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

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

February 24, 2014

I have reviewed medical records, mortality reviews (where they exist) and psychological autopsies (where they exist) pertaining to the following ADC prisoners who died by suicide between February 12 and September 27, 2013:

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

[redacted], ADC No. [redacted]

As noted in my previous reports, there have been additional suicides in ADC since September 27, 2013, but it is my understanding that defendants refuse to produce records pertaining to those suicides. It is also my understanding that, for the eight prisoners listed above, defendants have produced only the medical records from the one-year period preceding the prisoner's suicide.

My review of these documents reveals serious systemic deficiencies, both in suicide prevention and in the provision of mental health care more generally. These deficiencies include:

Inadequate follow-up and infrequent contact with qualified mental health staff.

Poor documentation and inadequate and incomplete medical records.

Dangerous prescribing practices.

Inadequate history taking, exploration of symptoms, mental status exams, and risk assessment.

Perfunctory and inadequate mortality reviews and psychological autopsies.

As a threshold matter, it is deeply concerning that, although the most recent of these suicides took place several months ago, psychological autopsies have been completed for only three of these eight suicides. I have previously explained the importance of psychological autopsies in preventing future suicides; ADC's failure to perform them on all suicides as a matter of course shows a startling level of indifference.

In addition, the psychological autopsies and mortality reviews that do exist are, with rare exception, rote formalities; the mortality reviews usually consist of little more than checking a

series of boxes. They seem to have been completed with very little care; for example, the mortality review for [redacted] states that there were "no clinical signs of depression or suicidality noted prior to successful attempt" (p. 2) – a statement that Mr. [redacted] medical record clearly shows to be false.

The deficiencies in these reviews are exemplified by the fact that, in the mortality reviews for [redacted] and [redacted] in the space for "Lessons Learned" the reviewer has written "None" (the "Lessons Learned" space in [redacted] mortality review was left blank). This is completely contrary to the purpose of mortality reviews in medicine. The purpose of these reviews is not to confirm that everything is fine, but to learn from bad outcomes and avoid them in the future. ADC's psychological autopsies and mortality reviews – both in the failure to perform them in all cases, and in the poor quality of those that are completed – fall far below the standard of care.

[redacted]

The defendants have not provided Ms. [redacted] medical file, so the only sources of information are the mortality review (which contains virtually no information) and the psychological autopsy. The latter portrays a chronically and severely mentally ill woman who had a clear escalation and worsening of symptoms in the two months prior to her suicide, with little or no apparent response from mental health staff.

Ms. [redacted] had a long history of suicidal ideation, as well as a suicide attempt by hanging (psychological autopsy (PA), pp. 7-8), meaning that she was at chronically high risk for suicide. She made statements indicating DTS (danger to self) in December 2012 and January 2013 (PA, p. 8). On January 21, 2013, she said "I dream to die," and the same day reported auditory hallucinations telling her it is "okay to die" (PA, p. 12). There is no indication whether or how these symptoms were addressed, or whether they affected risk assessment, diagnosis, or treatment planning.

On [redacted], Ms. [redacted] was seen by mental health and "denied any suicidal intent" (PA, p. 3). She hanged herself later that same day. There is no other information about this encounter with mental health. For example, why was she seen that day? By what level of mental health staff? What was her condition in terms of mood, thought process, speech, affect, and other elements of a mental status exam? What was the risk assessment? Given that this encounter with mental health staff occurred hours before Ms. [redacted] suicide, this lack of information is puzzling and concerning.

One other aspect of Ms. [redacted] mental health treatment raises additional concerns. The psychological autopsy states that Ms. [redacted] became "fixated" on breathing problems (PA, p. 4). This is a fairly common symptom of a panic disorder, but there is no indication that this diagnosis was ever considered, or that Ms. [redacted] ever received treatment for a panic disorder, which is a risk factor for suicide.

[redacted]

This man's medical record shows clear documentation of severe symptoms, including hallucinations, paranoia, psychosis, mood lability, and panic, for which he received little attention from mental health staff. A 10/14/12 note describes him as "crying," with very little mental health assessment, no plan to address this, and no referral to mental health (ADC 216263). Much of his contact with mental health staff consists of "cellfront check lists" which do not include a complete a mental status exam or fully evaluate hallucinations, anxiety, panic, or mood.

Throughout March and April of 2013 he is highly symptomatic, repeatedly placed on suicide watch, and at one point found to be "unstable with visual hallucination" (ADC 216424), but I can find no indication he is seen by a psychiatrist until April 18, 2013. On that date, Dr. Raza orders 450 mg Lithium BID, Risperdal 1.5 mg BID, Remeron 15 mg q pm and Cogentin 0.5 mg BID. This is a moderately aggressive starting dose for Lithium and Risperdal, which increases the risk of side effects and toxicity, yet there is no explanation in the note for this moderately aggressive regime. There are also no labs ordered; with these medications, the patient's Lithium needs to be monitored, as well as fasting labs done to establish a baseline when starting both Lithium and Risperdal. (ADC 216400-404). There is no MD follow-up until April 24, which is an unacceptably long time for a patient being started on such a combination of medications. (ADC 216393).

On May 7, 2013, Mr. [redacted] is seen by Dr. Winsky, who notes that "voices continue," but inexplicably checks the box indicating "no hallucinations" (ADC 216390). Dr. Winsky changes Mr. [redacted] medications, but provides no rationale for these changes; he also fails to perform a mental status exam. Dr. Winsky's order for these medication changes is dated May 17 – ten days after he wrote the note with the plan to make these changes (ADC 216379). This extraordinary delay falls far below the standard of care particularly where, as here, the patient has been highly symptomatic and suicidal in the interim. It appears that Mr. [redacted] was not seen by a psychiatrist again before he hanged himself on [redacted].

On May 15, 2013, Mr. [redacted] was pepper-sprayed, apparently because he "was in cell [and] began to sob and started punching cell door." ADC 216281. To pepper-spray this seriously mentally ill person, who was obviously already in great distress, was completely inappropriate. It almost certainly aggravated his mental illness and may well have contributed to his suicide.

[redacted]

Mr. [redacted] problem list indicates "multiple [psychiatric] meds" (ADC213613). The psychological autopsy recounts "a history of recurrent depression," past psychiatric treatment with antidepressants, and a suicide attempt while incarcerated. These factors identify him as a high risk for suicide. And yet his chart reveals absolutely no mental health evaluation or treatment in the last year of his life. This is particularly inexplicable given that Mr. [redacted] as a

prisoner under sentence of death, was held in conditions of extreme isolation in ASPC-Eyman Browning Unit. Such conditions are well known to significantly increase risk of self-harm and suicide.[1] It is very concerning that a prisoner with this history, held in such conditions, would not receive any monitoring of his mental health and risk of suicide.

Mr. [redacted] committed suicide by taking "a massive overdose of amitriptyline – a medication that had not [sic] prescribed to him" (PA, p. 2). The fact that a prisoner with a history of recurrent depression and a suicide attempt while incarcerated, housed in conditions known to increase the risk of suicide, was able to obtain and stockpile a lethal dose of a medication not prescribed to him demonstrates major deficiencies in ADC's suicide prevention program.

[redacted]

This is an egregious case of indifference to and neglect of a person who was obviously at very high risk of suicide. A 10/17/12 "initial mental health assessment" notes a history of suicidal ideation and multiple suicide attempts by highly lethal means (hanging in 2009, shooting 5 months prior to the intake, presumably May 2012), as well as auditory hallucinations and paranoia (ADC 216457-58). A "reception center screening" form on the same date notes current depression and anxiety. ADC 216463. The following day, Mr. [redacted] submitted an HNR asking to talk to mental health "ASAP please." ADC 216499. None of these resulted in any contact from mental health. Upon transfer to Eyman-SMU on 11/27/12, he rated his depression 7 on a 10-point scale. ADC 216507. A "cellfront visit checklist" note on 12/28/12 indicates "depressed – hasn't seen [psychiatry]" ADC 216501.

Mr. [redacted] hanged himself on [redacted] at the age of 22. I can find no evidence that he was ever seen by a psychiatrist.

The mortality reviewer for Mr. [redacted] answers the question "Was sufficient care offered/provided regarding Mental Health issues?" by checking the box indicating "no." The reviewer also checked boxes for "failure to recognize symptoms or signs," "delay in access to care," "failure to follow-up/identify abnormal test results," and "failure of provider to assume responsibility for patient." The reviewer also provides the following narrative:

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[1] A February 2014 study in the American Journal of Public Health found that detainees in solitary confinement in New York City jails were nearly seven times more likely to harm themselves than those in general population, and that the effect was particularly pronounced for juveniles and people with severe mental illness. *See* Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104:3 AM. J. PUBLIC HEALTH 442, 442-447 (March 2014), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742

> Patient initially reported no history of mental health hospitalizations, but subsequently did report he was treated briefly after a previous suicide attempt. He also reported two prior suicide attempts, one by hanging and one by shooting. It is notable that the most important indicator of a successful suicide is the number of previous attempts. Patient placed a HNR to see mental health services on 10/08/12, but was not seen for the remaining 6 weeks while he was held at the Phoenix intake site and remained classified as MH-1. When transferred to Eyman complex, he reported on 11/27/12 that he has significant degree of depression. However, no mental health follow up was scheduled as a result of his intake evaluation. Patient was seen on 12/26/12 by mental health and self-reported recurring suicidal ideation, and was placed on ten minute watch. He was taken off of watch on 12/28/12 and was not seen by mental health again prior to his suicide.
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> Per psychological autopsy:[2] mental health score incorrectly entered into AIMS as MH-1, HNR requests for mental health services at Phoenix not acted upon, intake at Eyman showed depression, but was not referred for further services, was not seen every 30 days as required by policy, no further follow up evaluation conducted after release from suicide watch.
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> * * *
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> There were signs of suicide present that were not acted upon.

The mental health care provided to Mr. [redacted] falls far below the standard of care, and contributed to his suicide.

[redacted]

According to the mortality review, this man had a history of depression requiring hospitalization, which indicates a high risk of suicide. Security referred him to mental health on 2/23/12 for suicidal ideation; the patient said he was in debt to other prisoners and thought his best option was dying. He requested protective custody in November 2012 due to difficulties with other prisoners. The reviewer also writes that "suicidality my [sic] have been exacerbated by numerous letters from his wife in Texas telling him she loved him but still needed to have sex with her boyfriend." Mortality review, p. 2.

An 11/1/12 note by an RN reads "IM to medical for protective segregation screening. Form was completed. IM denies having any suicidal thoughts." ADC213972. This is entirely inadequate as a risk assessment for a prisoner with a history of major depression and recent suicidal ideation who is currently feeling threatened to the point of seeking protective custody. The "Initial Protective Segregation Inmate MH Screening" form, also dated 11/1/12, indicates that Mr.

[2] No psychological autopsy for Mr. [redacted] has been provided to me.

[redacted] "seriously thought about committing suicide" about four years ago. ADC 213997. The first mental health note after this event is an unsigned 11/27/12 chart review. Although the note indicates a history of suicide attempt, the reviewer checks the box for "inmate requires no referral to mental health services at this time." Again, there is no risk assessment or mental status exam. ADC 213996. I can find no indication that Mr. [redacted] was seen by mental health again before his suicide on [redacted]. I can also find no indication that he was ever seen by a psychiatrist, psychologist, or other qualified mental health staff in the year preceding his suicide. Mr. [redacted] treatment falls below the standard of care.

[redacted]

The mortality review for Mr. [redacted] contains virtually no information. According to the psychological autopsy (titled "Completed Sentinel Event Review Form"), he had a diagnosis of depression NOS (ADC 211763), and had taken Remeron due to depression while in the county jail. ADC 211770. Yet his record indicates absolutely no mental health treatment or monitoring in the year preceding his suicide on [redacted], and the psychological autopsy confirms that his last contact with behavioral health was on 8/20/12. ADC211765. This is far below the standard of care, particularly given Mr. [redacted] history of depression and the fact that he was housed in the isolating conditions of Florence-Central Unit.

The psychological autopsy indicates that Mr. [redacted] requested protective custody on the day of his suicide, and was moved to a new housing unit as a result, but there is no further discussion of this obviously significant event. There is no indication that any suicide risk assessment was performed at this time, which should be routine in the case of a prisoner seeking protective custody.

The psychological autopsy is internally contradictory in several respects. For example, p. 3 indicates that a suicide risk assessment was completed; p. 5 says there is no documentation of such an assessment. Page 4 indicates that Mr. [redacted] was taking no medications, but also says that he takes ">80% of scheduled doses." Such obvious errors reflect a lack of care in completing the psychology autopsy, and render it unreliable as a source of information and therefore of very little value in preventing future suicides.

Another deficiency involves the fact that Mr. [redacted] committed suicide by cutting the blood vessels in his elbow. This raises the obvious question how he was able to obtain a cutting instrument able to inflict such lethal injuries while housed in a maximum security unit, immediately after being moved to a new cell. In addition, this is a method of suicide that typically takes a relatively long time to result in death. There is a note that there was "difficulty maintaining patient airway due to I/M stiff neck" (ADC 211773), suggesting that rigor mortis may have set in by the time Mr. [redacted] was found. The fact that Mr. [redacted] was not found until he was dead, possibly with rigor mortis, indicates a serious deficiency in ADC's monitoring practices.

[redacted]

The treatment received by Mr. [redacted] was below the standard of care.

Mr. [redacted] had a diagnosis of Psychotic Disorder NOS and was classified as MH3. ADC 218345. On 7/5/12 he sees the psychiatrist, who changes his diagnosis to Dysthymic Disorder and prescribes Wellbutrin. There is no explanation for this change to a very different diagnosis. ADC 218379. On 8/14/12, Mr. [redacted] submits an HNR saying "Please cancel my Wellbutrin. Things started out remarkably well, but at about 4 weeks it all went very, very bad, with crippling depression, OCD, hostility and apathy." ADC 218368.

Mr. [redacted] is not seen by the psychiatrist until 9/6/12. This is far too long a delay given the very serious and dangerous symptoms he described on 8/14/12. The 9/6/12 psychiatrist's note indicates that Mr. [redacted] stopped taking Wellbutrin because "it didn't agree with him," but there is no explanation of the nature of his adverse reaction; no risk assessment; and no plan except to discontinue Wellbutrin. ADC 218376. It appears that after this, Mr. [redacted] was simply ignored; the mortality review (p. 3) indicates that this was the last time he was seen by mental health before his suicide by hanging more than eight months later on [redacted]. A 9/21/12 "cellfront visit checklist" indicates that Mr. [redacted] was dysthymic, irritable, depressed, and angry, but this apparently generated no follow up by mental health. ADC 218377.

In addition, Mr. [redacted] received inadequate medical care that may well have contributed to his suicide. His Thyroid Stimulating Hormone (TSH) levels were elevated at 6.28 on 7/18/12 and 6.29 on 2/13/13. ADC 218361, 218363. This indicates possible hypothyroidism, which can exacerbate depression. Because there are no Medication Administration Records (MARs) in the file, it appears that this condition went untreated, which would have greatly increased Mr. [redacted] risk of suicide.

[redacted]

An "Initial Mental Health Assessment" from 3/12/13 documents a previous diagnosis of Bipolar Disorder vs. Paranoid Schizophrenia, as well as multiple current medications including Lithium, Risperdal, Tegretol, Propranolol, and Benztropine. Mr. [redacted] says he hears voices and sees shadows, feels paranoid, and has serious episodes of depression "at night, every other day." The form also notes previous psychiatric hospitalization, "10-15" previous suicide attempts, with the most recent "3-4 months ago." An incomplete mental status exam shows he is distracted, confused, disheveled, and anxious, with inappropriate affect and disjointed speech. This assessment, though incomplete, strongly indicates a possible psychiatric emergency requiring hospitalization; yet the only apparent response is to refer Mr. [redacted] to psychiatry "@ next yard." ADC218384-85.

There is a 3/12/13 note by Dr. Cleary, indicating "continue with current medications," and attaching a prescription. There is no mental status exam, no risk assessment, no diagnosis, and

no rationale for prescribing these medications at these doses, which are relatively high. ADC218397, 218399.

On 3/26/13 Mr. [redacted] is seen by Dr. Bishop who, without explanation, changes his diagnosis to Anxiety Disorder NOS and Mild Mental Retardation, discontinues all his medications, and prescribes 45 mg Remeron instead. This is completely outside the norms of reasonable practice and highly dangerous. The discontinuation of relatively high doses of five medications put Mr. [redacted] at grave risk of recurrence of past symptoms, including psychosis, depression, anxiety, and suicidal ideation. Also, the starting dose for Remeron is 15 mg; 45 mg is the maximum dose. There is no documentation of the rationale for this change or acknowledgment of the risks to the patient. Follow-up is indicated as 3 months, which is far too long given this drastic medication shift. ADC218431-33.

On 4/6/13 Mr. [redacted] files an HNR saying "I would like to see the mental health doctor reason being is that I would like to speak to him about some concerns relating to my meds, if I may be seen ASAP please." ADC 218426.

On 4/16/13 Mr. [redacted] sees Dr. Bishop again. Dr. Bishop notes continuing anxiety and checks a box indicating "mood disturbance," but provides no explanation. He continues Remeron and adds Buspar 30 mg BID. Again, this is the maximum dose and inappropriate as a starting dose. Dr. Bishop again indicates follow-up in 3 months. ADC 218429. Mr. [redacted] killed himself [redacted] days later.

It is very likely that these drastic and dangerous medication shifts, combined with poor follow-up, contributed to Mr. [redacted] suicide on [redacted].

Dated this 24th day of February 2014, at San Francisco, California.

PABLO STEWART, M.D.