It is apparent that Mr. [redacted] is in great distress, and requires additional treatment.

113. Mr. [redacted] was recently transferred out of L-11 to Buckley, and then transferred back. The reason he was transferred out was because there was a patient who was being transferred out of a hospital, and no infirmary level beds were available. This is one of multiple examples I have found of a patient being transferred in and out of L-11 because of the shortage of skilled nursing beds or sheltered housing in the Arizona system. [redacted] (Eyman, [redacted]). Mr. [redacted], a 46 year old man, has Hepatitis C. He told me he sought follow-up for this chronic condition. On December 30, 2012, he placed an HNR in order to see a provider. On January 18, 2013, there was a response sent to Mr. [redacted] – "Appointment set." As of July 16th, when I reviewed his medical

record, six and a half months later, the HNR was unanswered, and there was no documentation he had seen a provider for a chronic care appointment.

Appendix D

Robert L. Cohen, M.D.
Revised List of Testimony in Previous Four Years

1. *Martin Hernandez Banderas v. U.S.*, CV 08-6594, N.D. Cal. (testified at trial)

2. *Baires v. U.S.*, CV-09-5171, C.D. Cal. (testified at deposition)

3. *Lin Li Qu v. Cornell Companies, Inc*, C.A. No. 09-53-S, D.R.I. (testified at deposition)

4. *Jennings v. Hart*, No. 3:08-cv-00028, W.D. Va. (testified at deposition)

5. *Castaneda v. California*, Case No.: VCO50229, Los Angeles County Superior Court (testified at deposition and trial)

SFI-850521v1