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

Parsons, et al. v Ryan, et al.

No. 2:12-cv-00601-NVW

FEBRUARY 24, 2014

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1. I reviewed medical records and, when available, mortality reviews that defendants provide for ADC prisoner patients who died of natural causes between March 4, 2013 and September 27, 2013. According to the defendants, 40 prisoners died during this period. I reviewed the records for the 28 prisoners whose deaths were not classified by ADC as accidental deaths, suicides or homicides.

2. In each of the twenty-eight cases, I was provided with medical records for approximately one year prior to the death, and for 16 cases, I was also provided an ADC Mortality Review. Some records were incomplete, and none included an autopsy report.[1]

3. For my November 2013 report, I reviewed records for deaths in 2012 and found patterns of significant delays, lapses and generally poor medical care. My findings were consistent with my review of care at the prisons I visited in July 2013.

4. The records I reviewed for the 2013 deaths reveal that the legacy of poor care under ADC and Wexford management has continued under Corizon. In at least 13 of the 28 cases, patients received care that was grossly deficient and well below the standard of care.[2] In some of these cases, the poor care clearly caused or hastened their death, while in others this is very likely, but would require an autopsy review to confirm. It is alarming that almost half of the natural deaths occurring during the brief half year

[1] Attached as Appendix A is a list of the documents I reviewed to prepare this report.

[2] In eight of the 28 cases, the medical records I received were so sparse that it was difficult to draw conclusions about the care provided. In two of these files, I also found evidence of access to care problems. See infra at pp 53-56.

period under review would reveal such significant problems with delivery of basic medical services.

5. In most of these 13 cases, patients suffered unnecessary severe pain and treatment complications because care was delayed or denied repeatedly. The serious failures of care described below are not just the results of one doctor's failure, or one health administrators' incompetency. They occurred at different institutions, with different nurses, different providers and different administrators. They have in common ADC's centralized, dysfunctional medical program. These records provide a grim window into a system that is grossly dysfunctional on many levels and poses an unacceptable risk of harm to the patients who must rely on it.

Mortality Reviews

6. In my initial report, I opined that the ADC's death review process failed "to identify even the most obvious deficiencies in care and thus take any action to further review or correct any problem." Cohen Report at 50. I concluded that this failure "is a certain sign of a completely inadequate medical delivery/quality assurance process and creates a substantial risk of harm to prisoner-patients." *Id.*

7. For this supplemental report, I reviewed 30 additional ADC Mortality Reviews. Of those reviews, I focused on the sixteen that reviewed "natural" deaths that occurred between [redacted] and [redacted], and compared them to the medical records I was provided. (I did not have the autopsies for these decedents, and I did not receive a Mortality Review for all of the natural deaths that I reviewed.) Dr. Robertson performed all but one of these reviews, with the last being done by Dr. Rowe. This most recent

review of documents confirms my opinion that the ADC's mortality review process fails to identify obvious deficiencies in care despite a clear need for corrective action, and that this gross failure places prisoner patients at substantial risk of harm.

8. In fourteen of the sixteen reviews that I evaluated in conjunction with the medical records, Dr. Robertson indicated that the care provided met community standards without negative findings. These cases include:

a. [redacted] a case involving shocking delays in care for laryngeal cancer that may have shortened his life. On several occasions in the months before his death, he was denied appropriate pain medication for his metastatic cancer. (See pp. 35-38, infra.)

b. [redacted] a 49 year old woman, had several serious chronic conditions that required careful monitoring. Although she had orders for weekly lab tests, she stopped having those tests months before her death, although there was no "stop" order. The prison never scheduled a necessary specialty consult, and she was unnecessarily prescribed medications that are dangerous when described together. (See pp. 46-48, infra.)

c. [redacted] age 36, died of liver failure. Shortly before his death, he presented to a nurse with symptoms of liver disease, and had highly abnormal labs. At that point, he should have been hospitalized for acute liver injury, or at the very least examined by a physician. He was not. (See pp. 53-55 infra.)

d. [redacted], age 52, had liver and heart disease. In the three weeks before his death, medical staff failed to recognize his need for emergent response when he presented with unstable vital signs and extremely abnormal lab results. (See pp. 50-51, infra.)

e. [redacted] age 54, died of lung cancer that was not detected until days before his death. During the months before his death, he steadily deteriorated, experienced numerous falls, and complained of severe pain, yet was never properly worked up to determine the cause of his alarming symptoms. Instead, he was repeatedly ridiculed by nursing staff for "faking" his symptoms. (See pp. 25-32, infra.)

f. [redacted], age 59, showed clear signs of sepsis in the week before he died, but ADC failed to provide necessary and timely emergency care. (See pp. 41-44, infra.)

9. In each of these cases, the medical records demonstrate serious medical lapses that caused the patients harm, may have hastened their deaths and, in many cases, demonstrate systemic deficiencies. In a functioning health care system, any of these gross deficiencies would have triggered corrective action to protect patients in the future. That Dr. Robertson could conclude that these cases complied with the community standard of care is incomprehensible.

10. In two of these cases, the reviewers correctly concluded that the patients' deaths could have been prevented or delayed by more timely intervention. In both cases,

the reviewers' Corrective Actions are grossly inadequate to address the problems identified.

11. According to Dr. Rowe, the identified lapse in the case of [redacted] was the "failure to follow-up tests results," *i.e.,* provide an HIV test despite two requests. ADC211618. (See p. 51 infra.) The patient died from preventable AIDS-related pneumonia [redacted]. The Corrective Action Dr. Rowe proposed was "It is anticipated that the EHR implementation will address transfer issues as it relates to continuity of care in order to minimize misplaced or lost information during transfer." As ADC still lacks an electronic health record, this "Corrective Action" is no action at all.

12. In the case of [redacted] a 38 year-old patient who unnecessarily died of a highly treatable form of cancer, Dr. Robertson identified more than a half dozen failures, including delay in access to care, failure to follow clinical guidelines, and failure to follow up on test results. Dr. Robertson made recommendations to "develop a tracking system for more important/urgent cases; have more providers available to review the reports that come in; develop a system where nursing may screen lab reports … and call provider when necessary." ADC211652. For a Corrective Action plan, he simply refers to these brief recommendations. The failure to develop a comprehensive plan to address the myriad lapses evident in this clearly avoidable death is simply inexcusable and is symptomatic of a system that is incapable of assessing and correcting its gross deficiencies.

Inadequate Care In Prisoner Deaths

13. Several of the cases demonstrate shockingly poor care for patients suffering from various forms of cancer. The medical record of [redacted] vividly illustrates the ongoing pattern of delayed and inadequate care. [redacted] died of metastatic liver cancer on [redacted]. A mass in his liver which was suspicious for liver carcinoma had been identified in December 2011. Had he received appropriate treatment when it was first identified, his cancer most likely would have not metastasized and might have even been curable. The level of care provided, however, under the ADC, Wexford and Corizon delayed his access to diagnosis, denied him treatment for his cancer, and ignored his complaints for relief of the severe pain of his metastatic disease.

14. [redacted] had cirrhosis and Hepatitis C, which placed him at significantly increased risk for development of hepatocellular carcinoma. Abnormal abdominal CT scans were obtained in December 2011, January 11, 2012, and February 1, 2012. They all showed a liver mass suggestive of liver cancer. These scans required definitive evaluation for possible hepatic carcinoma, a disease which is treatable if found early. Diagnosis was delayed, no treatment was offered, and [redacted] suffered great pain and a possibly preventable death.

15. The earliest records I received for [redacted] show a CT scan that was done of the chest, abdomen and pelvis at an outside hospital on 12/05/11. The CT scan showed a 2.8 cm liver mass that was worrisome for hepatocellular carcinoma. The radiologist recommended a triple phase MRI. ADC214629. On 2/1/12, [redacted] had another CT scan done of his liver which showed that he still had a 2.8 cm mass in his

liver. The radiologist opined that the persistent lesion was not consistent with hepatocellular carcinoma, but still recommended that a liver biopsy be performed because there was clear evidence of advanced liver disease. ADC214615.

16. He was also noted to have an enlarged lymph node around the splenic artery and a stable pulmonary nodule which was biopsied on 1/11/12 and 2/1/12. ADC214629. Both of these biopsies were negative for malignancy. These are essentially the only records I was provided for the pre-June 2012 period.

17. It is unclear who ordered the two follow-up CT scans and the two lung nodule biopsies as I received no records from the ADC that indicate these procedures were ordered, performed, or that the abnormal results acknowledged. It appears that no action was taken following the February 1, 2012 CT scan, which recommended liver biopsy. ADC214615.

18. This CT scan finding in a patient with known cirrhosis is highly suggestive for liver cancer and merited expedited workup and treatment (with an MRI as recommended and referral to an oncologist or hepatologist for treatment of the likely cancer). In addition, given that he was noted to have cirrhosis with esophageal varices, [redacted] should have been put on propranolol prophylaxis to prevent esophageal variceal bleeding. (Varices are enlarged veins around the esophagus, commonly seen in persons with cirrhosis of the liver. They are fragile, and are easily torn causing life threatening bleeding. Preventive treatment with propranolol, or other beta blocker medication, is indicated. See November 2013 Cohen Report at 52.) There is no record that this occurred. In addition, all patients with cirrhosis due to hepatitis C should

receive a right upper quadrant (RUQ) ultrasound every 6 months to screen for liver cancer, and possibly an alpha-fetoprotein (AFP) blood test. Since no records are available prior to 2012, it is unclear if [redacted] received any of this chronic care for his cirrhosis. If an AFP blood test had been ordered and the results reviewed in January 2012, it is possible that his liver cancer would have been identified at an early stage, prior to its metastasis.

19. On 6/6/12, [redacted] was seen for a chronic care visit by a nurse practitioner who documented that he "claims he was diagnosed with liver cancer metastatic to the lung." Dr. Catsaros reviewed this note and ordered a chest x-ray. ADC214696. The x-ray was negative. Again, most physicians would be highly concerned about this history and obtain all of [redacted] records and refer him for immediate workup and treatment. There is no record that this happened.

20. [redacted] filed a Health Needs Request (HNR) on 6/8/12 stating that he was still in a lot of pain from his liver cancer. He was put on naprosyn and placed on nurse's line for 6/9/12. ADC214646. Again, no action was taken re: his liver cancer, and per the notes, it appears that perhaps providers did not believe his reported history.

21. [redacted] was not seen until 6/21/12, at which time he was referred to the provider for pain management and his history of liver cancer. ADC214696.

22. On 6/27/12, [redacted] submitted an HNR stating that "When I used the bathroom on 6/26/12, there was a lot of blood, most of it was dark in my stool. There is pain from my liver due to the cancer all the time. Some days better than others. There was no pain from my bowels at that time. I will let you know if it happens again."

ADC214645. It appears that this HNR was not reviewed until 7/3/12 at which time he was seen by nurse Brian Staples (ADC214696), who documented that the patient complained of blood in his stool and liver pain. The nurse documented normal vital signs, a soft stomach and RUQ pain and gave [redacted] supplies to do 3 fecal occult blood tests (which came back negative later that day—this is not helpful though, given that the patient reported frank blood earlier) and again, referred him to the provider (second request since 6/21/12; he was scheduled for 7/16/12). ADC214695. This is completely inappropriate. Melena (dark blood in the stool) is usually a sign of upper gastrointestinal bleeding and should always be evaluated emergently. In patients with known cirrhosis, the most likely cause is from esophageal variceal bleeding. [redacted] was known to have esophageal varices from his December 2011 CT scan. Even if this was not known, most providers would have referred him to the emergency room because even though his vital signs were stable at the time of evaluation, patients with esophageal variceal bleeding are at high risk for acute decompensation and death. At minimum, the nurse should have called a physician on call to describe the situation, and determine if further referral was necessary. In addition, he definitely should have been started on propranolol for bleeding prophylaxis if his vital signs were stable. It is fortunate that [redacted] did not have further bleeding at that time, which could have caused death.

23. On 7/16/12, [redacted] was finally seen by a physician, Dr. Catsaros. ADC214692. Dr. Catsaros documented stable vital signs and appropriately referred him for a liver biopsy of the mass (urgent referral: ADC214809) and gave him Tylenol #3 for

pain. While this is appropriate, he should also have ordered basic labs, an AFP to help with his cancer workup, and propranolol prophylaxis for his esophageal varices. He should have determined his hepatitis A and B status and provided hepatitis immunization if needed. None of this appears to have been addressed.

24. On 7/31/12, [redacted] filed another HNR complaining of pain. ADC214641. He was seen by a nurse on 8/6/12 (ADC214689) who noted that the Tylenol #3 ordered by Dr. Catsaros was not on formulary and the prescription had been returned on 7/25/12 with a non-formulary drug request form which had been filled out. No one had filled this out, so since 7/16/12, [redacted] had continued to suffer in pain. He was appropriately given vicodin for 7 days.

25. On 8/6/12, [redacted] was seen again by Dr. Catsaros for chronic care for Hepatitis C and liver cancer. ADC214697. He added lisinopril for [redacted] elevated blood pressure, but again, did not start propranolol or obtain any labs.

26. A liver biopsy performed on 8/8/12 revealed a poorly differentiated adenocarcinoma. ADC214811. [redacted] was seen by Dr. Catsaros on 8/27/12 (ADC214688) and appropriately referred to an oncologist for consultation and treatment. ADC214804. This urgent referral was ignored.

27. He was seen again by Dr. Catsaros on 9/6/12 for a chronic care visit where again, none of the cirrhosis chronic care measures described previously were done, and the plan was "refer to oncology." ADC214687. Dr. Catsaros wrote a progress note on 9/6/12 stating "We have not heard yet from oncology." ADC214686. At this point, [redacted] has had untreated known liver cancer since at least December 2011. Most

physicians would have followed up with the referral coordinator to obtain an urgent oncology consult. This was not done.

28. On 10/17/12, [redacted] filed another HNR stating, "I need to see an oncologist for cancer of the liver. I need my liver cancer taken care of. It has been too long!!" ADC214958.

29. Three and a half weeks passed before [redacted] was seen, not in response to the HNR, but for a new complaint. On 11/10/12, [redacted] was seen by an RN, complaining of lightheadedness and dizziness since the previous day. ADC214683. The nurse documented mild orthostasis (i.e., decline of blood of blood pressure when standing up), noting that [redacted] "loses balance upon standing". He was simply counseled to not change positions too frequently and scheduled for the provider line on 11/15/12. This is completely inappropriate. First, the nurse did not address any of [redacted] HNR request—there is no mention of why he still had not seen oncology, despite an urgent referral that was submitted on 8/27/12, more than two months earlier. Secondly, dizziness and lightheadedness in a patient with known cirrhosis and liver cancer could be a sign of internal bleeding and severe anemia. [redacted] should have been seen immediately by a physician, assessed for the need for IV fluids, had a blood count checked, and possibly even have been referred to the emergency room. None of this was done, again, reflecting very poor medical knowledge and triaging systems amongst the nursing staff.

30. On 11/12/12, Dr. DeGuzman wrote a second referral to oncology for evaluation and treatment of [redacted] hepatic adenocarcinoma. ADC214786. This referral was also ignored.

31. On 11/27/12, [redacted] was seen by Dr. DeGuzman (his first visit with a physician since 9/6/12, which is highly inappropriate given his untreated liver cancer). Dr. DeGuzman wrote a third oncology consult, marked urgent, and ordered basic laboratory tests and 60-day follow-up. He did not start [redacted] on propranolol or obtain an AFP as described above. ADC214684.

32. On 12/5/12, [redacted] filed another HNR requesting "I would like to see the doc about my liver cancer and the lack of doing something about it. It has been almost a year and nothing has been done! You guys have not been able to keep my pain meds together once I got them ordered and that took 7 months." ADC214957. The response by the nurse to this HNR was 'see medical provider 12/10/12', however, there is no indication that [redacted] was actually seen by the physician on this date—only that his chart was reviewed. This again points to poor systems of follow-up care, especially for urgent cases.

33. On 12/10/12, Dr. Catsaros reviewed the record and noted that [redacted] had still not seen an oncologist (despite referrals submitted on 8/27/12 and 11/12/12). ADC214681. He appropriately submitted another urgent oncology referral noting that this was the third referral (it was actually the fourth). ADC214699. However, no other attempts were made to expedite the oncology appointment. Clearly, the mechanisms for outside referrals and follow-up are severely broken in this system.

34. Given that the three previous referrals (made almost 4 months previously) were completely ignored, in a patient with documented cancer, most physicians would not have simply written another referral. They would have contacted the referral coordinator or even considered sending the patient to the hospital to be admitted for treatment if there were no other options. None of this was done.

35. On 12/20/12, [redacted] had lab tests done, which, not surprisingly revealed abnormal liver function tests. Again, no AFP was ordered. ADC214819. A nurse practitioner was contacted on 12/26/12 regarding these lab results, and [redacted] was seen by a nurse. ADC214679. He reported pain and fatigue. There is no mention at all of his oncology follow-up or cancer.

36. On 12/31/12, [redacted] was seen by Dr. Moyse who documented continued pain, renewed his vicodin and simply wrote "follow-up with oncology consult." ADC214677. Given [redacted] cancer, which was detected ONE YEAR earlier on CT scan, it is horrifying that he has still not seen an oncologist despite numerous requests by the treating doctor. Most physicians would have taken further action as described previously. In addition, his pain is clearly inadequately controlled on vicodin, and it is extremely likely that his cancer has progressed since his last imaging—most physicians would have started him on a stronger pain medication and obtained repeat imaging.

37. On 1/28/13, an emergency was called by prison guards for severe abdominal pain. ADC214674. [redacted] was found to have guarding of his right upper quadrant, although normal vital signs. He was evaluated by Dr. Moyse and the plan

was simply to give him intramuscular pain medications until his scheduled visit with the oncologist later that week. Again, this is inappropriate. Although [redacted] had stable vital signs, as noted above, acute abdominal pain in a patient with liver cancer raises concerns of possible hemorrhage or other complications. At minimum, he should have had an urgent RUQ ultrasound and laboratory tests, or been referred to the ER. After this episode of worsened pain, [redacted] was finally switched from vicodin to morphine 15mg twice daily. ADC214672.

38. On 1/31/13, more than one year after his initial CT scan showing liver cancer and more than 5 months after his oncology referral, [redacted] was finally seen by Dr. Gopal at 21st Century Oncology. The oncologist reviewed the CT scan from February 2012 and the biopsy results and noted that the pathology from the liver biopsy showed poorly differentiated adenocarcinoma. The oncologist recommended getting a repeat CT scan of the chest/abdomen/pelvis and tumor markers to determine if this truly was liver cancer versus metastatic cancer from some other source. ADC214748, ADC218784.

39. On 2/1/13 (and again 2/14/13), Dr. Moyse noted the recommendations described above from 21st Century Oncology. ADC214784. Follow-up was initially scheduled for 2/7/14, and then 2/21/14, but each of these dates was crossed out for unclear reasons. See ADC214784.

40. On 2/17/13, [redacted] submitted an HNR complaining that his pain medications were not working. ADC214952.

41. On 2/19/13, Dr. Moyse ordered the requested lab tests again. On 2/20/13, [redacted] finally had his labs done which revealed a markedly elevated AFP of 5248, confirming a diagnosis of hepatocellular carcinoma. ADC214818.

42. On 2/25/13, Dr. Moyse reviewed [redacted] chart and documented that [redacted] still needed the CT scan of his neck/chest/abdomen/pelvis for staging and to rule out metastases (ADC214673) and filed a referral. ADC214785. This was an additional three week delay after the oncologists' recommendation from 2/1/13.

43. On 2/28/13, a nurse finally responded to [redacted] 2/17/13 HNR for additional pain medications, noting that he had also lost 9 lbs in 2 months and had constant pain due to cancer. He was appropriately referred to the provider for an increase in pain medications, but there are no records to indicate he was seen in response. ADC214673

44. On 3/4/13, [redacted] finally had his CT scans done (more than 1 month after oncology recommended them) which unfortunately showed a 2x2x2.1cm necrotic mass in his L neck consistent with metastatic liver cancer as well as numerous lung masses and lymph nodes, and multiple liver masses with portal venous thrombosis. ADC214790, ADC214799. In short, his malignancy was widely metastatic, beyond cure, as a direct result of the numerous delays he faced in workup and oncology referral. Surgical resection of isolated hepatocellular cancer lesions in the liver can be curative. Had he been offered treatment when his mass was first identified (2.8cm in December 2011), he might have been cured of his cancer.

45. On March 4, 2013, Corizon assumed responsibility for [redacted] care.

46. On 3/5/13, Dr. Moyse reviewed the chart and requested urgent oncology follow-up. ADC214673, ADC214803. Unfortunately, similar to previous episodes, it does not appear that oncology follow-up was ever scheduled or that [redacted] ever saw 21st Century Oncology again. It also appears that no one gave [redacted] the results of his CT scan until one month later, which is unethical.

47. On 3/7/13, [redacted] filed another HNR requesting follow-up on his request to increase pain medications to which he received a response over 10 days later (on 3/18/13) that simply said "no increase at this time per MD." ADC214950. Given [redacted] CT scan findings of widely metastatic cancer, it is shocking that any physician would deny such a patient increased pain medications, prolonging their suffering. On 3/15/13, [redacted] filed an HNR requesting an increase in pain medication from morphine 15mg twice daily to morphine 30mg twice daily. ADC214949.

48. On 3/25/13, [redacted] morphine was increased to 30mg twice daily. ADC214670.

49. Also on 3/25/13, Director Charles Ryan denied [redacted] Grievance Appeal seeking adequate pain management and timely treatment of his disease. In the denial, Mr. Ryan recounted part of [redacted] treatment history, including that he had returned to ADC custody on 2/7/12, and was referred for a liver biopsy five months later. The denial further stated that [redacted] was referred to an oncologist in August 2012, and was not seen until 1/31/13. Mr. Ryan advised [redacted] to continue to follow the recommendations of ADC medical staff and to advise them immediately regarding pain

issues, and to submit an HNR regarding "additional medical concerns or needs." PLTF-PARSONS-032037.

50. Two days later, on 3/27/13, [redacted] filed another HNR requesting to be seen by a doctor as soon as possible. ADC214946. He was placed on the nurse's line, but never seen.

51. On 4/7/13, [redacted] filed another HNR stating, "I Just got my answer back from Mr. C. Ryan that my cancer has metastasized that was an answer from 1.5 years ago! To what extend have the cells divided? How much time do I have left?" ADC214945.

52. On 4/8/13, he was finally seen by a physician who noted that [redacted] now had swelling of his abdomen (ascites) and swelling (edema) of his lower extremities. ADC214667. There is no mention of his oncology follow up appointment, prognosis or advance directive, which should have been addressed.

53. On 5/2/13, [redacted] was seen by a nurse and noted to be was retaining large amounts of fluid. ADC214665. He was appropriately sent to the University Physicians Hospital Emergency Department, where he was hospitalized from 5/3-5/6/13. The hospital summary clearly documents that [redacted] has metastatic liver cancer and had received no treatment for the past 1.5 years. ADC214751. The note also documents that they discussed his cancer with him and that he "wants to go back to his unit, not hospice." ADC214758.

54. [redacted] returned to the ADC and was scheduled for the provider line on 5/7/13 to review his medications—but was apparently not actually seen on that day.

There are no further provider notes until [redacted] repeat hospitalization at UPH from 5/25/13-5/28/13. It is unclear who referred him to UPH on 5/25/13, if anyone evaluated him in between these visits to determine a plan of care, or to follow-up with oncology.

55. During this hospitalization (ADC214702), [redacted] was found to have altered mental status and interview of the guards who accompanied him revealed that "he has been altered for the past few days." ADC214727. He was treated for elevated calcium. The hospital staff recommended palliative care with hospice.

56. On 5/29/13, [redacted] was evaluated by a nurse upon his return to prison and sent to the acute medical unit because he was too weak to be on the yard. ADC214664.

57. On 5/30/13, Dr. Moyse saw him and determined that he was 'clinically dying' and didn't seem to understand what was going on. ADC214663. He was continued on pain management, with palliative intent. On 5/31/13, he was sent to the University Medical Center South Emergency Department when he was found by nursing staff to be unresponsive. ADC214659. No further records are available, but this is where he presumably passed away on [redacted].

58. [redacted] cause of death was hepatocellular carcinoma that was left untreated for over 1.5 years and was certainly treatable, and possibly curable, if he had received treatment at diagnosis. His care was continuously abysmal. He was denied basic diagnostic testing. He submitted repeated requests for treatment and was ignored. Indeed, he was never provided with any treatment for a treatable disease. Instead, his

cancer was allowed to metastasize. On frequent occasions, including the three months prior to his death, from [redacted] after the extent of his metastatic cancer was well known, his requests for pain relief were ignored, and he was allowed to remain in severe pain, without benefit of medical examination or treatment. No diagnosis, no treatment, preventable deterioration, preventable death, and failure to treat severe cancer pain comprised [redacted] appalling experience with ADC health care. The neglec [redacted] endured during the last 18 months of his life amply illustrates the overwhelming dysfunction in the ADC's sick call, diagnostic testing, specialty referral and poor training/supervision of clinicians.

59. The case of [redacted] is likewise shocking. [redacted] died of untreated Hodgkin's lymphoma on [redacted], about a month after the Corizon takeover, at age 38. This is a shocking death because, as the ADC's mortality review acknowledges, this young man's death was entirely avoidable.

60. His mortality review correctly identifies a 3+ month delay between [redacted] lymph node biopsy results which showed Hodgkin's lymphoma and the time that ADC providers reviewed these results and referred him for treatment. ADC211650-652. However, the review fails to identify any of the delays that occurred after [redacted] was referred for oncology treatment in February 2013, including failure to obtain appropriate diagnostic tests as recommended by oncology, and failure to have port placed for administration of chemotherapy immediately as ordered. Because no port was placed, [redacted] died without ever having received a single dose of chemotherapy. Given that

cure rates for Hodgkin's lymphoma can be as high as 84%, the fact that [redacted] died at age 38 without even being given treatment for his (likely curable) cancer is a tragedy.

61. [redacted] was a previously healthy male with no chronic conditions who first filed an HNR on 10/27/12 complaining of painful lumps on his neck. ADC214094. Dr. Joseph Moyse saw him two days later, noted a rapidly enlarging neck mass in his L-sided lymphatic chain, concluded that he needed to be assessed for Hodgkin's lymphoma and referred him for a CT of the neck. ADC214017, ADC214037. Utilization review, however, denied this request and recommended a biopsy instead. ADC214036. On 10/29/12, [redacted] was evaluated by Dr. DeGuzman who agreed that the mass was suspicious for Hodgkin's lymphoma and recommended a biopsy and CT scan, chest x-ray and a complete blood count for work-up. ADC214016. The biopsy was performed on 10/31/12. ADC 214015.

62. [redacted] 11/1/12 lab tests showed a markedly lower hemoglobin compared to his 2010 baseline (ADC214050 and ADC214053), which is suggestive of severe underlying disease. Both of these results were noted by Dr. Moyse on 11/19/12. His chest x-ray done on 11/6/12 showed no masses, but a CT chest scan was recommended by radiology. ADC214048. I found no CT results in his record.

63. The 10/31/12 biopsy reports should have been reviewed expeditiously, so that treatment could be provided. Instead, they were not obtained and reviewed until 2/8/13, over three months later.

64. On 11/14/12, Dr. Moyse reviewed an 11/3/12 report from LabCorp, stating that the pathology from the lymph node biopsy was forwarded to UCLA for further

review. ADC214049, ADC214015. Dr. Moyse reviewed [redacted] medical record on 11/19/12, noting the negative chest x-ray and that they were waiting for biopsy results from UCLA before proceeding with the CT of the neck. ADC214014. He wrote a similar note in the chart on 11/26/12, "Still waiting for result of biopsy from UCLA." ADC214014. After this, there are no follow-up notes until February, 2013. The failure of [redacted] physicians to follow up on the missing report for over two months, despite signs that he suffered from Hodgkin's lymphoma suggests a critical lack of tracking systems, and a failure to recognize a patient requiring time sensitive therapy for a life-threatening illness. Had ADC obtained these results, [redacted] care would have been drastically altered, and he would likely be alive today.

65. When Dr. Kevin Lewis finally reviewed the pathology report on 2/8/13 (ADC214013), he noted the diagnosis of Hodgkin's lymphoma and submitted an urgent consult for oncology (ADC214034), a CT of the chest/abdomen/pelvis for staging and basic laboratory tests, and e-mailed the clinical coordinator for urgent approval and scheduling of both consults. ADC214013. He also ordered the patient to be seen on the provider line in 2 weeks for a status update. *Id.* I found no records documenting this follow-up visit, again demonstrating failed tracking systems and a disturbingly casual response to a a life or death situation.

66. [redacted] laboratory tests done on 2/14/13 revealed a low albumin of 2.7, an elevated alkaline phosphatase of 273 (both abnormal liver function tests) and a hemoglobin of 9.3 (low red blood cells, consistent with significant anemia) (ADC214044-ADC214045)—markedly worsened compared to his previous labs done in

November 2012 and reflecting a worse stage of Hodgkin's lymphoma than what he likely had at the time of the biopsy. Dr. Moyse reviewed these labs and scheduled provider line follow-up 1 month after his oncology appointment. ADC214012

67. The CT of the chest, abdomen and pelvis was done on 2/21/13, two weeks after the original request, however I was unable to find results in the chart. There are also numerous medical records that are missing from [redacted] oncology provider, 21st Century Oncology.

68. On 2/27/13, three weeks after the referral, [redacted] was seen by the oncologist (ADC214012), however the evaluation note is missing from the medical record. The physician order sheet from the oncology group recommended port placement ASAP for chemotherapy, an echocardiogram to determine ejection fraction (which would affect the choice of chemotherapy agents), and scheduled the patient for a bone marrow biopsy on March 5th. ADC214031. The oncologist also ordered a follow-up clinic visit on March 21st. *Id.* These orders were all noted by Dr. Moyse who submitted consults for the port placement and echocardiogram. ADC214012, ADC214032 and ADC214033.

69. [redacted] appears to have been seen by 21st Century Oncology on 2/28/13, however, again, no note is available. The recommendations from that visit are to obtain pulmonary function tests (PFT's) as soon as possible and then every two months while the patient is on chemotherapy. . ADC214028. Again, it is unclear what was actually done at this visit since there are no notes—but there is no evidence that [redacted] ever had the intravenous port for chemotherapy placed, received chemotherapy,

nor had the bone marrow biopsy. It does not appear that anyone at the ADC actually reviewed these notes, or that PFTs were ordered, again pointing to poor systems of follow-up.

70. On March 4, 2013, Corizon assumed responsibility for [redacted] medical care.

71. On 3/4/13 [redacted] again had a visit at 21st Century Oncologists, for which, again, no notes are available. The order sheet only documents that the consultant wanted weekly labs and that chemotherapy would be delivered bi-weekly on March 7th, 21st, April 4th and April 18th. ADC214027. According to this note, [redacted] should have already had his port placement done as previously ordered on 2/27/13 and also have received 4 rounds of chemotherapy by April 18th. Had these orders actually been carried out, it is very likely that [redacted] would not have died on [redacted] None of these orders appear to have been noted or carried out by ADC providers—again, pointing to a highly disorganized system of carrying out consultant orders and providing follow-up care which is particularly disastrous in cases such as this which require great urgency.

72. There is no evidence available in the medical record that [redacted] went to his appointment on March 5th at 11am for a bone marrow biopsy as scheduled by 21st Century Oncology, nor is there any indication why this appointment was not kept.

73. On 3/22/13, [redacted] filed an HNR that read, "I was informed that I have Cancer and would be receiving chemotherapy, it's been months yet they have not started my treatments. Prior to that I went for test, all this has been going on for over 6 months." "I need medical attention, time is of [the] essence." ADC214008. The HNR clearly

outlines the chemotherapy regimen, port placement and diagnostic testing he was supposed to receive (but had not), suggesting that none of the 21st Century Oncology orders were carried out. He still had not received port placement, which was ordered "ASAP" almost a month earlier on 2/27/13. Of note, this HNR was written on an inmate grievance (letter) form, because no HNR forms were available to [redacted] *Id.*

74. Perhaps in response to this HNR, a nurse on 3/24/13 documented that she or he had placed a call on the status of the chemotherapy. ADC214012. There was no documented response. [redacted] 3/22/13 HNR should have generated an immediate and aggressive response by Corizon utilization/referral management staff to arrange for immediate placement of his port and whatever testing was required prior to initiation of chemotherapy. Instead, they apparently did nothing.

75. Instead, [redacted] was scheduled for insertion of a peripheral access port(for administration of cancer chemotherapy) on [redacted] by which date, according to 21st Century Oncology's orders, he should have already received 4 chemotherapy treatments. He had received none. [redacted] initially refused his appointment stating he was "tired" and was noted by nursing staff to look very different compared to his baseline – he had lost a lot of weight. He didn't appear well, and when the nurse measured his oxygen saturation it was low, at 92% (normal oxygen saturation is greater than 95%). Instead of referring him for clinical evaluation by a physician , she referred him to mental health. ADC214012.

76. At this point, in light of his significant hypoxia, anemia severe fatigue, untreated cancer, [redacted] physician should have considered a referral to an emergency room or direct admission to the hospital. This did not happen.

77. Instead he was returned to his cell where he died later that afternoon.

78. [redacted] died due to untreated Hodgkin's lymphoma. His death was preventable. He died of neglect. He found his own cancer and requested diagnosis and treatment on October 22, 2012. Hodgkin's disease is a cancer which usually responds to therapy and is usually curable. The clinical failures that led to [redacted] death were not isolated unusual errors. They were systematic. Medical care for prisoners require a system in which access to specialty consultation, diagnostic and therapeutic procedures occurs in a timely manner. Each of these systems failed. Six months later, [redacted] died, without ever having received treatment. He was 38 years old.

79. [redacted], died in hospital at age 54 of previously undiscovered adenocarcinoma of the lung. ADC211705. He was housed in an infirmary unit at ASPC-Florence until shortly before his death.

80. [redacted] suffered from multiple serious chronic illnesses, including diabetes, hypertension, chronic obstructive pulmonary disease, coronary disease, hypothyroidism, and schizophrenia. ADC219546. [redacted] had received seven cardiac stents, sustained three heart attacks, and experienced reversible ischemic events affecting his brain. He was not a well man. ADC219372 In late 2012, his condition deteriorated dramatically when he was hospitalized with chest pain, for which he apparently underwent a cardiac catheterization. ADC219945, ADC219948.

81. During the succeeding six weeks, [redacted] had multiple hospital visits and admissions. ADC219908 (12/25/12 – abdominal pain); ADC219836 (1/5/13 – hematuria); ADC219866 (1/13/13 – chest pain); ADC219765 (1/19/13 –blood in his urine); ADC219781 (1/23/13 – chest pain); ADC219793 (1/24/13 – chest pain);ADC219938 (1/28/13 - slurred speech and possible stroke).

82. In February, [redacted] health further deteriorated and he fell on several occasions: ADC219544 (2/8/13 – fell out of bed); ADC219543 (2/27/13 – fell in shower).

83. On 2/19/13, he reported chest pains to a nurse and stated that he had not received all of his medications. ADC219544. The nurse obtained vital signs, but did not refer him for a physician appointment. He did have an EKG, which was normal.

84. On 3/26/13, [redacted] reported that he was unable to move. ADC219539. It appears he may have been seen by a provider, who wrote "neuro reflex excellent." There is no documentation of what type of exam was performed. *Id.*

85. On 4/11/13, he was returned to the hospital with chest pains and high blood pressure (180/88). ADC219424.

86. On 4/24/13, he again reported chest pains in the evening. ADC219425. The nurse consulted the on-call physician, who prescribed a narcotic pain reliever. *Id.* He was returned to his infirmary bed around midnight the same night. There is no indication that [redacted] was seen by a physician to follow up on this episode.

87. On 4/28/13, he fell out of his bed and complained of chest pain. ADC219423. There is no indication that a physician saw him after this episode.

88. On 5/2/13 he was found unresponsive on the floor of his room. On 5/3/13 he was sent to Florence Hospital and admitted. He was found to be profoundly anemic, with a hemoglobin of 8.3 gms/Dl (normal hemoglobin 13.8-17.2 gms/DL) and an altered mental state. He received a blood transfusion of two units. He returned from Florence Hospital at Anthem on 5/4/13. The discharge summary was not reviewed by the medical staff at the prison until four days later, on 5/8/13. There is no mention in the medical record of his anemia, or of the fact that he received a transfusion.. ADC219405-ADC219409 The profound anemia was probably the reason why he fell on the two prior occasions.

89. On 5/5/13 at 0330, within 10 hours of his return from Florence Hospital, he complained of burning in his stomach. He had not been seen by a provider since he returned from the hospital. His blood pressure was 205/103, and his pulse was 113, both extremely abnormal, but he was not examined by a licensed provider. Dr. Vukcevic was contacted by phone and prescribed pain medication and ranitidine for abdominal pain. An appointment in the prison medical clinic was scheduled for 5/8/13. ADC219403

90. At 0900 on 5/5/13, five hours later, [redacted] was brought to the yard medical clinic by correctional staff, who stated that he was complaining of chest pain. The nursing staff wrote: "I/M denies chest pain, states his complaint was abdominal pain." He was not examined by a physician or other licensed provider. Dr. Vukcevic was called again and ordered an antibiotic and clonidine, for treatment of uncontrolled hypertension. An EKG was also obtained "for MD evaluation the next day," 5/6/2013. There was no evaluation of [redacted] on 5/6/13 or 5/7/13. ADC219402.

91. On 5/8/13 [redacted] was initially noted to be slurring words and unresponsive. He had his "tongue rolled in mouth mumbling and slurring speech." He complained of back pain with a severity of 10/10. His blood pressure was measured at 201/89 , dangerously elevated, placing [redacted] at great risk for a stroke or another heart attack. His pulse was also significantly elevated at 115/minute. ADC219401, ADC219402.

92. Despite these grossly abnormal vital signs, RB, the physician's assistant wrote VSS (vital signs stable). Parenthetically he noted "(BP was elevated mildly)." The physician's assistant evaluated the patient and during the course of his evaluation described the patient as initially slurring his words, but by the end of the examination, no longer slurring. The PA prescribed pain medication, but indicated that he also believed that [redacted] was being manipulative. No EKG was ordered and no EKG from 5/5/13 was reviewed. ADC219401.

93. The nurses in his unit believed that [redacted] was faking his symptoms and did not provide him with the care he required. On 5/10/13 a nurse wrote in the chart that [redacted] had not been showering and that pills were found in his bed. The nurse wrote "i/m is malingering and continuing manipulative behavior." ADC219398.

94. On 5/12/13, [redacted] complained of shortness of breath: "I can't catch my breath." His oxygenation was very low at 91% and he was breathing rapidly, at 21 per minute. He was not examined by a provider, but Dr. Vukcevic was called and prescribed an albuterol inhaler. Sometime later the same day, [redacted] fell and was found unresponsive. When he came to, he complained of pain. He was breathing rapidly at 24

per minute, and his pulse was rapid at 102/minute. No provider examined [redacted] after his fall, no EKG was obtained, and no laboratory studies were ordered. ADC219399.

95. On 5/15/13 [redacted] complained that he was short of breath, wheezing, feeling dizzy, and had back pain. He was noted to have urinated in his bed the previous night, and it was noted in the medical record "CO's also confirm that IM is NOT [caps in original] getting out of bed much and is demanding people do things for him." Vital signs on this date were extremely abnormal. The BP was 184/97, pulse was very elevated at 111, respirations were elevated at 20/minute and oxygen saturation was significantly decreased at 90%. Additionally, physical examination revealed rales (sounds consistent with pneumonia) on both sides of the lung when inhaling and exhaling. [redacted] was given a nebulizer treatment but [redacted] did not feel there was any improvement in his breathing. No EKG was obtained. A chest x-ray was ordered, but was never obtained. The provider's note concludes: "Increase fluids, Increase walking. DO NOT [emphasis in original] allow patient to lay in bed indefinitely! Must walk to get anything he needs! Discussed urination issue and he admits he has been lazy with his personal ADL (Activities of Daily Living) care (urinating, hygiene [sp], etc.)" ADC219396.

96. On 5/16/13 a nurse wrote: "continue to monitor for malingering behavior." ADC219397.

97. On 5/17/13 at 0030, [redacted] requested emergency medical attention stating "I can't breathe." The LPN's response was: "IM (inmate) constantly initiates attention seeking behavior. Always signaling nurse 'come here' and will repeat the same

exagerated [sp] comment time and time again of the topic we covered the previous 5 minutes before. …. Previously stated 'I can't walk.' Inmate walked fine in front of security and medical staff, sat in his wheel chair." Plan: "Educate i/m to stop playing games, stopping seeking attention." ADC219395.

98. On 5/23/13 at 1700 [redacted] complained of coughing up yellow phlegm and being short of breath for three days. "Sats (oxygen saturation) decreased 82% RA." The "8" is than crossed out and replaced with a "9." Oxygen saturations in the previous weeks and been from 90% to 94%; 92% would not have represented a decrease, but 82% would have been a significant decrease. The on-call provider was contacted, who recommended checking blood sugar and oxygen saturation every 30 minutes. The only other oxygen saturation measured, at 1800, also showed "82%" which was again rewritten with the "8" crossed out and replaced by a "9." [redacted] was then sent back to his room. ADC219395

99. No follow-up was scheduled. On 5/27/13, just after midnight, [redacted] again requested emergency care, stating "I can't breathe." His oxygen saturation was measured at 83-85%, dangerously low. He was breathing rapidly, at 32 respirations per minute, twice the normal respiratory rate. His pulse was 114/minute and his blood pressure was elevated to 184/78. He was very ill and unable to breathe. Remarkably, and disturbing, the provider on call, rather than send [redacted] out for emergency evaluation and treatment, elected to treat [redacted] with oral prednisone and oral antibiotics. He also ordered nebulizer treatments. The on-call provider requested that [redacted] be seen that morning. [redacted] was sent back to his housing unit. ADC219394.

100. Later that morning at 06:30, [redacted] again requested emergency care. He complained of shortness of breath and inability to sit or stand. He complained of coughing up blood, and said he hadn't eaten in days. Dr. Vukcevic was called and told the nursing to staff to give [redacted] more oxygen, and to send him via transportation with the ADC van to Florence Anthem hospital. ADC219393

101. [redacted] was sent to the hospital, where it was discovered he had previously undiagnosed stage IV terminal cancer. ADC219393.

102. [redacted] had multiple life threatening medical conditions, which were well documented. He had sustained multiple heart attacks and had seven stents. He had unstable angina, with recurrent severe chest pain. He had recurrent transient ischemic attacks -- brief duration reversible episodes of neurological symptoms, including slurring of speech. He was chronically short of breath. He had metastatic lung cancer that was undiagnosed. During the last month of his life in the ASPC-Florence, he was constantly accused of lying about his medical condition, and criticized for inactivity. When he was emergently hospitalized after several falls and episodes of loss of consciousness which were found to be due to profound anemia, on his return he was criticized and chastised for inactivity. He spent the last two weeks at ASPC Florence with severe chest pain and difficulty breathing, while provider staff ignored him and nursing staff humiliated him and accused him of exaggerating his symptoms. Two weeks later, on [redacted] he died from Stage IV lung cancer.

103. Even in retrospect, in preparation of their mortality review, Corizon staff and Dr. Robertson did not identify the following item on their checklist: "Failure to

communicate effectively with patient," as a contributing factor to his death. ADC211704. Based on their review, they had no recommendations for change regarding policy, procedure, or education. Corizon's abandonment of [redacted] as he lay dying requires education, new policies, and supervision. Medical staff consistently failed to provide him with access to care for chest pain and shortness of breath. It did not happen once, or twice. Time after time he sought care and was denied access to relief for his shortness of breath, for his pain, and for his underlying complicated medical illness. His severe anemia was ignored, and he was allowed to continue to fall, and forced to walk alone when he was severely disabled by his illness and required assistance The mortality review of [redacted] should be redone to reflect necessary changes in practice for treatment of patients with severe chronic disease. ADC211707.

104. [redacted] was another young cancer victim. He died at age 37 of familial colorectal cancer on [redacted] at ASPC-Tucson. At the time of his death, he also suffered from Hepatitis C and peripheral neuropathy due to chemotherapy. The records I was provided begin on 9/24/12. According to an oncology note dated 10/26/12, [redacted] was first diagnosed with rectal cancer in December 2011. ADC221288. He had a biopsy in December of 2011 which showed adenocarcinoma, moderately to poorly differentiated with perineural invasion. A CT of the abdomen and pelvis showed possible liver metastases. He got 12 doses of FOLFOX chemotherapy. *Id.*

105. He was seen on 11/7/12 by colorectal surgery to review the CT scan results, (ADC221290) and then on 11/26/12 by his oncologist. ADC221282. His oncologist, however, did not have documentation of his CT scan. The oncologist noted that they

wanted to see the patient in 3 months, and to consider second line chemo. ADC221282. The corresponding physician order, however, changed the follow up visit to 4 months out. ADC221291. This delay is excessive for a patient with advanced stage cancer.

106. On 12/4/12, a PET scan was ordered for [redacted] but he did not undergo the test until almost two months later. When finally available, the 2/1/13 PET scan results showed very advanced disease – liver metastases, bony metastases and probable lung nodules. ADC221410. He subsequently underwent two rounds of chemotherapy. ADC221267.

107. On 3/15/13, [redacted] potassium was critically high at 6.2. There was one day delay in treatment notification to [redacted] doctor, and no EKG was performed to determine if there was cardiac toxicity from the elevated potassium. [redacted] received treatment with furosemide. His physician appropriately ordered further labs, but failed to order an EKG, as should have been done to assess whether there was any adverse effects on his heart being caused by the elevated potassium. ADC221265, ADC221266 and ADC221312.

108. [redacted] began to complain of back pain and leg weakness on 4/6/13. He was found to have a fever of 101.2, and the prison physician sent him to the hospital to rule out neutropenic fever., often a sign of severe infection caused by depletion of white blood cells from chemotherapy. ADC221252. [redacted] received an appropriate work-up, including a chest x-ray, CT scans of the head and spine, and blood cultures. ADC221448-ADC221452, ADC221419- ADC221440. The CT showed T1 metastasis and a T3 compression fracture. ADC221439. An MRI was

recommended to check for spinal cord compression. *Id.* The MRI is not available in the medical record.

109. [redacted] underwent chemotherapy until 7/30/13, when he refused to continue. ADC221605. On 8/7/13, his provider wrote to "continue comfort care." ADC221546. During this period he had poor pain control. He wrote an HNR on 8/10/13 saying that he was pain which made it difficult to sleep, and that was losing weight. ADC221645. Five days later, without provider evaluation, the nurse wrote back to him that Dr. Thompson had said that he was on the maximum medication for his condition. *Id.* Dr. Thompson should have evaluated [redacted] and discussed his request for pain management.

110. On 9/8/13, [redacted] complained that he felt like he had pneumonia or respiratory infection. ADC221644. He did not see the nurse until 9/12/13, when he was found to have a rapid heart rate (122 beats per minute). ADC221539. Although he was referred to the physician, it appears he was not seen until 9/18/13, a ten day delay for a dying, sick patient with vital sign abnormalities. On that date, he again had a rapid heartbeat, and a low oxygen level. He had lost 45 lbs., and complained of brownish sputum. ADC 221538. Dr. Catsaros noted that [redacted] blood had been drawn for labs a month ago, but the results were not yet in the file. He was found dead by a nurse [redacted] on [redacted] ADC221533.

111. [redacted] had a familial cancer which is very resistant to treatment. However, treatment of this cancer does relieve pain and extend life. The PET scan was necessary to determine the response to chemotherapy; the delay of two months is

inexcusable, and delayed necessary treatment. When [redacted] decided to stop active cancer treatment, he still required supportive palliative care which was not provided appropriately or timely. The systemic problems which plague ADC affected [redacted] Abnormal laboratory tests were lost to follow-up. There was a two month delay in getting his PET scan, which delayed further necessary therapy. When he was dying, he was repeated denied access to timely effect relief of pain and shortness of breath. When a patient is dying, in pain, with a very rapid pulse and is short of breath, a request for provider assistance should be considered urgent, not delayed for ten days. [redacted] did not have a curable disease. However, when he lay dying, his requests for relief of pain and suffering should have been heeded, not ignored.

112. [redacted] died on [redacted] at ASPC-Tucson while receiving palliative care for glottis (laryngeal) carcinoma and small cell lung cancer with extensive metastasis. He was 53 years old. His care was marked by serious delays and alarming neglect of his treatment and pain issues.

113. [redacted] underwent radiation treatment for laryngeal cancer in the spring of 2012. Following his final radiation treatment on 4/13/12, it appears he was not seen again by an oncologist again until 8/29/12. ADC212912, ADC 212918. [redacted] began submitting HNRs complaining of throat pain in early August 2012. ADC213025. On 8/9/12, he wrote asking for morphine for his pain related to his throat cancer, and explaining that the Tylenol that he was given was not effective for his pain. *Id.* I found no physician's progress note documenting a physician appointment in response to this request, but on the request itself, a physician wrote in response four days later "Dr. Latif

at 21st Century on 4/30/12 states you were non-compliant with treatment and 'no symptomatic treatment was needed.' Therefore, the morphine was discontinued by myself." *Id.* This callous response to a patient with a history of a painful cancer, who had been poorly followed since treatment had ended four months earlier, is shocking, and suggests inadequate training and/or supervision of clinicians.

114. On 8/17/12, [redacted] submitted another HNR, complaining of throat pain that interrupted his sleep. ADC213023. In response, someone wrote "you have a pending appointment with the doctor." *Id.* The patient submitted another HNR on 8/17/12, requesting ice to soothe his throat, explaining that although he drank water frequently, his throat remained dry because he had undergone radiation. ADC213022. The HNR was apparently reviewed on 8/22/12, when someone wrote in response, "Water is fine." *Id.* Based on the records I was provided, it appears that [redacted] did not see a physician in response to any of these HNRs.

115. Dr. Latif, [redacted] oncologist, saw him on 8/29/12, and referred him to an Ear Nose and Throat (ENT) specialist to evaluate the patient's vocal cords response to the radiation. ADC212920. [redacted] ADC physician, Dr. Bell, apparently did not review the report until a month later, on 9/28/13. *Id*. The ENT consult did not take place for another two months. ADC212948. On 11/26/12, the ENT, Dr. Lee, noted that [redacted] complained of constant neck pain that he had had for four months. ADC212947. Dr. Lee wrote that he had not detected recurrence of the cancer by physical exam, and that the laryngoscopic exam was consistent with healing after radiation and

chemotherapy. *Id*. He recommended a PET scan to rule out residual disease or recurrence to explain his neck pain. *Id.*

116. This PET scan should have been scheduled expeditiously. It was not. In fact, it was not scheduled for another eleven weeks. This is shocking. On 2/6/13, the scan results showed that [redacted] had metastatic cancer. ADC212943-ADC212944. [redacted] continued to submit HNR's complaining of pain, including on 2/11/13, when he wrote, "the cancer in my throat is killing me with pain I just had a PET[(text says PAP] scan so I know now that you know now this is to be true. I need antibiotics and pain meds. The Tylenol I eat like candy and still they do nothing. I need morphine." ADC213018. In response, someone wrote, "We don't issue morphine." *Id.* On 2/14/13, [redacted] was prescribed tramadol, a pain medication, which was ineffective, and was finally prescribed morphine two weeks later on 2/27/13. ADC212999, ADC212993. This delay in providing effective pain medications was unnecessary and shows a system that lacks the capacity to provide necessary care to patients when they require it, and callously allows patients with metastatic cancer to suffer severe pain without providing treatment.

117. [redacted] died two and a half months after receiving the PET scan. The ADC's failure to adequately monitor this patient's condition following his radiation and chemotherapy in April, 2012, and the delays in scheduling his ENT follow-up consultation and PET scan may are extremely disturbing. [redacted] death demonstrates multiple systemic failures. Urgent diagnostic testing and consultation was delayed for many months – he waited two months for ENT consultation and 11 weeks for the urgent

PET scan. . Requests for management of cancer pain were rejected with callous written responses and denial of treatment, rather than with basic clinical courtesy.

118. It is particularly disturbing that these written comments were not identified by Dr. Robertson in his mortality review. There were clear failures in assuring access to care, and in place of effective provider to patient communication, part of the checklist of the Corizon mortality review, there was ridicule and intentional refusal to treat cancer pain. ADC211611-15.

119. Poor care in the ADC is not limited to cancer patients. The records I reviewed also demonstrated serious deficiencies in the ADC's care for the chronically seriously ill. [redacted], was a prisoner at Florence when he died at age 52. His past medical history included coccidioidomycosis (Valley Fever), tuberculosis, partial lung resection, bilateral hip replacements, and chronic lung disease. He was sent to the hospital for chest pain and shortness of breath on 3/26/13 where he was diagnosed with sepsis and pneumonia, and he died [redacted] ADC215611-13 ADC218194, ADC218324, ADC218301. No autopsy results are available.

120. The patient was seen in a pulmonology clinic on 4/19/12 for consultation regarding his extremely complicated lung disease. ADC218217-ADC218218. The pulmonary consultant recommended follow-up in 3 months, though this appointment did not occur. At the 4/19 visit, he had pulmonary function tests which demonstrated severe pulmonary disease. He was on a medication, theophylline, which is rarely used now due to high risk profile and narrow therapeutic window. This medication can reach toxic levels and can lead to arrhythmias, seizures, vomiting and death. In all the records

provided from 4/12/12 to the date of [redacted] death on [redacted] there is no record of a theophylline level. See ADC218224-ADC218231.

121. Eight months after the April pulmonology consult, on 12/28/12, ADC's Dr. Vukcevich ordered a chest x-ray to rule out pneumonia. ADC218185. [redacted] chest x-ray results were suggestive of a pneumothorax (an abnormal collection of air or gas in the space that separates the lung from the chest wall). ADC218236. He was started on antibiotics for 10 days for probable pneumonia. Labs were ordered on this date, including a theophylline level (apparently never done). ADC218188. The MD who evaluated [redacted] also requested a STAT pulmonary consult on 1/1/13. ADC218191. On 1/10/13, the pulmonary consult was denied, with suggestions to instead repeat the chest x-ray. ADC218194. Given this patient's severe COPD and extensive pulmonary history, including TB and coccidioidomycosis, as well as abnormal findings on the chest x-ray the consult should have been scheduled expeditiously. This denial was inappropriate.

122. [redacted] repeat chest x-rays on 1/11/13 and on 1/23/13, again showed possible pneumothorax. ADC218234, ADC218235, ADC218195, On 1/23/13 the radiologist recommended a CT scan because the nature of [redacted] lung disease could not be resolved with a plain x-ray film. ADC218234. On 2/1/13 another chest x-ray showed left upper lung collapse and that pneumothorax again could not be excluded. Again the radiologist recommended that a CT scan be done in order to diagnose and treat [redacted] lung disease. ADC218233.

123. A repeat reading of this chest x-ray was called into the medical department at ASPC-Florence on 2/2/13. ADC218177 and ADC218232. [redacted] was again sent to the Health Unit at Florence and again treated for pneumonia on 2/2/13. ADC218177, ADC218178. This was the second time he was treated for pneumonia in less than five weeks. On 2/2/13, he was treated with azithromycin, an oral antibiotic. ADC218197. This oral antibiotic is inappropriate treatment of persistent pneumonia in a patient with severe restrictive and obstructive lung disease. Pulmonary consultation and CT scan was required to appropriate treat [redacted], but he was denied consultation. The "stat" (i.e. immediate) pulmonary consultation as requested one month earlier might have prevented this hospitalization.

124. Finally on 3/12/13, Dr. Michael Thompson submitted a request was submitted to Corizon for the critically necessary lung CT scan. Corizon did not respond to this request. The CT scan never occurred. ADC218176.

125. On 3/26/13, at 0200, the inmate was noted to have difficulty breathing per security. He was appropriately triaged and an ambulance was called which transported him to Mt. Vista Hospital. Of note, the EKG machine at the prison facility was not working. ADC218174.

126. At Mt. Vista Hospital he received 2 liters of saline and was transferred to Tempe St. Luke's Hospital. No notes are available from the brief Mt. Vista Hospital admission. Limited hospital notes are available from Tempe St. Luke's Hospital, (History + Physical and discharge summary only), but they note an extensive left lower lobe infiltrate on chest x-ray. ADC218327-28. His discharge summary (death

summary) from [redacted] noted that he died of sepsis, acute renal failure and hypotension. ADC218324.

127. [redacted] had severe lung disease with complex radiological findings. He had had part of his lung removed. He had been treated for active tuberculosis and coccidioidomycosis (valley fever). Evaluation of his x-rays and his pulmonary status was behind the capabilities of the on-site physician staff at Florence, but their request for emergency pulmonary consultation was denied. Two requests by radiologists for CT scan's were ignored, and when a CT scan was finally requested, Corizon staff ignored the request. [redacted] had a persistent pneumonia in from December 2012 through March 2013. The failure to adequately diagnose and treat [redacted] complex pulmonary disease and his persistent pneumonia contributed to his death from sepsis on [redacted] Failure to provide timely access to necessary consultation and radiologic testing contributed to his death from inadequately treated pneumonia. The delays experienced by [redacted] in obtaining access to necessary pulmonary consultation and CT scans are the consequences of the systemic failure to provide these basic essential services to prisoners in the ADC.

128. [redacted], [redacted] died at ASPC – Tucson on [redacted] at the age of 58. He had multiple medical problems including chronic liver disease with esophageal varices. He was treated prophylactically with propranolol, a drug that lowers the pulse and blood pressure, and spironolactone, another drug which lowers blood pressure and serves as a diuretic, to decrease fluid accumulation. [redacted] received inadequate

medical care and inexcusable delays in access to necessary emergency care that contributed to or possibly caused his death.

129. According to his hospital discharge summary, [redacted] died of ventilator dependent respiratory failure type 4 and septic shock in addition to other diagnoses. ADC215340. Based on his labs, imaging and provider notes from [redacted] hospital records, [redacted] died from septic shock, due to overwhelming infection from clostridium difficile, a diarrheal illness.

130. On 7/19/2013, [redacted] complained of several days of diarrhea, back pain and that he had fallen down in his cell. His blood pressure was 122/72. He was only given ibuprofen, and no further evaluation occurred. ADC215395, ADC215238.

131. Four days later, on 7/23/2013, at 0540, he complained of back pain and was found to have a blood pressure of 82/54, which is extremely low. His pulse was 90, and his oxygen saturation was 97%. ADC215393. [redacted] was on two medications, propranolol and spironolactone, for chronic liver disease. Dr. Bynum, the on call physician, was contacted and ordered a non-steroidal anti-inflammatory medication (NSAID) called ketoralac (Toradol) to treat his back pain. Dr. Bynum did not examine [redacted], order any laboratory examinations, or schedule a follow-up appointment. It is not usual to treat patients with diarrhea with NSAID's. It is dangerous to ignore a blood pressure of 82/54. [redacted] should have been evaluated immediately by a physician. This did not happen. Instead, the medical staff at ASPC-Tucson continued to administer [redacted] long-term medications spironolactone and propranolol, both of which lower blood pressure.

132. On 7/24/2013 at 1945, [redacted] was found confused in his cell with an even lower blood pressure of 78/43. His oxygen saturation had decreased to 95%. He could not speak, was disoriented, and could not walk. The RN notified the on-call provider, Dr. Bynum who ordered that [redacted] be given one liter of normal saline intravenously over three hours. ADC215238.

133. This previously ambulatory alert patient now had profound hypotension, profound mental status change with confusion, inability to speak, and unable to walk. He was clearly seriously, if not critically, ill, with signs of sepsis, and should have been transported to a medical facility immediately by EMS for examination by a physician as soon as this blood pressure was discovered. This was not done. Although fluid administration is the first step in responding to suspected sepsis, the failure of Corizon medical and nursing staff at the Rincon facility to refer [redacted] emergently was completely inappropriate.

134. Six hours later, on 7/25/2013 at 0200, [redacted] blood pressure fell even more to 60/30. A blood pressure this low is generally inadequate to maintain blood flow to internal organs. At this time, [redacted] was finally taken to the emergency room. ADC215245. The emergency room physician reported that [redacted] was also in tremendous pain when he arrived at the hospital. ADC215342.

135. On 7/23/2013, 7/24/2013 and 7/25/2013, ASPC-Tucson medical staff recorded [redacted] as having low blood pressures consistent with shock, but he was denied appropriate treatment until 7/25/2013, when his illness progressed to being beyond salvage. Sepsis should have been suspected on 7/23/13 and appropriate

emergency care sought. No treatment or follow-up of his profound hypotension was provided or planned. When his blood pressure continued to fall on the evening of July 24, 2013, when he lost the ability to speak, and when he became disoriented, medical and nursing staff still refused to send him to the hospital. The failure of the medical staff to recognize and act on his clear need for emergent care over several days shows poor training and supervision of staff.

136. Delay in antibiotic treatment of sepsis dramatically decreases the chance of survival. If [redacted] had been treated emergently beginning at 0540 on July 23, when his blood pressure was extremely low but he was conscious and ambulatory, he could have been treated with fluids and antibiotics, and his bacterial sepsis was likely to have responded favorably to treatment. Intentional delaying treatment for an additional forty hours made the chance of successful treatment extremely unlikely. [redacted] died of sepsis and respiratory failure on [redacted] The failure of the medical and nursing staff to provide emergency care to a crtically ill patient is extremely disturbing. There is a systemic failure in the ADC with regard to provider staff attending to patients with serious medical needs. Repeatedly serious signs and symptoms are obtained by nurses, reported to providers, without any response. Providers do not come to see patients with serious medical complaints. This systemic failure of physicians and other providers to respond directly to urgent and emergent medical problems contributed to [redacted] death from sepsis..

137. [redacted] died at ASPC – Tucson on [redacted] He was 72 years old. At the time of his death, he suffered from multiple serious medical problems,

including coronary artery disease, ischemic cardiomyopathy/congestive heart failure, diabetes, hypertension, atrial flutter, history of pulmonary embolism, anemia and chronic kidney disease. He was receiving multiple medications: Lisinopril, pravastatin, warfarin, aspirin, furosemide, aspirin, and nebulizer treatment for asthma/COPD. He was also receiving mental health care (ADC 212453), and his mental illness contributed to his intermittent refusals of medication.

138. Throughout June 2013, [redacted] refused to take his multiple prescribed medications. These medications were necessary to sustain [redacted] health, and without them, he was at high risk of suffering an adverse outcome including congestive heart failure exacerbation, cardiac arrhythmia, stroke, pulmonary embolism or myocardial infarction. Unfortunately on [redacted] [redacted] was found unresponsive on the floor of his cell. CPR was administered and EMS was called in a timely fashion, but emergency responders were unable to revive [redacted] and he was pronounced dead in his cell. It is highly likely that his refusal of medications and medical treatment , and the failure to see mental health professionals to review the reasons for his refusals, hastened or possibly even caused his death.

139. [redacted] did not have an immediate psychiatric evaluation or medical work up. On 6/18/2013, after many days of refusing medical treatment, a medical provider wrote "pt verbally acknowleges (sic) understanding but maintains refusal. He is unable to give me a reason why he is refusing meds…place on psych provider line for assessment." ADC212442. To demonstrate capacity to make one's own medical decisions, a patient must be able to explain medication refusals.

140. On 6/24/2013, a "Psych Associate II" Michelle Merbeth saw [redacted] regarding his refusal to take medications. ADC 212752. Ms. Merbeth wrote "Explored IM reasons for stopping medications and he indicated they were making him sick (detailed explanation that did not appear to make sense), and states he believes the nursing staff is doing something wrong and there is a multimillion dollar lawsuit…IM appeared to be fatigued, confused, bizarre/paranoid thoughts." ADC212752. This assessment further raises concern for an organic or psychiatric disorder leading to irrational behavior and decisions regarding his health.

141. Ms. Merbeth wrote in her 6/24 assessment "Mood d/o, hx delusional d/o" and in her plan "requested psychiatry evaluation." ADC212752. Because [redacted] had multiple serious medical problems, and was refusing to take his medications, a psychiatric evaluation was required urgently. Unfortunately, [redacted] died before receiving the planned psychiatric evaluation.

142. [redacted], was 49 when she died at ASPC – Perryville. She suffered from severe congestive heart failure. Her ejection fraction was extremely low 8-15% (normal is greater than 55%). She had recently been given an intracardiac defibrillator (ICD), and it had discharged twice when she experienced dangerous arrhythmias. [redacted] was receiving many medications: albuterol, allopurinol, aspirin, bumetanide, carvedilol, lactulose, lisinopril, loratidine, losartan, pravastatin, potassium, omeprazole, promethazine, and spironolactone.

143. The last time [redacted] saw a cardiologist was May 15 for analysis of her ICD (the full chart note is not provided). Her previous cardiology consultation was on

March 22, 2013. During the March visit, the cardiologist recommended that the patient take bumetanide 2mg twice a day and spironolactone 12.5mg daily. ADC217521. Yet on 3/18/13, Perryville's Dr. Irving increased the patient's spironolactone to 100mg twice daily with no discussion of why this decision was made. ADC217213. This represents a dosage more than 15 times that recommended by the cardiologist, and may have contributed to the deterioration in kidney function.

144. During a three-week period (3/6/13 - 3/27/13), [redacted] serum creatinine level, which reflects kidney function, rose from normal to significantly raised (1.43). A note from 4/9/13 states that the provider "spoke with the nephrologist" and deemed that the increase was due to "cardiorenal syndrome." ADC217477. The provider writes that a nephrology consult request was written on 4/19/13 (ADC217477), and yet the only record of such a request is from May 7, 2013 (ADC217698). The patient was not seen by a nephrologist prior to her death two weeks later.

145. The provider also states that the patient requires "weekly labs." There is evidence of laboratory data from: 3/6, 3/27, 4/5, 4/11, and 4/19 (ADC217307-217313; ADC217578-217580; ADC217552-217555) but none after that, despite the fact that there is no "stop" order for the weekly lab checks. There is a request that labs be drawn "today" on May 10, 2013 (ADC217779), but there is no record of these being done. Notably, on [redacted], the patient had already been reporting daily symptoms, and she died [redacted] days later.

146. Finally, this patient was prescribed losartan 25mg daily and had been taking this consistently from January 2013 until her death. Close to the time of her death

- on May 9, 2013 - she was also started on lisinopril 2.5mg daily. ADC217592. The combination of losartan and lisinopril can lead to dangerously high levels of potassium, which can cause sudden death. There was never any reason given for adding this medication, and there was no follow-up laboratory data check, which is customary if patients are going to be on both agents.

147. [redacted] serious medical conditions warranted more careful monitoring of her condition and analysis of medication interactions. Although providers placed orders for weekly laboratory checks (ADC217477; ADC217561; ADC217767), no laboratory studies were obtained after April 19, 2013. The medical examiner report does not include any information on this patient's serum testing (electrolytes or creatinine), but it is possible that [redacted] may have had an electrolyte disturbance that precipitated her death. Frequent monitoring of electrolytes as ordered, particularly after changes in cardiac medications, is essential in the care of patients with severe cardiomyopathy. It must be noted, however, that the prognosis for patients with [redacted] degree of heart failure, and her functional disability, is very poor.

148. [redacted], was a 58 year old man with chronic kidney disease, diabetes, complicated by neuropathy and amputation of his second toe on his left foot, hypertension, coronary artery disease (after insertion of stents), dementia and a diagnosis of hypereosinophilic syndrome, a rapidly fatal disease. He died [redacted] at ASPC-Tucson. The records provided contained multiple gaps, and I was provided no autopsy or other death records, so I am not able to determine his cause of death.

149. From 7/21/12 to 3/4/13, [redacted] was admitted to the hospital at least six times, and his health deteriorated rapidly. During his hospital admission of 9/3/12 through 9/14/12, [redacted] was diagnosed with Hypereosinophilic Syndrome, for which he was appropriately treated with steroids. Hypereosinophilic Syndrome is a group of blood disorders that occur when a patient has a high numbers of eosinophils — a type white blood cells that play an important role in the immune system. Over time, these high numbers of eosinophils enter various tissues, causing inflammation and eventually damaging organs, most commonly targeting the skin, lung, heart, blood and nervous system. This is a very serious illness with a high mortality. At discharge, it was noted that he would require surgical, renal and oncology follow-up appointments. ADC220445.

150. During the months after his return to prison, [redacted] was frequently noted to be anemic but was never adequately evaluated for treatment of this condition. He tested positive for gastrointestinal bleeding on a Fecal Occult Blood Test (FOBT) on 11/9/12, and again on 11/14/12. ADC220452. However, the FOBT is a screening test for colorectal cancer, designed for the general population. A patient like [redacted], with profound anemia, should have had a gastro-intestinal work-up, including a colonoscopy and EGD to localize the source of the blood loss. The staff noted [redacted] gastro-intestinal bleeding and provided him iron, and appears to have referred him for a GI work-up on 11/20/12 (ADC220450), but there is no record that this consult ever happened. Even after a later hospital admission, when [redacted] again tested FOBT positive and underwent two blood transfusions, he still received no EGD or colonoscopy. ADC220827.

151. Additionally, on 11/27/12, he was referred on an urgent basis to Hematology to identify and treat other causes of anemia. An oncology referral was provided on 2/26/13, three months later. The failure to timely schedule these critical evaluations for this very fragile patient, and the failure of his physicians to follow up when they were not done, falls well below the standard of care and demonstrates a poorly functioning specialty referral process.

152. [redacted] chart often references his confused mental state. See ADC220454 (11/12/12 note – "confusion:); ADC220628 (12/15/12 note – "hallucinating" and "confused"); ADC220680 (12/23/12 note – dementia "chronic in nature"); ADC220654 (1/6/13 report – "demented at baseline"). On 2/12/13, a psychologist found that he had cognitive impairment due to encephalopathy (a build-up of ammonia in the brain), and recommended bringing in a health care proxy to make further decisions about his health care. ADC221000. There is no indication in the chart that a health care proxy was contacted.

153. Following [redacted] EGD and feeding tube placement on 5/11/13, there are virtually no medical records, although he did not die until [redacted] ADC220856, ADC220803. Without those records, I cannot opine as to whether the care he received hastened his death or caused him unnecessary pain. This lack of documentation is distressing, and has great significance for clinical care, since the chart I reviewed is the medical record available to the medical staff for the last three months of his life.

154. [redacted], died [redacted], when he was 52 years old. He had a receiving screening on February 12, 2013. He had Hepatitis C infection, end stage liver disease,

and a history of hepatic encephalopathy. On 2/12/13 an admission history and physical was performed and labs were ordered. [redacted] was continued on his usual medications including a furosemide, potassium, omeprazole, and lactulose for hepatic encephalopathy,

155. [redacted] 2/14/13 lab results were extremely abnormal, showing a bilirubin of 4.1, platelets of 79K, a serum ammonia of 292 micrograms/dl, and an albumin of 2.7 Gms/Dl. These values suggested advanced, unstable liver disease. These labs were not reviewed.

156. On 2/27/13, he submitted an HNR because he was too weak to walk to get his medications. He was seen two days later on 3/1/13 by physician's assistant D. Onore. He was noted to have respirations of 24, oxygen saturation of 92%, a pulse of 105, BP 136/82, and a temperature of 97.2. These are unstable vital signs, suggesting significant respiratory distress. Labs were ordered to be drawn on 3/5/13.

157. On 3/5/13 he complained of spitting up blood, abdominal pain and swelling, light color of stool, with shortness of breath for three weeks. He was admitted to the hospital where he died on [redacted] of complications of end stage liver and kidney disease.

158. Medical staff failed to appreciate that his weakness and unstable vital signs on 3/1/13 represented significant deterioration in his status, and required emergent evaluation. This is another example of the systemic failure of physicians and other providers at ADC to respond to medical complaints of patients with complex serious illness.

159. [redacted] died at age 24 at Yuma Regional Medical Center on [redacted] from respiratory failure due to AIDS-related pneumocystis carinii pneumonia. ADC213053. According to his Mortality Review, he entered ADC custody on 2/16/12. ADC211618. On 12/31/13, he was transferred to Yuma County Detention Center for a court appearance. *Id.* While at YCDC, he became ill on 2/23/13. He was sent to the hospital five days later, where he was diagnosed with AIDS. ADC213062.

160. HIV/AIDS is highly treatable with timely diagnosis and, had [redacted] HIV status been identified earlier, his death could have been prevented. According to the Mortality Review, [redacted] was ordered an HIV test on 2/17/12, the day after he entered ADC custody. ADC211618. On 12/26/31, he submitted an HNR requesting HIV testing. ADC213177. The fact that this critical test was not performed despite two requests was responsible for his death. Had the HIV test been provided to him on 2/17/12 or on 12/24/12, as he had requested, he would have been treated with medications to to restore his immune system. and to prevent pneumocystis pneumonia, the infection which killed him.

161. [redacted], died on [redacted] at the age of 54. He had end-stage liver disease, hepatic encephalopathy and massive ascites requiring frequent paracentesis (withdrawal of fluid from the peritoneal cavity) for relief of pain. Of note, on February 26, 2013, [redacted] days before his death, [redacted] condition was noted to be deteriorating dramatically, had become disoriented, and was unable to take his "keep on person" medication appropriately. Dr. Barclay ordered that his medicine be provided to him directly (DOT – directly observed therapy), which was appropriate. However he also

ordered that [redacted] be placed in segregation status. Patients with end stage disease should not be placed in segregation because of their illness. They should be provided necessary treatment and accommodations in a supportive environment. ADC218967

162. Of the twenty-eight files that I reviewed, eight had records that were quite brief and/or markedly incomplete, making a comprehensive review of care provided impossible. [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted] [redacted].) Nevertheless, in two of the abbreviated records, I also found evidence of health care lapses that point to systemic problems.

163. [redacted], died at ASPC-Lewis on [redacted] of liver and kidney failure.

164. On 4/8/13, he was evaluated by an RN, who wrote that the patient stated others told him he had "yellowing of the eyes." ADC217794-ADC217796. The nurse reported that the patient's eyes had a "slight yellowing of color." The patient also reported that his urine was "very dark," and a urine dip done that date showed bilirubin was present, a sign of possible liver disease. ADC217795. Although these notes are stamped by Dr. Merchant, there is no evidence that Dr. Merchant or any other licensed provider examined the patient.

165. The combination of jaundiced eyes, dark urine, and urine with clear evidence of bilirubin spillage raises serious concerns about hepatitis, and requires an urgent evaluation by a physician. Instead [redacted] was treated with an antibiotic for bronchitis, and liver studies were obtained.

166. Laboratory studies obtained on 4/8/13 were critically abnormal, showing elevated bilirubin, evidence of liver injury, and abnormal thyroid levels. It does not appear that these results were reviewed by a physician. These studies showed, available on 4/10/13, revealed that [redacted] was having acute liver failure. His bilirubin was extremely high 8.1 mg/DL (0.2-1.2 normal), and his liver enzymes were AST/ALT 703/799 U/L, more than twenty times the normal range. His kidney function was completely normal at that time, and he had no evidence of chronic viral hepatitis infection because his tests were negative for hepatitis B and C virus. ADC217815-ADC217817. Prior laboratory studies are not available, but in 2012 [redacted] received atorvastatin at the facility, and laboratory studies of liver function would have been required to monitor his treatment.

167. [redacted] was finally brought to the hospital on 4/13/13. ADC217801. By this time his liver was failing; his bilirubin was 64, his liver enzymes were 2901/1755 U/L (AST/ALT) and his creatinine 3.1. ADC217806. These results demonstrate liver and kidney failure.

168. [redacted] had been in good health, and was not receiving any medications at the time of his death. The sudden development of signs of severe liver injury on [redacted] should have been prompted immediate physician evaluation. When his laboratory results were available on 4/10/13 he should have been hospitalized for diagnosis and treatment of acute and severe liver injury. There was a dramatic deterioration of [redacted] liver status from 4/8/13 to 4/13/13 when he was hospitalized.

169. Dr. Robertson's mortality review suggests that nothing should have been done differently and that [redacted] probably died of chronic viral hepatitis. Dr. Robertson's mortality review fails to acknowledge that [redacted] presented with liver disease on 4/8/13 but was not provided treatment, that Dr. Merchant stamped his agreement with the nurse's faulty assessment and plan without seeing the patient, that the critically abnormal laboratory studies from 4/8/13 were not reviewed, and that necessary emergency clinical response failed to occur. AC 211654-56 Systemically, there is a failure to assure that ordered laboratory tests are reviewed in a timely manner by a competent provider, and that an abnormal results elicit appropriate clinical response.

170. [redacted] died on [redacted] at ASPC-Yuma, at age 56. He had a history of endocarditis, DVT and anemia. ADC221020. Hospital records were not available to me, and I do not know the cause of his death. On 6/10/13, he saw a nurse because he complained of fatigue and found it hard to walk. ADC221023. His pulse was high (104) and his temperature was 99.8. No examination took place, and the patient was evidently sent back to his housing, and the nurse directed that the patient's chart be "designated for practitioner review." ADC221024. I found no evidence that a practitioner reviewed his file, however.

171. His next clinical and encounter was dated two weeks later on 6/24/13, when he again saw a nurse, complaining of severe leg pain and difficulty walking. ADC221020. Again, his pulse was high (106) and he was breathing rapidly, 24 times per minute. Laboratory studies that had been obtained on 6/12/13 were noted to be abnormal,

with low platelets 76,000 (150-400,000 normal) and low hemoglobin of 10 gms (13.5-17.5 normal) . ADC221142.

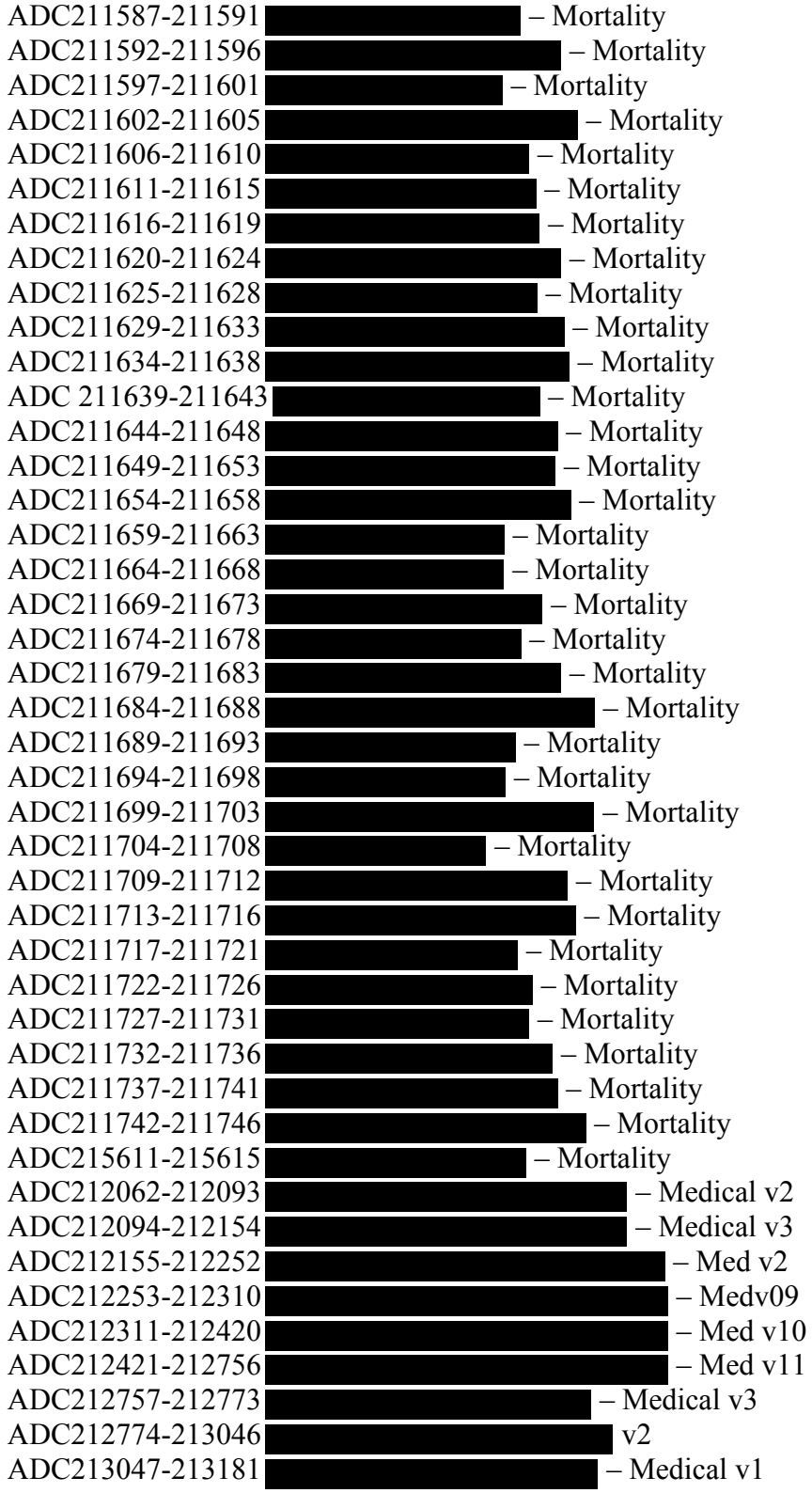
172. Noting the patient's history of deep vein thrombosis, that nurse performed a cursory review, again sent him back to his cell, and directed that he be referred to a practitioner on a routine basis. ADC221024. On both occasions, [redacted] complaints should have prompted a complete exam by a physician or mid-level provider. This did not happen.

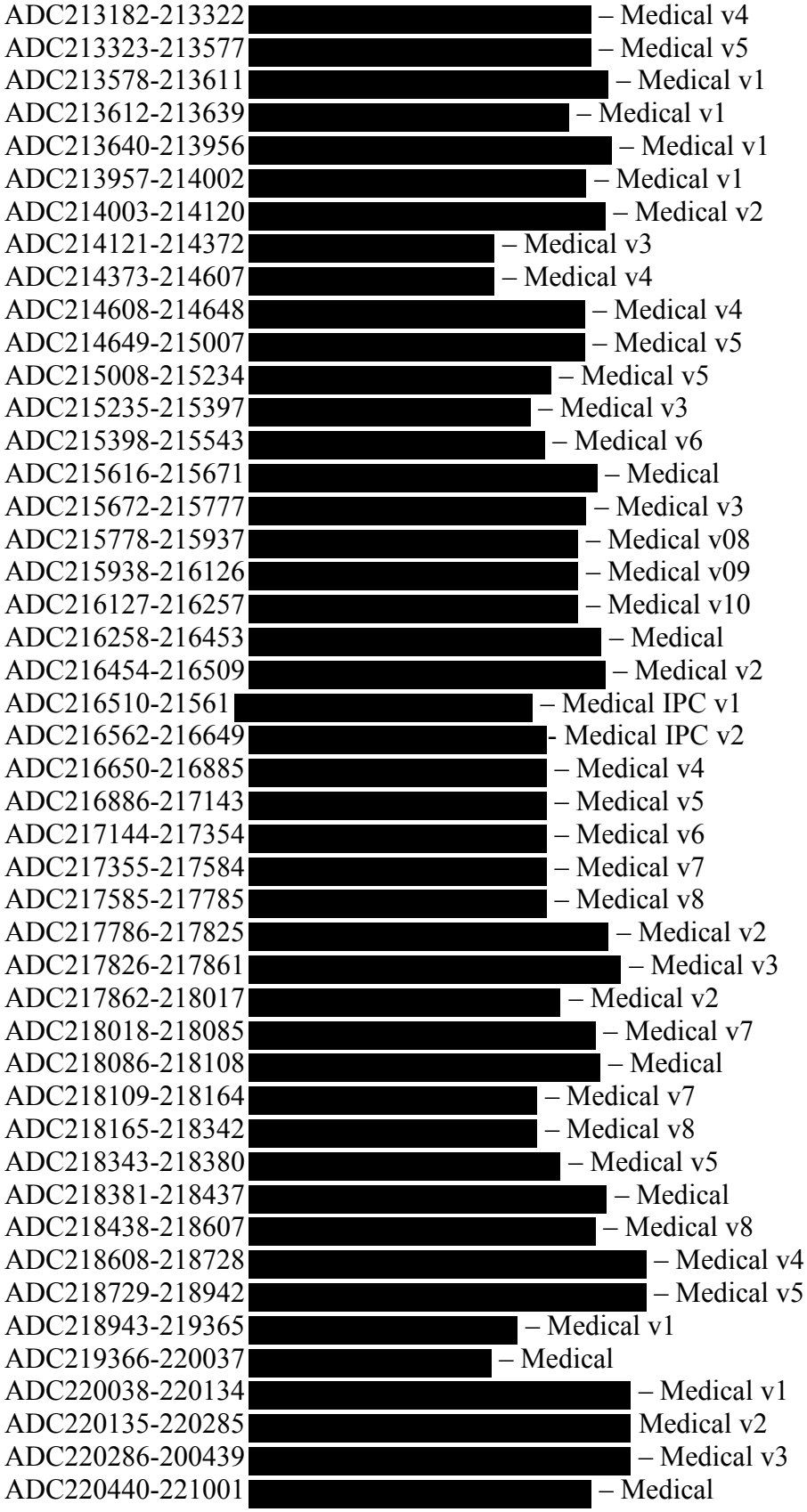
173. On 6/25/13, he complained of leg pain and difficulty walking. ADC221018. This time, he was finally sent to a local hospital for his complaints. [redacted] died [redacted]. The fact that [redacted] was seen twice for serious symptoms yet was not evaluated by a practitioner either time indicates that there is a lack of access to provider care and a failure by nursing staff to recognize and respond to serious medical symptoms.

Conclusion

174. For all of the reasons stated above, my opinion remains that the ADC's medical care delivery system is sorely deficient, and places Arizona state prisoners are serious risk of substantial harm.

APPENDIX A
List of Documents Reviewed for Supplemental Report




ADC213182-213322 – Medical v4
ADC213323-213577 – Medical v5
ADC213578-213611 – Medical v1
ADC213612-213639 – Medical v1
ADC213640-213956 – Medical v1
ADC213957-214002 – Medical v1
ADC214003-214120 – Medical v2
ADC214121-214372 – Medical v3
ADC214373-214607 – Medical v4
ADC214608-214648 – Medical v4
ADC214649-215007 – Medical v5
ADC215008-215234 – Medical v5
ADC215235-215397 – Medical v3
ADC215398-215543 – Medical v6
ADC215616-215671 – Medical
ADC215672-215777 – Medical v3
ADC215778-215937 – Medical v08
ADC215938-216126 – Medical v09
ADC216127-216257 – Medical v10
ADC216258-216453 – Medical
ADC216454-216509 – Medical v2
ADC216510-21561 – Medical IPC v1
ADC216562-216649 - Medical IPC v2
ADC216650-216885 – Medical v4
ADC216886-217143 – Medical v5
ADC217144-217354 – Medical v6
ADC217355-217584 – Medical v7
ADC217585-217785 – Medical v8
ADC217786-217825 – Medical v2
ADC217826-217861 – Medical v3
ADC217862-218017 – Medical v2
ADC218018-218085 – Medical v7
ADC218086-218108 – Medical
ADC218109-218164 – Medical v7
ADC218165-218342 – Medical v8
ADC218343-218380 – Medical v5
ADC218381-218437 – Medical
ADC218438-218607 – Medical v8
ADC218608-218728 – Medical v4
ADC218729-218942 – Medical v5
ADC218943-219365 – Medical v1
ADC219366-220037 – Medical
ADC220038-220134 – Medical v1
ADC220135-220285 Medical v2
ADC220286-200439 – Medical v3
ADC220440-221001 – Medical

ADC221002-221245 [redacted] – Medical v3
ADC212146-221656 [redacted]9 – Medical v2-4
ADC221657-222035 [redacted] – Medical
PLTF-PARSONS-032037 [redacted] Appeal
No Bates Number - [redacted] – 14.01.30
No Bates Number - [redacted] - 14.01.30
No Bates Number – [redacted] - 14.02.06
No Bates Number – [redacted] - 14.02.06
No Bates Number – [redacted] - 14.02.06
No Bates Number – [redacted] - 14.02.06
No Bates Number – [redacted] - 14.02.06
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