CONFIDENTIAL REPORT OF
TODD RANDALL WILCOX, M.D., M.B.A., C.C.H.P.-A

Parsons, et al. v Ryan, et al.

No. 2:12-cv-00601-NVW

NOVEMBER 8, 2013

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I, Todd Wilcox, declare:

I have personal knowledge of the matters set forth herein and if called as a witness I could competently so testify.

I. Introduction and background

This report assesses Arizona's prison medical care by reviewing the system's building blocks (such as adequate staff and facilities) and its performance in four broad categories: timely access to care, the exercise of professional medical judgment, delivery of care that is ordered, and processes to minimize preventable negative outcomes. I found major deficiencies in all of these primary drivers of healthcare, as I discuss in detail below.

A. Qualifications

I have worked as a physician in jail and prison environments for 17 years. My opinions in this case are derived from extensive experience in the design, administration, and delivery of correctional healthcare as well as the national standards that govern the field. I actively practice in correctional healthcare as the Medical Director of the Salt Lake County Jail System and I am frequently called upon as a consultant to assist facilities and organizations nationally in improving their delivery of care, including Maricopa County (Phoenix, AZ), California Department of Corrections and Rehabilitation, Mississippi Department of Corrections, Pima County (Tucson, AZ) Department of Institutional Health, Seattle-King County Jail System (Seattle, WA), the National Commission on Correctional Health Care (Chicago, IL), the National Institutes of Corrections, the American Jail Association, the American Correctional Association, and The Rand Corporation.

I am one of a select group of individuals to have achieved the advanced level of certification in correctional healthcare (CCHP-A) from the National Commission on Correctional Health Care and I frequently present to national audiences on pertinent

topics in this field of medicine. I am the president-elect of The Society of Correctional Physicians and I am currently the chairman of the National Commission on Correctional Health Care's Committee on Physician Certification.

My curriculum vitae is attached as Appendix A. The cases in which I have been deposed and/or given trial testimony in the last four years are listed in Appendix B, along with my rate of compensation for my work on this case and publications subsequent to those listed on my curriculum vitae.

B. Information sources

I undertook an extensive investigation to develop my opinions expressed in this report. I reviewed thousands of pages of documents produced by the State in this case, as well as documents produced by Wexford and Corizon. I reviewed well over a hundred partial and full healthcare records of Arizona prisoners and carried out several dozen patient interviews. I reviewed depositions of prisoners, Arizona Department of Corrections (ADC) staff, and Wexford and Corizon staff as well as Defendants' Responses to Plaintiff Verduzco's First Set of Requests for Admission. These documents are listed in Appendix C. In addition, I reviewed documents during the course of my tours, such as binders and loose filing and notices posted on the walls. I describe these documents in the course of this report.

I toured five prison complexes in Arizona: Phoenix, Perryville, Yuma, Florence, and Tucson. At each complex, I viewed the majority of the clinical and support facilities where medical care was prepared and delivered, including inpatient units, exam rooms, urgent care facilities, medication rooms, medical records rooms, and medical supply rooms. I also witnessed pill call at Yuma's Cheyenne Unit and I toured one food preparation unit. I reviewed numerous healthcare records, logs, and binders (such as descriptions of medical diet options and medication administration processes).

C. Methodology

I reviewed several dozen patient healthcare records at every prison I toured. I did not review a random sample; instead, I chose to look at files of specific types of prisoners. This is because when evaluating a healthcare delivery system, it is not generally as helpful to examine care for healthy people as it is to look at the treatment of sick people, particularly those with complex or chronic conditions that require coordination, communication, and judgment. Therefore, I attempted to focus on records of people with diabetes, hypertension, HIV, kidney failure, hepatitis, and infections. I reviewed records for cancer patients and pregnant women, and for people who had been identified on ADC's monitoring reports as not receiving tests or specialty care or experiencing other problems with care. I reviewed records for the class representatives. I also looked through lab reports, diagnostic test logs, and Health Needs Requests on site at each facility to identify patients who had objective findings that were concerning and then I asked for their charts to be pulled for my review and if I found areas of concern I would frequently request that the patient be pulled for me to interview to confirm my findings.

I felt it was important to speak directly with the patients in order to gather additional information and to make my own professional medical judgment with respect to the acuity of their illness as best I could without being able to examine them except visually. I also randomly spoke to prisoners on my tours about their healthcare challenges and I routinely reviewed their medical files in order to verify the information they gave me. I asked prisoners about information I heard from staff, and staff about information I heard from prisoners. I was able to verify information I gathered through consulting multiple sources and triangulating the information available to me.

On the tours of the institutions, my goal was to observe general living conditions for the patients and the working conditions for medical care staff. I performed a basic check to see if the standard equipment was present and to get a broad sense of how the

flow of patient care operated, from screening to sick call to routine appointments and medication administration to chronic care.

Although my role on these tours was to gather information, I felt obligated to report life-threatening cases to the prison officials and attorneys for the State and for Corizon who accompanied me on these tours when I discovered them. I reported such problems at Perryville ([redacted]), Yuma ([redacted]), Florence ([redacted]), and Tucson ([redacted]), many of whom are discussed in some detail in this report.

D. Acronyms

Although I try to avoid professional lingo, a certain number of acronyms are unavoidable in the healthcare and correctional contexts. Throughout this report, I refer to the following, some of which are Arizona-specific terms:

CNA Certified nursing assistant

CO Correctional officer

DOT Direct observation therapy (medications that patients must take in view of medical staff who give it to them)

HCP Health care provider[1]

HNR Health needs request

ICS Incident Command System (emergency response protocol)

IPC Inpatient Care Unit

KOP Keep on person (medications that patients can self-administer)

LPN Licensed practical nurse

[1]For purposes of this report, I use the term "provider" to mean primary care provider: physician, nurse practitioner, or physician's assistant.

PA Physician's assistant

RN Registered nurse

II. Opinions

In my opinion, the medical care provided in Arizona prisons is significantly below community standards and places patients at serious risk of harm. In order to provide community standard of care in a correctional setting, a system must be in place – complete with centralized management, policies and procedures, adequate staff and clinical space and budget – that allows patients reasonable access to healthcare providers, professional clinical judgment on their case, delivery of the care that is ordered, and self-correcting processes designed to minimize preventable negative outcomes. I discuss defendants' systemic deficiencies in each of these major categories in the following sections. I identified these deficiencies in my reviews of patient healthcare records and interviews with patients as well as in the documents produced by the State and others and the depositions of various staff and administrators.

I toured five of the ten prison complexes in the Arizona system and undertook thorough reviews of the care at those institutions. My findings in this report are system-wide, however, and not just confined to those five complexes. I am confident in making systemic findings for several reasons. First, the deficiencies in care were consistent across the prisons that I toured. I found some variations and distinctions, but overall the prison complexes I toured were subject to the same serious problems, as described throughout this report. Second, those problems were of a system-wide nature, caused by deficits in organizational structure, staffing, and quality assurance measures that are not the responsibility of individual prisons to develop. In addition, I have seen testimony that policies and practices are statewide, as are the deficits. Third, I reviewed many dozens of healthcare records of prisoners who had been housed at prisons around the state. I have therefore reviewed care from a wide range of prisons beyond what I toured. Finally, I have reviewed numerous documents attesting to poor care and serious deficits throughout

the system. These documents are listed in Appendix C and I allude to them throughout the report.

Before I move on to a methodical review of the elements of the healthcare delivery system, I would like to discuss an emblematic case. One patient I met in my investigation experienced so many errors in so many areas that his case serves as an introduction of sorts to the remainder this report.

[redacted] whom I met in Yuma's La Paz unit on August 1, 2013, has experienced horrendous care in ADC with potentially disastrous consequences. On April 19, 2013, he received a diagnosis of advanced colon cancer as a result of an emergency department visit for abdominal pain. As of August 1, it had not even been staged. Staging is critical for cancer cases and it requires a number of diagnostic tests in order to know how extensive the cancer is at the time of diagnosis. All treatment plans for cancer depend heavily on staging because the treatment plans vary widely based on the severity and spread of disease. On a fundamental level, the staging process answers the question regarding whether the cancer is locally contained or whether it has metastasized to involve organ systems other than where the cancer started. The failure to stage this new cancer diagnosis guaranteed that care could not proceed because no treatment plan could be formulated. His medical records contain a referral for consultation, but it had not yet been done in early August. This is a patient for whom every day counts, and more than 100 days had passed since initial diagnosis without even taking the first step toward a treatment plan.

There were numerous serious errors in his care. It is a screening failure: he should have had a screening colonoscopy at age 50 (he is 51 currently). It is an access to care failure: on December 12, 2012, he complained of lumps and bowel problems but received no follow-up; on January 10, 2013, a physician's assistant saw him for his complaints of lumps in stomach and change in bowel habits on the provider line but did not perform a rectal exam or perform a test for blood in his stool; on January 21, 2013, his labs showed

that he was anemic with strong evidence of iron deficiency, which is very common in colon cancer cases, but the physician's assistant did nothing to evaluate these abnormalities further when he signed off the labs. On March 7, 2013, a prison doctor ordered a screening test for colon cancer that came back positive (occult blood positive); the test result was sent to the facility doctor for review and no action was taken to evaluate this abnormal critical lab further. Staff did not know he had cancer until April 19, when they found a huge tumor and obstructed bowel. They should have known far earlier. [redacted] was not referred to oncology until May 8 and not seen until July 5. The PET and CT scans ordered at that time to accomplish the staging had not been done by early August.

His case also shows additional treatment planning failures: he has no teeth and cannot open his mouth well and he has a deformity of his gumline. As a result, it is not possible to fit him with dentures without completing some dental surgery to enable the dentures to fit properly. In cancer patients it is critical to maintain nutrition, weight, and hydration to help them deal with their treatment. Dealing with his eating limitations is a long-term planning issue. I saw no evidence of any such planning in his file, and he told me there had been none, to his knowledge. Instead of treating him so he can effectively masticate, the prison system has left him untreated and edentulous. I saw him again at the end of October when I toured Tucson and he was edentulous and he appeared much more gaunt and in significant pain. He informed me that he had seen the oncologist on October 24, 2013, and that chemotherapy had finally been ordered. He was six months after initial diagnosis of his cancer and treatment had yet to begin.

Moreover, his case shows medication failures: he has severe pain from his advanced colon cancer and obstructed bowel. At Yuma, he was given Vicodin (hydrocodone / acetaminophen) four times a day, which is a short-acting pain killer that is medically inappropriate for chronic cancer pain. To make matters worse, the Facility Health Administrator at Yuma executed a written order dated June 21, 2013, that I saw

posted that mandated that all pain medication be crushed prior to administration, which greatly reduces the duration of effectiveness of an already short-acting medication. As such, his pain regimen was inappropriate and ineffective for the severity of his disease.

Finally, his case raises serious ethical concerns: when I saw him again by chance in Tucson he told me that his pain regimen had been changed to longer acting medications but that the nursing staff refused to give him his pain medications until he signed a broad waiver of care that was initiated by his assigned nurse with no physician involvement. By his account, this waiver – which I reviewed, and on its face find unethical and deeply disturbing – was offered to him under troublingly coercive circumstances. I discuss the profound ethical and legal violations inherent in this situation below, in Section II.B.6.

In sum, this patient's experience displays the incompetence, heartlessness, and deliberate indifference I found throughout the system as a whole. [redacted] is dying a needless, painful, and preventable death.

A. Essential building blocks to a correctional healthcare delivery system

It is well established that functional healthcare delivery systems are comprised of certain building blocks that allow them to provide effective care. As all competent healthcare administrators know, the failure to carefully design, implement, and maintain these building blocks can cause a system to devolve quickly into chaos and substandard care. In the Arizona system, I found ample evidence that most of these elements are either missing or profoundly flawed.

1. Centralized organization/management structure

It is axiomatic that a functional system must be well structured, with clear lines of authority, oversight, and accountability. The healthcare delivery system in Arizona prisons has none of these characteristics. Instead, it has experienced years of chaos. The State ran its own healthcare system for many years, before contracting to the lowest bidder in July 2012. Wexford, the company that won the contract, by ADC's own

account failed utterly to implement a healthcare system that met minimum constitutional requirements, and was replaced in early March 2013 by Corizon, the next lowest bidder. Corizon has run healthcare in the Arizona prisons since that time.

(a) ADC to Wexford to Corizon

It is clear from the documents and depositions I have reviewed that medical care has been systematically deficient during these transitions.

With ADC in charge prior to July 2012, healthcare reportedly suffered from many of the same deficits I see in the present system and discuss throughout this report, including failures in intake screening, with "grossly incomplete" transfer summaries, poor documentation of medical histories, and failure to provide preventive care (WEXFORD000023-25)[2] ; medical records that were disorganized, incomplete, and sometimes lost (27, 68); chaotic and unreliable chronic care (29, 73); poor care for HIV patients, with incorrect dosages and medication combinations that placed patients at risk for developing drug-resistant HIV (35); a backlog of thousands of referrals for outside specialty consultations dating to 2008 (39-40); lack of negative airflow infirmary beds (43); care "below acceptable standards" (46), inadequate or nonexistent quality improvement programs and "[w]idespread quality deficiencies" (54); nurses practicing outside the scope of their licenses (59); and "longstanding medication administration practices that were not only dangerous and outside accepted scope of practice, but also threatened nurses' licensure" (66-67). In sum, "[t]he ADC system is broken, and does not provide a constitutional level of care." WEXFORD000003; see also ADC048247-48250. More specifically, "[a]fter working within the ADC inmate health care system for four months, Wexford Health finds the current class action lawsuits to be accurate." WEXFORD000003; see also WEXFORD000130 (same), WEXFORD000075 (as of

[2] The citations in this sentence are to documents produced by Wexford, with the Bates number prefix WEXFORD0000. For the sake of efficiency, I do not repeat the prefix for each citation.

November 2012, "[p]rocesses and practices outlined in detail in the ADC's current class action lawsuits remain present; the ADC has not shared any improvement plans with Wexford Health"). At least one high-level ADC official admits to problems pre-dating Wexford's arrival. ADC's Medical Program Administrator admits that chronic care was a problem when ADC ran its own medical care because of short-staffing. Deposition of David Robertson, August 26, 2013 (Robertson Depo), at 65:1-65:6.

Wexford's eight-month tenure in Arizona was rife with serious problems. On September 21, 2012, ADC sent a "Written Cure Notification" to Wexford's Director detailing 20 significant areas of non-compliance, including, again, the same problems outlined in this report: lack of basic building blocks of a healthcare delivery system (inadequate staffing leading to treatment failures; inadequate quality assurance measures; poor communication between field staff, prison administrators, and Wexford); failure to provide timely access to care (patients not getting seen, patients' health needs requests and grievances ignored, chronic care patients not identified); and failure to provide care that is ordered (medication delivery failures, interruptions, discontinuations and changes; specialty care not provided). ADC027854-ADC027860. All deficiencies were identified at all ten ADC complexes. *Id*. at ADC027863-ADC027869. Wexford, in response, did not dispute the deficiencies; instead, they placed the blame on ADC, stating that they could not cure them in 90 days and that most "are long-standing issues, embedded into ADC health care policy and philosophy, and which existed well before Wexford Health assumed responsibility for the program." ADC027941-ADC027942.

In March 2013, Corizon assumed responsibility for healthcare in Arizona prisons. This report is grounded on information dated since that time, although I include older data when relevant. The current fundamental failures I describe are nearly identical to Wexford's portrait of ADC (WEXFORD000001-131) and to ADC's portrait of Wexford. ADC027854-27860. Corizon has clearly has not managed to turn this ship around.

There are surface differences between ADC and Wexford and Corizon, but care has been egregiously bad for years, under direct supervision of all three. I can state this confidently not only because of the finger-pointing reports from ADC and Wexford, but also because the types of problems I found and describe in this report – such as the widespread failure to follow policies, provide timely care, and deliver appropriate medications -- are chronic ones that do not develop overnight. I have also seen compelling evidence, in patients' charts and in the documents and depositions I have reviewed, that the problems are of long standing.

Privatization is inherently risky in the correctional realm, as Joe Profiri, ADC's Contract Bed Operations Director, points out: the profit motive leads to corners being cut. AGA_Review_00037464 ("Wexford by design will maintain minimum staffing to maximize profits"). It also leads to dilatory and inadequate responses to serious and life-threatening treatment failures: I agree with Mr. Profiri that Wexford (and Corizon as well, from my review) has displayed a lack of urgency to repair the problems, which "is all to[o] often a component missing with privatization." AGA_Review_00037465.

As Mr. Profiri stated, "Wexford's failure[s] in many ways are our failures." AGA_Review_00037462. The same is true of Corizon, and any private company the State contracts with to provide essential services. ADC is ultimately responsible for the lengthy catalogue of deficiencies and damage I describe in this report.

(b) Current oversight: the MGAR system

The oversight structure Arizona uses to monitor Corizon and ensure that care is delivered in its prisons is the Monthly Green-Amber-Red (MGAR) reporting process. In this system, certain performance measures -- such as timeliness of sick call, scheduling of urgent specialty consultations, and appropriate medical records filing -- are selected each month. Not all measures are monitored all the time. Declaration of Kathleen Campbell, Dkt. No. 707-1, October 28, 2013, at ¶ 4. The ADC monitor measures compliance for the selected performance measures, and enters a finding of green, amber, or red to

indicate compliance levels. *Id.* The computerized system automatically generates an emailed request for a corrective action plan (CAP) to Corizon to address each individual deficient finding. *Id.* at ¶ 7. Any CAP is entered into the MGAR system, but the monitor does not know unless he or she looks for it in the system, and the CAP for each individual performance measure is stored separately, making the review of a large number of CAPs onerous. *Id.* at ¶¶ 8, 11-12.

The MGAR process, while providing extensive evidence of the deficiencies of Wexford's and Corizon's performance, is a failure as a management oversight structure. While the MGAR reports are helpful for pointing out certain errors and omissions, they are not effective measures of compliance. At least one monitor agrees: the Perryville monitor testified that MGARs are "probably not" a fair representation of compliance. Haldane Depo, 136:20-137:5. The Corizon Vice President for Operations testified that she did not think the MGARs were a meaningful quality assurance process. Deposition of Vickie Bybee, October 10, 2013, at 6:17-6:18, 90:10-90:14; 91:7-91:20.

There are several reasons for this. First, monitors have no meaningful standards. The MGARs list performance standards and rate them on a color based system (green, yellow, and red) to indicate compliance levels. The scoring is arbitrary, there are no scoring standards, and the results do not conform to anything that resembles meaningful performance grading. Deposition of Kathleen Campbell, September 11, 2013, at 71:8-71:12 (no scoring criteria). The deficiencies associated with this process are demonstrated by the monitors themselves: Deposition of Arthur Gross, September 9, 2013, at 107:6-107:12 (individual monitors decide based on own judgment when a deficiency changes from amber to red); Deposition of Marlena Bedoya, September 10, 2013, at 113:15-113:24, 158:24-159:13 (decisions about severity and significance of data reported in MGARs based on personal feelings; Tucson monitor has no rubric); Deposition of Jenny Mielke-Fontaine, September 20, 2013, at 98:24-99:1, 238:16-238:21 (difference between amber and red is "subjective"), 229:9-229:24 (MGAR "is a

subjective tool"), 317:10-317:16 (no policy directs monitors on number of charts to review); Deposition of Anthony Medel, September 17, 2013, at 64:5-65:8, 192:25-193:8 (no personal rules for Yuma monitor about what colors correspond to what percentages compliance); Deposition of Mark Haldane, September 18, 2013, at 162:6-163:21 (although specific performance standard not met, it was marked green by Perryville monitor because "other deficiencies [are] of higher priority" and "if everything is a priority, then nothing is a priority"), 164:2-164:10, 165:12-166:14 (green rating for one item despite noncompliance over 30% because "progress [was] being made").

Second, the rating system is unreliable. I found deplorable treatment errors and systemic deficiencies in care at the Yuma complex, but the ADC monitor has never given Corizon a red mark because he does not believe they have warranted it. Medel Depo, 116:22-116:23. He rated one item amber that had a 44% compliance score, down from 55% the previous month. Medel Depo, 215:12-220:13. The same monitor was unable to explain why he rated Corizon better on staffing in June 2013 than in July 2013, despite the fact that staffing numbers were better in July. Medel Depo, 209:7-213:21.

Third, some monitors also lack the necessary skills to be effective. Mark Haldane, the Perryville monitor, has no formal health training at all. Haldane Depo, 13:9-13:11. Arthur Gross, ADC Assistant Director over the Health Monitoring Bureau which is responsible for the monitoring, has no clinical medical training. Deposition of Arthur Gross, September 9, 2013, 10:4-10:14.

Compounding all these problems is the fact that the individuals in charge of the healthcare system do not take the monitors or their reports seriously. Mr. Gross, the Health Monitoring Bureau chief, does not read the monthly MGAR reports or any CAPs from Corizon. Gross Depo, 13:17-14:2 (MGARs), 97:4-97:9 (CAPs). ADC's Medical Program Administrator similarly does not read the monthly MGAR reports. Robertson Depo, 79:13-79:16, 120:6-120:12. He knows so little about the process that he believes that if a monitor identifies a specific problem as amber status in an MGAR, it is the

monitor's responsibility to follow up on the problem and see that it is addressed (a responsibility disavowed by the monitors, as I discuss below). Robertson Depo, 83:11-83:21.

Although MGARs are inadequate measures of compliance, they do contain valuable information about deficiencies; many of my conclusions are informed by the problems they describe. However, I see no evidence that the MGAR process has contributed to any solutions for these problems, primarily because there is no evidence that the monitors or anyone else takes appropriate action to correct problems, even if they find chronic noncompliance. Bedoya Depo - Tucson, 160:8-160:21 (not the monitor's responsibility to take action if a measure is in noncompliance for consecutive months), 220:17-221:3 and 221:9-221:12 (monitor can't fix problems); Haldane Depo – Perryville, 78:5-78:17 (his responsibility is to report the problem; he can't force compliance), Haldane Depo – Perryville, 63:22-65:4, 176:25-178:23, 65:8-65:24 (monitor's role is to "keep reporting it, and if it's important to somebody above my level, then they can get it corrected. If it's not that big of a deal, if nobody cares, then it probably isn't my job to care either"), 53:12-56:1 ("no powers to force [Corizon] to do anything"); Mielke-Fontaine – Florence, 212:23-213:5 (Corizon's job, not hers, to solve problems), 213:6-213:10 (no change to her responsibilities if she finds repeated, chronic noncompliance).

The utility of these reports is further limited because monitors do no analysis: they do not investigate causes of noncompliance. Bedoya Depo - Tucson, 196:4-196:7 (no investigation of causes for noncompliance); Mielke-Fontaine Depo – Florence, 112:4-112:7 (not her job to look at past performance), 299:8-299:9 (no analysis of MGAR data), 196:7-197:23 (found poor compliance with patient access to care in July 2013, but did no follow-up or analysis).

There are also areas of oversight that the MGARs do not even address. For example, ADC does not monitor whether Corizon performs adequate training or orientation for staff. Gross Depo, 95:17-95:20. The MGAR process does not address

whether informed consents have been obtained. Deposition of Kathleen Campbell, September 23, 2013, at 52:19-53:6. The monitor for the Phoenix complex, where all male ADC prisoners undergo intake screening, does not know the requirements for intake medical screening; her job is merely to "monitor if they have complied with completing all the forms. . . . Medical, clinically what they're to be doing. . . that's not my area." Deposition of Helen Valenzuela, August 23, 2012 (Valenzuela Depo), 87:20-89:20.

The monitoring ultimately is ineffective. The CAP process is, essentially, a farce: chronic noncompliance is simply reported over and over and over again, and to the extent CAPs are even produced, nobody appears to review them to see if they are effective. Campbell Depo (September 11, 2013), 90:11-90:13 (statewide nursing monitor did not track whether she or the nurses she supervised ever received a CAP); Winland Depo, 41:16-41:23 (statewide pharmacy monitor has never seen a CAP); Haldane Depo – Perryville, 54:1-55:12 (CAPs had "canned responses" that "in many instances [were] not responsive to the issue that was raised"), 56:12-57:17, 143:3-143:17; Mielke-Fontaine Depo – Florence, 101: 6-101:9, 102:2-102:18 (doesn't know whether CAPS required for amber or red findings). The persistent deficiencies that plague ADC institutions highlight the inefficacy of the review process.

2. Consistently followed policies and procedures

Policies and procedures are fairly standardized across correctional healthcare systems. In the Arizona system, I was struck by the widespread violation of the policies and the lack of oversight and accountability that would compel compliance.

Basic healthcare policies – such as those governing sick call timelines, chronic care management, healthcare records filing, and specialty consultations -- are violated in the Arizona system to a distressing degree. For the sake of space, I will not repeat here the evidence set forth throughout this report, particularly in Sections II.B.1, II.B.2, II.C.2, II.C.3, II.C.4, II.D.1, and II.D.2.

In addition to its abysmal record in following its own policies, Arizona also lacks some critical written policies. The following are all policy omissions that fall below community standard of care for correctional healthcare systems: (all citations are to Defendants' Responses to Plaintiff Verduzco's First Set of Requests for Admission, June 11, 2013): ADC policy does not require diabetic prisoners be referred to ophthalmology if healthcare staff detect the presence of retinopathy (Response 211); ADC policy does not require that healthcare staff consult with an HIV specialist prior to initiating, changing, or discontinuing medications for HIV positive prisoners (Response 241); ADC policy does not require that prisoners with COPD be given an annual pneumonia or flu shot (Responses 199-202); ADC policy does not require that prisoners on anticoagulants have their blood tested every 4 weeks to measure their INR levels, and if the level is not within the therapeutic range that they be monitored every 7 calendar days (Responses 193-196); ADC does not have a tuberculosis control program at each prison complex (Response 167); ADC policy does not require that prisoners with symptoms of pertussis be single-celled (Response 171); ADC policy does not require that prisoners with symptoms of influenza be single-celled (Response 173); ADC policy does not require that healthcare staff always have a sharps container within arm's reach when using a needle or sharp instrument to reduce the possibility of blood-borne pathogen exposure (Response 189); ADC policy does not require prisoners suspected or confirmed to have chicken pox be isolated in a negative pressure room (Response 179); and ADC policy does not require prisoners with tuberculosis symptoms or positive tuberculosis tests be isolated in a respiratory isolation room (ADC does not have a respiratory isolation room, and states that if a provider suspects a prisoner has tuberculosis, that inmate will be sent to the hospital) (Responses 169-170).

Arizona lacks other policies that, while not strictly necessary in order to provide community standard of care, are nonetheless good practice. Because their absence contributes to the deficiencies in the system and because adoption of these policies would

be helpful as one aspect of system reform, I set them out as recommendations but not requirements: ADC policy does not require that prisoners on anticoagulants be examined by a healthcare clinician at least every 90 days (Response 197); ADC policy does not require prisoners with chronic obstructive pulmonary disease and forced expiratory volume 1 score < 50% be seen by a clinician at least every 90 days (Response 203); ADC policy does not require prisoners with cirrhosis be given at the time of diagnosis a baseline screening esophagogastroduodenoscopy for the diagnosis of esophageal and gastric varices (Response 229); ADC policy does not require prisoners with cirrhosis be screened with an abdominal ultrasound at least every 180 days (Response 231); ADC policy does not require prisoners with cirrhosis be examined by a clinician at least every 90 days (Response 233); ADC policy does not require prisoners with chronic Hepatitis C be given annual blood tests for their levels of aspartate transaminase, gamma glutamyl transpeptidase, bilirubin, platelets, and international normalized ratio level (Response 235); ADC policy does not require prisoners with chronic Hepatitis C be screened with an abdominal ultrasound at least every 180 days (Response 237); ADC policy does not require prisoners whose seizures are managed with anti-epileptic drugs be examined by a healthcare clinician at least every 180 days (Response 253).

3. Adequate staffing

Staff are the backbone for medical care delivery. There is no dispute that there is a medical staffing crisis in the Arizona prisons. The ADC Assistant Director over the Health Monitoring Bureau admits that "there are shortages of providers that need to be addressed" (Gross Depo, 97:22-23), and that as of June 2013, "the staffing patterns were insufficient. They were at 53 percent of staffing positions." Gross Depo, 115:7-9.

The evidence to support his conclusion is overwhelming.[3] Robertson Depo, 88:14-88:16, 90:8-90:15 (in April 2013 at Florence South Unit, staffing problems caused

[3] The numbers of prisoners in these individual units is relevant to the compliance numbers I describe. For the sake of efficiency, I have not included the population

the unit to be more than 500 behind on chronic care with at least 100 charts pending review), 93:15-93:21 (only one part-time physician at Tucson when the contract indicated that two should be employed); 95:9-95:13 (monitors are always pressing for more staff); 104:3-104:11 (staff shortages are "an outstanding issue" at all prisons); Haldane Depo - Perryville, 45:6-46:2 (Perryville is persistently noncompliant with requirement that referrals from sick call to providers be seen within 7 days because they "don't have the staff to meet that requirement, and it's almost never met"), 222:15-223:5 ("staffing shortages throughout the complex" and "nurses [were] reporting that without the ability to use registry staff or overtime and with nurse hours being cut beginning the week of 4/28/13, they do not have the ability to fill all shifts "); Deposition of Jeffrey Sharp, October 9, 2012, at 50:20-51:1 (according to Perryville physician, not enough medical staff at complex to provide adequate care). As of September 27, 2012, 35% budgeted full-time equivalent healthcare positions and 47% of all budgeted full-time equivalent medical provider positions statewide were vacant. ADC035214, ADC049045-49055.

ADC's own monitoring reports describe that widespread understaffing leads to inadequate care and delays in care. See, for example, ADC154342 (September 30, 2013) (nurses at Tucson frequently get called off, leaving the unit understaffed for total care patients); ADC154338 (September 28, 2013) (open positions at Tucson lead to missed sick call deadlines and chronic care backlogs); ADC154210-11 (September 18, 2013) (Perryville San Pedro does not have an RN and Perryville San Carlos has only one pill nurse); ADC154210 (September 18, 2013) (vacancies throughout Perryville "affect the ability of existing staff to meet the needs of all" patients); ADC137395 (July 29, 2013) (Tucson's open positions include 1.5 LPNs, 3.7 nursing assistants, 1.5 physicians, 4.1 RNs, 1 RN supervisor, and 1 regional director); ADC137335 (July 29, 2013) (open positions per the contract staffing pattern at Phoenix leave staffing insufficient to meet

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number for every housing unit in every reference in this report. Instead, I attach as Exhibit D a recent ADC population report to give some context to these numbers.

prisoner needs); ADC137309 (July 26, 2013) (for at least one year, Perryville has had only one nurse on duty between 0500 and 0700, and she conducts diabetic lines, leaving no nurse to respond to emergencies or the use of restraints); ADC137445 (July 25, 2013) (Yuma lacks 0.5 LPN, 3 full-time nurse practitioners, 0.4 nursing assistants, 1 physician, and 0.6 RNs); ADC137260 (July 26, 2013) (Florence is only 80% staffed); ADC137445 (July 25, 2013) (Yuma is not fully staffed and not able to meet the needs of the prison population); ADC137259 (July 19, 2013) (Florence Globe has only one RN working on assignment, and labs had not been drawn since March); ADC088885 (April 30, 2013) (Florence South has no regularly scheduled healthcare provider); ADC089055 (April 29, 2013) (Tucson staff vacancies include 1 nurse practitioner, 1 RN supervisor, 2 staff RNs, 7 nursing assistants, 1 psychologist, 2 mental health registered nurses, 1 physician, and 1 regional director); ADC088949 (April 30, 2013) (Perryville lacks a Director of Nursing, Assistant Director of Nursing, and a nursing supervisor); ADC088886 (April 29, 2013) ("Florence complex has onl[y] one HCP and two mid level providers at this time" and "[a]ll units have numerous in[ma]tes overdue for chronic care visits and referrals"); ADC088930 (April 29, 2013) (Perryville lacks dedicated medical records staff in three units); ADC088976 (April 28, 2013) (upper management at Phoenix Aspen does not permit overtime and the use of agency despite an "extremely high back load number of intakes, resulting in medical and medical records staff working until midnight); ADC089108 (April 26, 2013) (At Yuma, "staffing is not adequate/effective to meet[] the facility's needs"); ADC088951 (April 24, 2013) (April schedule at Perryville shows no or partial coverage by CNA some days leaving one RN for 5-7 infirmary patients, two of which are high acuity and one of which requires two-person transfer); ADC088885-86 (April 23, 2013) (according to nurses, nurse shifts at Florence are unfilled because hours are being cut, and they are prevented from using registry staff or overtime); ADC089057 (April 17, 2013) (Tucson infirmary has six total or almost total care inmates and only one day shift, part-time second aid staff); ADC088885 (April 16, 2013) (per Florence Central

staff, use of overtime or registry nurses is not permitted resulting in May schedule coverage gaps in the infirmary, on Sundays, and in cell blocks on some days); ADC088852 (April 14, 2013) (no provider on site during March at Florence Globe); ACD088771 (April 5, 2103) (Phoenix has only one mid-level staff member providing "all the patient care at this facility"); and ACD088750 (April 3, 2013) (Florence has only two full-time medical providers for all units and one part time medical provider for South and Kasson).

Some staffing problems appear to have grown worse under Corizon's management. The Tucson Medical Director reacted with dismay in February 2013 to the news that Corizon would cut back significantly on the already over-extended providers: "Our skeleton just lost a foot and tibia." AGA_Review_00001721. He explained that he "[a]nticipate[s] the already overloaded backlog to get worse over the next few months" and warned that "[a]ll providers are telling me they are mentally, emotionally and physically exhausted already and so am I. . . . there is absolutely no way we can provide contract required coverage w/ current staffing." *Id.*

Nursing coverage appears be similarly strained under Corizon: an ADC monitor noticed in April 2013 that Florence Central's May schedule showed "days that there is no coverage in any of the cell blocks"; Eyman's Cook Unit showed nursing hours cut by 40 hours per week. AGA_Review_00013126. The monitor noted that "[e]ven at current staffing levels," nurses were cutting corners to keep up with their work, including pre-signing medication administration reports, failing to take patients' vital signs, and failing to update problem lists in medical records. *Id.* See also AGA_Review_00001704 (Corizon cut pharmacy technical staff in half at Tucson, down to four pharmacy technicians for more than 5000 patients); AGA_Review_00009347 (as of March 28, 2013, pharmacy staff at Tucson too small to ensure prisoners are provided medications on release: "the current system IS NOT working").

I saw evidence of inadequate staffing on my tours. At Tucson, the Medical Director's concerns from February, quoted above, were clearly justified: there were only two physicians in the complex, one of whom is the medical director and thus has administrative duties in addition to seeing patients. The other is part-time. These numbers are completely inadequate for a prison with 5,000 prisoners. One patient in the infirmary (called IPC, or inpatient care unit), [redacted], told me he hardly ever sees a doctor, which does not surprise me. Nursing care suffered from similar deficits: there were only two RNs for 40 patients in the IPC.[4] I saw some of the results of Tucson's staffing deficiency on my tour: a large number of lab results and consult results and x-ray reports, some of which showed significant abnormalities, that had not been filed or reviewed for four to six weeks (described in more detail below in Section II.D.3).

At Perryville, I saw a notation in a healthcare record for a heart patient named [redacted]: her chronic care follow-up form dated April 2, 2013, by D.O. DL Palmer indicated that "I have concerns of patient on this yard – no weekend nurse coverage."

Staffing shortages endanger patients. Sharp Depo, 52:23-52:25, 53:1-9 (according to Perryville physician, the staffing problems can create delays in providing medical care which can create a serious medical risk). They do this in a variety of ways: they lead to excessive delays in access to care (Section II.B, below), healthcare staff acting outside the scope of their licenses (Section II.C.3, below), the failure to carry out providers' orders (Section II.D.1, below), and the failure to review and file diagnostic test results (Section II.D.3, below).

[4] Nursing staff is spread thin in other Tucson units as well: I saw a chart on my October 25 tour which laid out the nurse staffing per unit: in Cimmaron, 1 RN 2 LPNs; in Winchester, 1 RN 2 LPNs;in the Minors Unit, no RN 1 LPN (for passing out meds only); in Santa Rita, 2 RNs 1 LPN; in Rincon, 2 RNs 1 LPN; in Whetstone D, 1 RN 2 LPN; in Whetstone E, 0 1 LPN; in Manzanita D, 2 RNs 1 LPN. There are not enough nurses to meet the needs of these patients.

4. Adequate physical facilities

My observation of the physical facilities at prisons I toured showed me that basic elements are there: equipment, exam rooms, storage facilities, lab draw rooms, medication storage rooms were generally acceptable and generally clean.[5]

While the form was usually acceptable, the scale of the physical facilities is far too small: the clinic areas I toured in Perryville, for example, were surprisingly small and the infirmary – the highest level of care for the entire women's prison of over 3600 women – had only seven beds. At the time of my tour, only three were filled. I could not help wondering where all the sick women were, because in that large a population, many more infirmary beds are needed.

I was also shocked at the extremely small medication rooms in the prisons I toured. They simply do not have the capacity to address the medical needs of the number of people they are intended to serve.

Further, even undersized physical facilities are drastically underutilized, as was clear both from my personal observations and from the serious deficits in care evident in the healthcare records and from the interviews with prisoners. For one thing, there is no possible way staff are identifying and treating the medical needs of the population, given how few medications are being dispensed. I saw in Florence North an open metal case filled with medication bins. The population in this unit was 1078 at that time, and in a population that size I would have expected to see many more medications than were in the bins on the shelves of this metal case. Similarly, in Yuma, on a yard of 1000 inmates there were only three medication bins, far too small for the population. Because of the

[5] There are scattered problems with physical facilities for patient living and care, however. A Perryville physician testified about conditions in Lumley Unit Building 30, with prisoners living in cells exposed to the weather, with no climate control in the heat of the Arizona summers, and a small exam room on the end of the building for medical care delivery: "I was kind of shocked . . . that the prisoners would live like that and I would be expected to provide medical care in that physical facility." Sharp Depo, 82:20-83:19. I viewed that unit and agree that the facilities and patient living conditions are substandard: the cells are indeed exposed to the heat and the outdoor elements and the exam room is airless and lacks basic equipment and facilities for medical care delivery.

dramatic lack of evidence of medication I saw on my first day of touring Yuma, I specifically requested to attend a medication pass to verify my concerns. On my second day I attended medication pass on Yuma's Cheyenne Unit which had a population of approximately 800 prisoners. Pill line started at 11:58 am and was complete by 12:12 pm and a total of seven patients received medications that I observed. It is simply not possible to believe that the healthcare needs of the prisoner population are adequately met when less than 1% of the population receives medications from pill line.

It is not just the paucity of medications being dispensed that leads me to believe that the medical facilities are underutilized. I toured five prison complexes over a total of approximately eight days and saw hardly any encounters with nurses or primary care providers, hardly any patients in waiting areas, and hardly any medication being delivered. Aside from a few scattered finger sticks, a very few patients with providers, one short pill call, and a dozen prisoners waiting to be seen outside one clinic, I saw no evidence of care being delivered on my tours. Instead, I saw staff in their offices or moving around the prison and many empty exam rooms that clearly were not in routine use. On all of the tours I looked in the biohazard waste disposal cans present in the exam and treatment areas. These are generally not emptied daily in medical care settings and they contained scant biohazard waste material. This is not a definitive finding but it is an observation across the system that correlates with the general paucity of care I observed. It is simply impossible that so few people are in need of medical care at these prisons. In prisons the size of those I toured, even ones holding a primarily healthy population, I would expect the clinics to be a bustle of activity, with patients being seen, waiting to be seen, having vital signs taken, obtaining medications, being tested, and so forth.

I was surprised to hear that ADC does not have a negative-pressure rooms or respiratory isolation rooms; their policies state that any prisoners requiring such housing are sent to outside hospitals. Responses 169-70 and 179, Defendants' Responses to Verduzco's First Set of Requests for Admission. A system this size should have these

facilities. In a correctional facility there are multiple reasons why patients would need respiratory isolation as part of a precautionary step while they are assessed or treated. It is simply not reasonable in a system of this size to send all of these patients to the hospital. Many of these patients require extended isolation while the disease workup is completed. If Arizona does send all of the patients who legitimately need this type of isolation to the hospital, the cost would be extraordinary and wasteful.

B. Timely access to care

Having discussed some of the building blocks of a medical care delivery system, I turn now to consider the four broad categories of care. The most important major category of a functional medical care delivery system is access to care: the seemingly simple task of getting patients to see nurses and providers. Arizona fails this fundamental task. I have seen a shocking number of delays in access to care or even complete denials of care in Arizona's prisons. Some delays I saw were catastrophic and entirely preventable; other delays were less damaging to patients simply through luck of the draw: if a tumor turns out to be benign, a lengthy delay in providing a biopsy does not result in morbidity or mortality. However, the systematic failure to provide timely access to care places all patients at an unreasonable risk of serious harm. Patients with significant injuries or illnesses in the Arizona prison system are not safe: they are at serious risk of preventable negative outcomes.

One typical example of delayed access to care provides an introduction to the topic. [redacted] at Perryville found a lump in her breast on February 27, 2013. She filed an HNR immediately, saying the lump was "very sore." She was initially seen by a nurse on February 28 and a nurse practitioner on March 7. She had a mammogram performed on April 3 that resulted in an urgent consult being submitted by the facility doctor on that same date. There are several notes in her chart from her facility doctor that trace the care: May 6 (biopsy re-faxed to Dr. Irving); May 15 (still waiting for approval for biopsy); May 21 (no biopsy yet); May 22 (verbal approval for consult);

May 29 (official approval still pending doctor left message again); June 5 (doctor discussed case with supervising doctor still awaiting official consult approval); June 11 (doctor called and informed that patient was scheduled with surgeon); June 18 (patient sees surgeon for pre-op evaluation); June 20 (consult written to obtain biopsy per surgeon's recommendation); July 1 (local doctor sees patient again no biopsy yet); July 18 (patient has biopsy of breast mass); July 22 (patient given results of biopsy). The patient had Grade III invasive ductal breast cancer and it took five months to get a simple tissue diagnosis because of profound delays in access to care, even with her local physician actively advocating for her. The string of delays and incompetent treatment decisions is a catastrophe for [redacted]. She now faces a much more invasive and toxic treatment regimen with the probability of much more extensive surgery needed to address her advanced cancer than if she had been worked up expeditiously. The delays also greatly increase the risk of recurrence and metastasis of the cancer than if the cancer had been dealt with immediately upon discovery.

1. Sick call/HNR system

Correctional healthcare systems are resource-limited environments. In that setting, the most critical component of a sick call system is triage and it must be done face to face by an appropriately licensed healthcare provider (RN or above in Arizona), it must be done within 24 hours of receipt of the health needs request (HNR) and it must contain the basic elements of an assessment including brief history, vital signs, exam, and a disposition. This is the doorway to care, and patients must be seen quickly, sorted out, and provided quick referrals to urgent care or provider appointments as needed.

Arizona's sick call and HNR system is not effective and patients face lengthy, sometimes life-threatening, delays in obtaining care. Pursuant to Arizona's policies, prisoners in need of medical care must file written HNR forms, which are required to be triaged within four hours of the time they are stamped as received. ADC010827. The patients are to be seen the same day for urgent needs; otherwise, they are to be seen by

nurses for sick call ("nurse line") within 24 hours of the triage (or up to 72 hours if it is a weekend and clinically appropriate). *Id.* If higher level attention is warranted, patients must be seen by providers within seven days after that ("provider line"), as monitored on the MGARs. My review of healthcare records, documents, and depositions and my interviews with patients demonstrated to me that Arizona has a system-wide deficiency in providing an effective sick call process. The barriers to access at the front end are significant. Prisoners with serious conditions, including extremely fragile patients with chronic conditions, simply cannot get seen by the appropriate medical personnel.

Because this element is so critical, I expended significant effort to understand the HNR process on my tours, in my staff interviews, in my patient interviews, and in my chart reviews. What I discovered is that a triage system does not exist anywhere I visited. The existing sick call system consists of prisoners submitting HNRs to a mailbox; the HNRs are collected and answered several days after submission with the universal answer consisting of some variant of "you will be scheduled." There were no signs of triage, no face-to-face assessment in a timely fashion, no vital signs, and no disposition. I was unable to track individual HNRs through the process from submission to a provider visit and most of the charts I reviewed had stacks of HNRs that did not result in healthcare visits. I did find sporadic evidence of what was termed "nursing sick call lines" that were conducted by LPNs long after the HNRs are submitted. LPNs are not legally allowed to perform "assessments" on patients so those nursing sick call visits are ineffective and the LPNs are practicing outside of their legal scope of practice. The patients I interviewed assured me, however, that the prison system is unerringly effective at charging them the fee for submitting an HNR and it happens very quickly even though the healthcare encounter they pay for often does not happen quickly or may not ever occur. An excellent example of the consequences of an inadequate triage system and using nurses outside of their scope is the case of [redacted] that I discuss in Section II.C.3.

The documentation of Arizona's failure to provide patients with timely access to care is overwhelming. ADC's Assistant Director over the Health Monitoring Bureau acknowledges that prisoners are not being seen in the appropriate time frames after the HNR is triaged by the nurse, and says he told Corizon to correct this problem. Gross Depo, 66:24-67:11. ADC's monitors document extreme backlogs in HNR and nurse and provider lines. See, for example, ADC154280 (September 30, 2013) (in September, Tucson had 11 missed sick call lines, 357 HNR backlog, 226 provider chart review backlog, 303 nurse line backlog, and a 535 provider line backlog); ADC154338 (September 28, 2013) (open positions at Tucson lead to missed sick call deadlines and chronic care backlogs); ADC137626 (August 28, 2013) (at Tucson, 20 missed sick call lines, backlog of HNRs (439), charts requiring provider review (252), backlog for nurse lines (317) and provider lines (393)); ADC137395 (July 29, 2013) (Tucson has backlogged charts needing provider reviews); ADC137360-61 (July 29, 2013) (Tucson Whetstone had 231 unprocessed HNRs, a provider line backlog at 322, and a nurse sick call backlog at 169, with similar statistics for Winchester, Cimarron, Rincon West Medical, Catalina, and Manzanita, and Santa Rita); ADC137309 (July 26, 2013) (Perryville San Carlos and Santa Maria have provider review chart backlogs); ADC088949 (April 30, 2013) ("[p]rovider lines, nurse lines, and chronic care appointments are each backlogged to varying degrees" at Perryville); ADC089000 (April 28, 2013) (April had only 29 provider line visits, with over 140 prisoners waiting to be seen, and a 227 prisoner backlog for the nurse line at Tucson Cimarron); ADC088745 (April 4, 2013) (at Florence Central, 36 HNRs were awaiting nurse line); Valenzuela Depo, 139:5-139:13 (sick call not occurring according to policy at Phoenix).

Arizona nurses consistently fail to see patients within 24 hours of the HNR review. Haldane Depo - Perryville, 206:3-206:15, 34:5-34:12 (requirement "almost never met at Lumley"); Bedoya Depo – Tucson, 159:20-24, 186:17-24 (timeliness is common problem); ADC154281-85 (September 29, 2013) (56 of 80 Tucson charts reviewed show

noncompliance); ADC154096-97 (September 30, 2013) (Florence units 82% noncompliant); ADC154183 (September 24, 2013) (in September to date, 36% of sick call appointments untimely in Perryville); ADC137583 (August 30, 2013) (at Phoenix, nearly all files show noncompliance); ADC137497 (August 30, 2013) (at Florence, nearly all files show noncompliance); ADC137629 (August 29, 2013) (Tucson prisoner had multiple HNRs for surgical, prescription, and medical device issues all of which have not been addressed); ADC137627 (August 29, 2013) (67 of 80 Tucson charts reviewed show noncompliance); ADC137497-98 (August 21, 2013) (32 of 44 Florence files noncompliant); ADC137363-65 (July 31, 2013) (at Tucson, 57 of 80 files noncompliant); ADC137259 (July 30, 2013) (Florence Central and South have stacks of HNRs waiting to be seen on sick call and by the provider); ADC137395 (July 29, 2013) (2-3 week wait for Tucson prisoners who file HNRs); ADC137419-20 (July 23, 2013) (widespread noncompliance in Yuma files); ADC089002 (April 29, 2013) (Tucson patient not seen for more than a month after HNR); ADC088848 (April 15 and 27, 2013) (at Florence, most charts reviewed show noncompliance); ADC089085 (April 26, 2013) (noncompliance on multiple yards at Yuma); ADC088915 (April 23, 2013) (custody levels and housing at Perryville Lumley interfere with compliance); ADC088847-48 (April 14 and 27, 2013) (36 of 54 records reviewed at Florence Globe show noncompliance).

ADC prisoners frequently do not see a provider within seven days of sick call. Haldane Depo, 45:13-46:2 (Perryville is persistently noncompliant with requirement that referrals from sick call to providers be seen within seven days because they "don't have the staff to meet that requirement, and it's almost never met"); ADC137632 (August 29, 2013) (37 of 44 Tucson charts reviewed noncompliance); ADC137556 (August 26, 2013) (Perryville noncompliant); ADC137424-25 (July 23, 2013) (widespread noncompliance at Yuma); ADC089087 (April 26, 2013) (same); ADC088852 (April 18, 2013) (Florence

East sick call referrals seen in April were old as January 26); ADC088852 (April 14, 2013) (Florence Globe prisoners not seen in 7 days as there was no provider in March).

Some of the delay derives from the failure to conduct sick call consistently five days a week. See ADC154137 (September 30, 2013) ("[s]ick call is not being conducted 5 days a week at any unit on Florence complex. . . . Chronic condition back log of appointments is growing. Many inmates are not seen as ordered or required by disease management guidelines"); ADC154183 (September 24, 2013) (in September, only Perryville Lumley held sick call 5 days per week to date); ADC137497 (August 30, 2013) (sick call does not appear to be running 5 days a week on any unit in Florence); ADC137259 (July 30, 2013) (Florence sick call is not completed daily, requiring prisoners to continually reschedule); ADC137360 (July 29, 2013) (28 sick call lines were missed in July in Tucson); ADC088885 (April 30, 2013) (sick call line in Florence Central not run Monday to Friday); ADC089000 (April 29, 2013) (sick call not conducted 5 days a week at Tucson Rincon Minors); ADC089000 (April 28, 2013) (sick call not conducted 5 days a week at Tucson Cimarron); ADC088847 (April 27, 2013) (Florence Kasson demonstrated no evidence of a sick call nurses line during April); ADC089085 and ADC089108 (April 26, 2013) (multiple yards without sick call at Yuma); ADC088746 (April 4, 2013) (sick call was not conducted in Florence East Monday through Friday per policy); ADC088745 (April 4, 2013) (sick call was not conducted in Florence Central Monday through Friday per policy).

These findings are consistent with what I heard from prisoners, who described waits of weeks or months after submitting HNRs for conditions that should have been addressed in a far more timely fashion. In the healthcare records I reviewed, I saw numerous examples of HNRs that were ignored or had extremely delayed responses. For example, [redacted] in Tucson had testicular cancer and completed a course of chemotherapy at the end of 2012. He filed repeated HNRs seeking follow-up care. Despite his persistent attempts to receive care through the HNR process, his first

follow-up appointment after chemotherapy did not occur until June 11, 2013. A CT scan was ordered at that time and done on July 17, 2013, and he was finally seen in follow-up on September 25, almost a year after completing chemotherapy. The Arizona Cancer Center requested that he been seen again within one month but as of late October 2013 that visit has not occurred, and did not appear to be scheduled in the medical record. All of this delay has potentially life-threatening consequences for [redacted] and yet the delays in care are attributable completely to the caregivers, not to this well informed and very concerned patient.

At Perryville, I found in my chart reviews a pregnant woman named [redacted] whom staff had clearly forgotten about – as of July 31, 2013, she hadn't been seen since early May, when she arrived at the prison. An ultrasound consult was ordered for her on May 22, 2013, which is standard of care for pregnant women, but the ultrasound had not been completed. It is shockingly negligent not to obtain an ultrasound in a high-risk pregnant woman and the consequences are potentially dire for her and her baby. She told me that her due date was September 18.[6]

Clearly the HNR system in Arizona is broken. An appropriate way to run such a system would be for every HNR have a serial number on it, which gets a logged into a system by number and date. The log can then be reviewed closely to make sure that there are timely follow ups to medical needs set forth in the HNR. Under Arizona's current practice, nobody tracks HNRs electronically. Responses 36 & 37, Defendants' Responses to Plaintiff Verduzco's First Set of Requests for Admission (June 11, 2013); see also Mielke-Fontaine Depo – Florence, 221:5-221:11 (the only way Florence monitor knows about the timeliness of the triaging of HNRs is by pulling the patients' charts), 317:22-317:25 (monitor would not know if a patient is not seen in response to an HNR).

[6] I told the Perryville Director of Nursing the patient's name and number and urged her to have the patient seen and given the ultrasound that had been ordered two and a half months ago. She said "thank you" and walked away without writing the name down.

Thus, if an HNR is lost no one will know about it, and there's no accountability -- no way to reconcile a HNR request with actual proof that medical staff received it, saw it, and provided the necessary care. This allows staff to avoid their responsibilities. (I was not surprised to read about the discovery, in November 2012, of a pile of 768 HNRs in an office in Florence's Central Unit, many of which had not even been stamped or triaged. AGA_Review_00074092.) Also, the existing HNR process imposes a barrier to medical care. Prisoners soon recognize that the system is efficient at charging $4 to file HNRs, but not at responding to their healthcare needs. This creates a disincentive for prisoners to turn in HNRs: they know they will not get seen by medical staff but they do know that they will be charged. Prisoners delay asking for care until they are sicker and sicker, at greater risk of negative outcomes, and far more difficult to treat. Throughout my interviews on my visits, the prisoners consistently described a broken and unfair HNR process. They also explained that the workaround for the HNR process is to find a sympathetic corrections officer who, if sufficiently impressed with the patient's concerns, will call medical and make arrangements for an appointment. I describe my concerns with this situation in Section II.B.5.

The HNR process is also used to obtain refill medications. Prisoners with prescriptions who need a refill are required to submit the refill request on an HNR. In my experience, this process is designed to fail. Continuity of care for serious medical problems is compromised regularly because of the choice to use this broken HNR system to refill medications. One example of this deficiency occurred with [redacted] who is a very well-informed patient with HIV who is on a four-drug treatment cocktail. In order for him to be treated successfully he has to be on these four drugs consistently and without any gaps in daily therapy. Review of his medical records demonstrates clearly that the system has been unable to get him all four of his HIV medications refilled at the same time and the patient has filled out multiple HNRs explaining that he is missing some of the drugs from his regimen as a result of the HNR

medication renewal process. In looking at the medication administration records in his chart, it is obvious that he has had big breaks in therapy and that he has been getting less than his four medications and that all of the medications are out of sync with each other. The consequence for the patient is that treatment with less than all four of the medications at the same time induces resistance in the HIV virus and his immune system is failing because of incomplete therapy. All of this is unnecessary, but if Arizona continues to rely on this rudimentary HNR process that is horribly broken, cases like this will continue to be the norm.

2. Chronic care

Chronic care clinics are a major focus of healthcare in any correctional setting. Preventive care is essential with chronic care patients; it is impossible to provide community standard of care without regularly scheduled appointments that allow providers to track the progress of these patients and ensure appropriate treatment modification are made.

Insulin dependent diabetes is a good example. The standard of care is to schedule most of these patients for visits every three months. Providers will examine the patients, review how things have been going, update their care records, and obtain the basic healthcare screening needs. Various tests are employed at regular intervals, and providers can appropriately weigh risk and treatment options.

In Arizona prisons, the chronic care is haphazard at best. There is no meaningful computerized tracking system for appointments for chronic care inmates who are supposed to see a provider every six months, just a physical appointment book.[7] Robertson Depo, 136:16-136:25. Not surprisingly, chronic care prisoners in ADC

[7] According to Corizon Arizona Regional Medical Administrator Dr. Williams, Corizon has been using the IHAS database to track chronic care, but "it's our impression that the database is not complete," so they are developing a new system called Care Log. Williams Depo, 30:18-31:20, 32:20-32:24. The new database will not track how often chronic care patients are seen by providers, however. *Id.* at 36:24-37:3.

commonly do not see providers every three to six months as specified by their treatment plans; some chronic care patients go for years without seeing a provider. See, for example, ADC154294-96 (September 30, 2013) (at Tucson, widespread noncompliance in charts reviewed); ADC154228-29 (September 27, 2013) (15 of 43 Phoenix charts reviewed show noncompliance); ADC154108-10 (September 27, 2013) (74% noncompliance at Florence); ADC137587 (August 2013) (41% noncompliance at Phoenix); ADC137502-03 (August 21, 2013) (noncompliance rate ranges from 70% to 90% at Florence); ADC137637-40 (August 19, 2013) (noncompliance at Tucson); ADC137395 (July 29, 2013) (examinations past due for chronic care patients at Tucson); ADC137309 (July 26, 2013) (chronic care appointments not timely completed at Perryville); ADC088861 (April 27, 2013) (8 of 9 Florence South chronic care files reviewed demonstrate noncompliance); ADC088860 (April 27, 2013) (5 of 5 Florence Central files reviewed showed noncompliance); ADC089091 (April 27, 2013) (chronic care patients at Yuma Dakota and La Paz not seen as specified in treatment plans); ADC089091 (April 24, 2013) (Yuma Cheyenne prisoner who had open heart surgery in 2005 had not been seen by chronic care); ADC088958 (April 21, 2013) (noncompliance at Phoenix Aspen); ADC089017 (April 20, 2013) (Tucson prisoner with chronic seizures last saw chronic care provider on 11/10/11); ADC088927 (April 12 and 16, 2013) (at Perryville, 2 of 9 San Carlos charts and 7 of 11 San Pedro charts show noncompliance); ADC088772 (April 5, 2013) (some chronic care patients at Phoenix have not been seen for years).

Moreover, ADC has severe appointment backlogs for many chronic care prisoners. ADC154137 (September 30, 2013) (at Florence, "[c]hronic condition back log of appointments is growing" and therefore "many inmates are not seen as ordered or required by disease management guidelines"); ADC154338 (September 28, 2013) (open positions at Tucson lead to chronic care backlogs); ADC088885 (April 30, 2013) (Florence South is 500+ behind on chronic care appointments with at least 100 charts to

review); ADC088885 (April 30, 2013) (Florence North's mid-level provider is 150+ behind on chronic care appointments and has 100+ charts to review); ADC088885 (April 30, 2013) (Florence East's assigned healthcare provider is 250+ behind on chronic care appointments and has approximately 75-80 charts to review); ADC088949 (April 30, 2013) (Perryville chronic care appointments are backlogged); ADC088885 (April 30, 2013) (Florence Central is behind 400+ chronic care appointments); ADC089108 (April 26, 2013) (Yuma La Paz has a 3-4 month backlog of chronic care visits); ADC088746 (April 4, 2013) (chronic care at Florence East is 250+ appointments behind and 58+ charts were on a cart awaiting review).

Many chronic care patients are simply not managed according to ADC policy. See, for example, ADC154298-300 (September 30, 2013) (at Tucson, 9 of 10 Rincon/HU9 charts, 5 of 10 Rincon charts, 6 of 10 Manzanita charts, 7 of 10 Catalina charts, 8 of 10 Winchester charts, 6 of 10 Santa Rita charts showed that disease management guidelines were not developed and implemented for chronic disease or other conditions not classified as chronic care); ADC154112-13 (September 27, 2013) (Florence develops and implements disease management guidelines only 26% of the time for chronic disease and other conditions not classified as chronic care); ADC154230 (September 27, 2013) (28 of 49 Phoenix charts reviewed demonstrated noncompliance with disease management guidelines for chronic disease or other conditions not classified as chronic care); ADC088862 (April 27, 2013) (25 of 36 Florence chronic care files reviewed showed noncompliance with disease management guidelines).

My chart reviews and patient interviews bore out this data. I saw chronic care problems at Phoenix, especially for patients with seizures and diabetes, particularly in the coordination of insulin and finger sticks. See also AGA_Review_00006398 (March 5, 2013, email notes multiple chronic care patient forms missing important information and two significantly late chronic care appointments at Phoenix).

At Florence, chronic care was similarly bad. [redacted] had deficient and very sporadic attention for his poorly controlled diabetes, with blood sugars consistently in the 300s and some over 400 with no notes from the provider or nurses. At those blood sugar levels the patient could very easily slip into diabetic ketoacidosis, a life- threatening condition brought about by abnormally high sugars. I saw no acknowledgement that the nurses appreciated that risk or attempted to intervene to reduce it. Day after day his sugars ran high with no intervention. In addition, these out-of-control sugar levels cause accelerated damage to his other major organs so the longer he stays out of control the faster his other systems will fail. His long-term blood work returned a Hemoglobin A1C level on September 3, 2013, of 10.9% which indicates extremely poor blood sugar control. In looking at his medical records, he was housed at Lewis earlier in his incarceration where his sugars were well controlled and his Hemoglobin A1C was 6.4%, indicating ideal management. He clearly can be managed successfully; he just needs proper care. He put in an HNR on August 14: "want to see doctor to see why my sugars levels are so high" but he has yet to be seen as of the end of October.

I saw records for a Florence patient with diabetic retinopathy ([redacted]), who had only one chronic care visit on June 27, 2013. His records appropriately indicated he should be seen every 60 days, but as of October 16, 2013, no follow-up visit had been scheduled. A patient with HIV ([redacted]) at Florence had labs and a visit on January 13, 2013 (as far as I could tell from the file); the six-month follow-up that was requested (and is appropriate) was not done as of October 16, 2013.

These deficiencies present a serious danger because we know that those patients are fragile and at risk for developing significant complications. With this group of patients, more than anywhere else, an ounce of prevention is worth a pound of cure, because many complications of these diseases are preventable if clinicians keep a careful watch on them.

3. Emergency care

The problems described above with staffing and the HNR/sick call process also present barriers to appropriate responses to medical emergencies. See, for example, ADC137365 (July 31, 2013) (Tucson prisoner submitted an emergency HNR for chest pains on 6/15/13 and was not seen until 7/9/13).

Custody staff play an essential role in providing first response emergency services. Given the fact of incarceration, they are simply the only people around who can do so. It is essential for prisoner health and safety that these staff be properly trained and responsive to medical emergencies. I saw many examples in the documents produced by the State of just the opposite: dereliction of emergency response duty by custody staff, often with dire results. ADC 49423-24 (Employee Disciplinary Letter suspending sergeant 8 hours without pay: "As a supervisor you are required to respond to emergency incidents on your unit. You failed to respond to this emergency ICS for twenty five minutes after it was initiated. You also failed to generate the travel orders for this inmate to be transported which delayed her from obtaining medical treatment"); ADC 49438-39 (Employee Disciplinary Letter demoting sergeant to CO II for having an inmate perform CPR on another inmate who subsequently died); ADC 49440-42 (Employee Disciplinary Letter suspending CO II 40 hours without pay for "leaving the inmate experiencing a medical emergency, unattended, sitting on the floor").

I also saw multiple failures of custody staff to perform basic safety and welfare check on prisoners as required by ADC policy. These failures also endanger the health of prisoners. ADC 024177 – 83 (officer saw prisoner lying with head towards wall and legs draped over bunk's edge at 6:25 a.m., was called to other duties, and returned hours later to find inmate same position, dead, with rigor mortis set in: "another officer is 'supposed to' cover her post. However that does not always happen, and the issue has been addressed as it is 'a constant battle'" (024180)); ADC 49412-14 (disciplinary letter suspending CO II 40 hours without pay for failing to conduct and log hourly security

checks after prisoner found dead); ADC O24972 – 024973 (prisoner died of lung cancer in cell; body was stiff and cold when found); ADC049457-58 (disciplinary letter suspending CO II 80 hours without pay for falsifying records and lying to investigators about conducting security, health, and welfare checks of bathroom after prisoner found unresponsive in bathroom); ADC049471-73 (disciplinary letter firing CO II after prisoner found dead in cell, strangled by cellmate, with rigor mortis setting in; investigation determined staff did not observe living breathing flesh during his checks); ADC049474-75 (disciplinary letter suspending CO II for 40 hours without pay for same violation, same incident); ADC049465-68 (disciplinary letter demoting lieutenant to sergeant for failure to post a replacement officer on unit for an hour, during which prisoner committed suicide).

Staffing failures in ADC emergencies are not confined to custody staff. In one particularly disturbing case, on March 11, 2013, a prisoner in Tucson was found "covered in blood and feces" with "three lacerations from his neck and one laceration to his inner right forearm above the wrist" and "incomprehensible" speech. AGA_Review_ 00007169. Custody staff requested medical assistance, but the night nurse apparently did not have a vehicle and the Complex Shift Commander "had no staff available to pick up medical personnel." AGA_Review_00007168. An ambulance was called and arrived 16 minutes later. AGA_Review_00007169. For this patient, every minute counted and the lack of quick medical response might have had troubling consequences. Apparently, this is not the only time such a barrier to effective emergency response has been noted. AGA_Review_00007168 ("it seems like this also happened in the case of [redacted] as well where they couldn't respond").

At Perryville in August 2012, three prisoners overdosed in the course of several hours, but not one was sent to the hospital. AGA_Review_00038450. According to one staff at the institution, "one provider . . . said she medically cleared two over the phone – which was not true. One LPN requested guidance from the RN and was denied any and

she was left to her own devices. One RN. . . asked another RN to falsify documentation. Bottom line – 3 OD's – none sent and everybody blaming someone else." *Id.* See also ADC 025117 (RN refused to respond to asthmatic breathing emergency because she did not want to "burn her own gas"; patient died before he arrived at the hospital).

4. Inpatient care

I toured all three inpatient care units in ADC: Perryville, Florence, and Tucson. Generally, the physical plant was fine for basic in-prison inpatient care, especially given the availability of contract hospitals to provide more complex specialty services.[8] However, care was not significantly better in the inpatient setting than I have described for outpatients in the Arizona system. The recognition that these are extremely high-needs patients did not translate into better or more attentive treatment. I saw evidence of serious problems with inpatient care in patient cases and other evidence that I discuss elsewhere in this report: inadequate staffing, discussed in Section II.A.3; nurses practicing as primary care providers ([redacted]), discussed in Section II.C.3; failure to provide needed specialty referrals ([redacted]), discussed in Section II.C.4; failure to fulfill providers' orders [redacted] discussed in Section II.D.1; and failure to provide necessary diagnostic tests [redacted] discussed in Section II.D.3.

I saw other examples of problems with inpatient care in the ADC monitoring reports. See, for example, ADC137397 (July 29, 2013) (Tucson infirmary patients not seen every 72 hours by a doctor or mid-level provider as required); ADC088885 (April

[8] One disturbing finding I saw in many of the ADC monitors' reports, however, was in the lack of a functioning call light system in many of these units. See ADC154140 (September 27, 2013) (three infirmary rooms at Florence do not have a call system); ADC154214 (September 26, 2013) (Perryville does not have an infirmary call system); ADC137519 (August 29, 2013) (there is no working call light in the single man rooms at Florence); ADC137578 (August 27, 2013) (Perryville's infirmary patients must call through the door for staff as there is no call system). Almost more disturbing is the fact that Dr. Williams, the Corizon Arizona Regional Medical Director, was unaware of any such problems. Williams Depo, 128:22-129:6.

30, 2013) (Florence Central infirmary and HU8 prisoners are not receiving required physician rounds or follow up, and approximately 160 charts are awaiting provider review for labs, reports, medication renewals, and the like); ADC089057 (April 16, 2013) (Tucson prisoner had 33 falls in the infirmary since November 2012, the last of which required a craniotomy); ADC088887 (April 28, 2013) (as of 4/25/13, prisoners in the Florence infirmary and HU8 had not been seen for at least six days); ADC089057 (April 17, 2013) (Tucson infirmary has six total or almost total care inmates and only one day shift, part time second aid staff); ADC089057 (April 17, 2103) (Tucson infirmary has no supervising nurse 24 hours a day); ADC088951 (April 24, 2013) (April schedule at Perryville shows no or partial coverage by CNA some days, leaving one RN for 5-7 infirmary patients, two of which are high acuity and one of which requires two person transfer.

5. Custody involvement

Custody support is essential to achieve physical access to care. In Arizona they act as gatekeepers to care, both preventing patients from reaching medical staff and intervening to try to get patients seen by medical staff (which demonstrates access problems as well as raising privacy concerns).

In the absence of a functional sick call system, custody staff act as gatekeepers for medical care: patients must persuade them that they need help in order to get to medical staff. Many prisoners described having to beg custody staff to help them get medical care. For example, [redacted] at Perryville went into labor in June 2013. She told me that her water broke in the morning, but staff refused to take her to the hospital. She reported that nurses refused to believe that her water broke, even though they tested the liquid and it tested positive for amniotic fluid. After having contractions all day, she reported, she started to scream at about 7:45 p.m., and officers called 911 and had her taken to the hospital, where she gave birth.

[redacted] also at Perryville, told me that she went into labor on July 27, 2013. She reported that at approximately 11 a.m. she told a correctional officer she was in labor, only to be told to "wait until the contraction is over, I'll bring a wheelchair." At noon, she says, she was rolled to medical, where she waited for over an hour; by the time an ambulance was called and arrived, her contractions were one minute apart. She told me she got to the hospital at 1:55 p.m. and had the baby 20 minutes later. Throughout, she says, she was never checked for dilation. Medical staff seem to have almost entirely abdicated responsibility to custody staff to get these women to the hospital to give birth.

[redacted] is a young otherwise healthy patient I met at Florence North Unit, who has had multiple methicillin-resistant staph aureus (MRSA) outbreaks in 2013. He told me that when he developed his second outbreak in May 2013 he walked immediately to the medical office on his yard to seek care because he knew what the problem was as a result of his previous outbreak a few months earlier. The medical department refused to see him even for basic triage and told him to turn in an HNR to be seen. [redacted] told me that he knows how fast these MRSA infections spread so he immediately appealed the refusal to the Deputy Warden on the custody side and after proving to the Deputy Warden that he had turned in an HNR and showing him his rapidly advancing infection, the Deputy Warden had him escorted to medical and demanded that they care for him. The medical staff did ultimately care for him after correctional officer insistence for that episode but follow-up care that was ordered by the providers in his medical record has not been carried out and no attempt to eradicate the MRSA from his system has been undertaken so he can avoid future infections.

Reliance on custody staff as gatekeepers to such a degree is a dangerous practice. Unlicensed, unqualified people are making medical decisions. It also raises patient privacy concerns, as does the practice in ADC of having custody officers dispense keep-

on-person (KOP) medications at some prisons. Gross Depo, 63:22-64:1; Mielke-Fontaine Depo – Florence, 278:11-278:15 (Florence).

6. End-of-life care and waivers of treatment

I encountered one situation that is worth describing in detail, since to me it is emblematic of the utter disregard for patient care presented by the Arizona prison system, as well as serious problems with understaffing and lack of oversight. In the Inpatient Care Unit at the Tucson complex, I chose two patients to interview because they were both alert and talkative; I knew nothing about them beforehand. After hearing their medical concerns, I reviewed their healthcare records. Both of their records had on prominent display a blanket cessation of care form. This type of document is commonly called a "do not resuscitate" (DNR) form, but these were far broader: they included a waiver of ongoing care, lab work, intravenous medication and sustenance, and the like. These forms were filled out by the nurse in the unit and signed by the nurse and the patients. There were no informed consents documented by a physician or competency evaluations by a psychiatrist

Surprised and concerned about such comprehensive waivers of treatment without the protections that standard of care requires in such situations, I went back to talk to the patients. The first patient ([redacted]) acknowledged his signature on the form and identified it as "the form I had to sign before the nurse would give me any pain medications." I asked him to clarify and he told me that when he came to that unit he was in so much pain from his colon cancer that he was crying in bed at night and couldn't sleep. He requested his pain medications and the nurse told him that she was worried that his pain medications might kill him so she wouldn't give him any pain medications until he signed the form. I clarified the information a third time with him and had him repeat his story to be sure I fully understood.

The second patient ([redacted]) has end stage liver disease that results in occasional increases in his blood ammonia level which results in hepatic

encephalopathy. He was recently in the hospital for hepatic encephalopathy and during that time he was not conscious of his surroundings or what was happening to him, as is typical in such situations. He does not remember being at the hospital or any of the care he received. At the hospital, they executed a DNR upon admission, as is standard practice with conscious patients, despite his inability to comprehend his actions. The attorney for the State on my tour informed me that the hospital DNR was merely carried forward to the Arizona prison system and that the one I saw in his file, signed in ADC custody, was simply "extra." I am extremely concerned, based on the documentary evidence I reviewed, that this patient executed the hospital DNR while he was totally incompetent with a sky-high ammonia level. In my opinion, no reasonable physician would honor such a document. After his condition stabilized at the hospital, he was returned to Tucson and signed the comprehensive waiver of care order I saw in his file. I asked him if he knew what the form was for. He told me that could not read the form when he signed it because he didn't have his glasses, and had no understanding of what it was. I explained the form to him and he indicated that those were not his desires. As with the first patient, there is no record of any physician or psychiatrist involvement in this process.

I hesitate to generalize from two data points, but it is at the very least striking and disturbing that two such blatant violations of patients' rights to treatment and to agency in end-of-life decisions could exist with no apparent review or oversight. Any medical professional should be disturbed on a on medical, psychological, ethical, emotional, humanistic, and legal level by the mere existence of these forms in these patients' files, lacking as they do any informed consent, provider involvement, or indicia of review, much less the patients' accounts of coercive circumstances under which they were signed.

I believe that this practice has a great deal to do with the severe and profoundly irresponsible understaffing I observed in these high-acuity care settings. I also suspect

that many more patients in this unit have such forms in their files and that it is essentially a work reduction technique by an overwhelmed understaffed nursing group with extremely limited physician engagement.

I did see an indication of other questionable practices in Tucson relating to DNRs and end of life care. Shawn Jensen (032465), a class representative, testified in his declaration of November 6, 2012, that he and others had been presented with living wills, healthcare power of attorney forms, and DNR forms in Tucson in March 2012. According to Mr. Jensen, prisoners were given no education about the forms and no assistance with reading them; no healthcare staff were available to answer their questions; patients were simply told to complete them. Prisoners who were monolingual Spanish speakers were provided with forms only in English. This report makes it all the more urgent to investigate such matters thoroughly and to ensure patients in Arizona's custody are provided individual education and information about their options.

End of life planning and compassionate palliative care are important components of the practice of medicine, but they must be done with extreme caution in a correctional setting, with assiduous attention to detail, multiple independent reviewers, meticulous observation of informed consent requirements, and continual review of the appropriateness of the end of life plans given the condition of the patient. None of that was present in Tucson. The circumstances surrounding the clear violations of these patients' rights suggest that the problem is widespread and places patients at serious risk of denial of care. I am deeply concerned that I do not know, and am unable to discover the depth and breadth of this problem, given the limitations placed on my ability to investigate in this case.

C. Exercise of professional medical judgment

The heart of a functional healthcare delivery system is the ability of the appropriate clinicians to exercise their professional medical judgment regarding patient care. In order for that to happen, providers must first be able to see patients and second

must be equipped with the appropriate information to diagnose and treat them. Nurses cannot dictate care in the same way; I am extremely concerned about the degree to which Arizona relies on nurses practicing outside the scope of their licenses to provide basic care. I am similarly concerned about the degree to which providers are denied access to consultations from appropriate specialists, thereby forcing them to make patient care decisions outside the scope of their expertise. Finally, I saw extensive evidence that providers often simply make very bad treatment decisions, and sometimes disastrously bad ones, to the serious detriment of their patients.

1. Access to care

The issues I discussed above relating to timely access to care in Section II.B are relevant in this context. Patients must be seen and care needs identified, both on intake and throughout their prison terms. If access to care is poor, the system blocks professional judgment from operating.

In Arizona prisons, access to care for many patients is so poor that they are forced to rely on the "professional medical judgment" of custody staff, as described above in Section II.B.5. If they can persuade officers, sergeants, or lieutenants that they need treatment, those staff will sometimes break through the barriers set up by the healthcare delivery system.

2. Medical records and access to medical histories

Providers cannot render a professional medical judgment without appropriate medical data. If a provider sees a diabetic without access to the blood sugar data because it hasn't been filed yet, or without results because they have not arrived, he or she is treating the patient with a blindfold, lacking appropriate information about the condition. Without a full medical record, providers don't have adequate information to render a professional medical judgment. The problem is compounded for complex or chronic care patients. If the charts lack historical information on the patient, filed in a logical place, it makes treating that patient very difficult, if not impossible. Arizona's Assistant Director

over the Health Monitoring Bureau agrees. Gross Depo, 122:25-123:6 (it is important to have paperwork properly filed so that the information can be in a chronological order for others to read and interpret).

The charts I reviewed at all the prisons were inadequate to convey current patient care. Simply put, they were a gigantic mess. There was often no way to track the care logically through the chart; it was generally very hard to tell medical histories and medication administration. Medication orders should be consistent with the medical administration records (MARs), but in the Arizona charts I reviewed, I saw very little correlation between the orders and the MARs. It was often unclear who had ordered a medication and when that medication needed to be renewed. While half of the medication record might be in the medical chart, half of it might be somewhere else (for example in a Pharmacorr binder), which makes no sense. A treating clinician picking up a chart to review before an appointment or a provider trying to design a treatment plan would have no idea what the medications the patient is taking. This is a patient safety issue. It is no wonder Arizona makes the prisoners submit medication refills via HNRs -- none of the healthcare staff can tell when something needs to be renewed based on the records I reviewed.

I was not surprised to read the reports from ADC monitors of record-keeping delays and errors. See, for example, ADC154302 (September 30, 2013) (46 of 80 Tucson charts reviewed showed that medical records were not current, accurate, or chronologically maintained with all the documents filed in the designated location); ADC137309 (July 26, 2013) (Perryville San Carlos has a large amount of unsecured and incorrectly sectioned filing); ADC088931 (April 29, 2013) (Perryville San Pedro and San Carlos have significant backlogs of MARs in loose filing); ADC088930 (April 29, 2013) ("[l]oose filing at [Perryville] San Carlos can be measured in feet. Unfiled MARs date back to January"); ADC088915-18 (April 23, 2013) (large amount of loose filing at Perryville Santa Maria, San Carlos, and Lumley prevented an accurate assessment of sick

call); ADC088929 (April 18, 2013) (medical records not current, accurate, and chronologically maintained with all documents filed in the designated location at multiple Perryville units).

The monitors have also consistently found that prisoner medical records often lack necessary information, as was my experience. See, for example, ADC154383-84 (September 30, 2013) (at Yuma, 7 of 10 Cibola charts, 9 of 10 Dakota charts, 5 of 10 Cheyenne charts, 4 of 10 Cocopah charts, and 7 of 10 La Paz charts reviewed were not noted daily with time, date, and name of the person taking the orders off); ADC137393 (July 31, 2103) (medication errors at Tucson are not all documented); ADC137256-7 (July 30, 2013) (non-formulary medication approval or denial not in charts at Florence); ADC137443 (July 29, 2013) (31 of 50 Yuma charts reviewed have missing initials on dates indicating that the medicine was not administered); ADC137236 (July 14, 2013) (hospital-setting open reduction notation missing for a Florence prisoner's oral surgery on 6/21/13); ADC088887 (April 28, 2013) (on 4/11, there were no daily nursing notes on any charts reviewed in Florence); ADC088874 (April 18, 2013) (staff report Florence East does not report or document appointment no-shows); ADC088864-65 (April 14, 2013) (0 of 10 files Florence Central files reviewed had provider orders taken off and daily annotated with time, date, and name of person taking the orders off); ADC088856 (April 14, 2013) (4 of 10 Florence Globe charts reviewed revealed consultation reports were not timely reviewed by providers). It was not a surprise to me to read that a five-foot stack of unfiled records was found in the Tucson complex in February 2013. AGA_Review_00004833.

According to the monitors, medication administration records (MARs), an essential aspect of record-keeping, are frequently not completed to standard nursing practices: they often lack doses, routes, frequencies, start dates, and nurses' signatures. See, for example, ADC154407-08 (September 30, 2013) (at Yuma, 9 of 10 Cibola MARs, 9 of 10 Cocopah MARs, 10 of 10 Cheyenne MARs, 10 of 10 Dakota MARs, and

9 of 10 La Paz MARs noncompliant); ADC154327-332 (September 30, 2013) (at Tucson, 10 of 10 IPC/HU9 charts, 6 of 10 Rincon charts, 10 of 10 Manzanita charts, 10 of 10 Catalina charts, 10 of 10 Whetstone charts, 8 of 10 Minors/CDU charts, 10 of 10 Winchester charts, 6 of 10 Santa Rita charts, and 7 of 10 Cimarron charts reviewed had noncompliant MARs); ADC154306 (September 30, 2013) (16 of 32 Tucson MARs noncompliant); ADC154137 (September 30, 2013) ("MARs are not being completed correctly at any unit on Florence complex"); ADC154115-16 (September 30, 2013) (33 or 34 Florence MARs noncompliant); ADC154245 (September 27, 2013) (MARs at Phoenix are not compliant, and "nurse signatures do not match initials on MARs, prescription information crossed out and written over without initiating a new MAR entry"); ADC154205-07 (September 26, 2103) (at Perryville, 10 of 10 MARs at San Carlos, Santa Cruz, Lumley, PU/SM/PI, and San Pedro noncompliant); ADC154385-86 (September 1, 2013) (42 of 46 Yuma MARs noncompliant); ADC137591 (August 28, 2013) (medication at Phoenix is administered without a retrievable record of the recipient); ADC137656-59 (August 26, 2013) (at Tucson, 8 of 10 MARs at Rincon, 6 of 10 MARs at Santa Rita, 6 of 10 MARs at Manzanita, 8 of 10 MARs at Whetstone, 6 of 12 MARs at Catalina, 5 of 10 MARs at Winchester, 8 of 8 MARs at Minors, 9 of 10 MARs at CDU, 7 of 10 MARs at IPC/HU9, and 9 of 10 MARs at Cimarron not compliant); ADC137331 (July 31, 2013) (conflicting MARs for allergies for Phoenix prisoner); ADC137331 (July 31, 2013) (MAR for Phoenix prisoner has blank spaces on administration of antibiotics, no start date shown, and no diagnosis); ADC137295 (July 24, 2013) (Perryville MARs may be inaccurate); ADC137254-5 (July 30, 2013) (9 of 10 Florence East MARs, 10 of 10 Florence North MARs, and 10 of 11 Florence South MARs noncompliant); ADC137442-43 (July 29, 2013) (at Yuma, 8 of 10 La Paz MARs, 8 of 10 Cibola MARs, 10 of 10 Dakota MARs, 7 of 10 Cheyenne MARs reviewed were noncompliant); ADC137373-74 (July 24, 2013) ("the MARs are so messed up" at Tucson Santa Rita); ADC137303 (July 16, 2013) (Perryville Santa Maria, Santa Rosa, and

Piestewa Unit MARs noncompliant); ADC137303 (July 19, 2013) (Perryville San Pedro and Lumley MARs noncompliant); ADC088880-81(April 28, 2013) (multiple blank dates in most MARs reviewed at Florence); ADC089105 (April 27, 2013) (MARs at Yuma Dakota, Cocopah, and La Paz noncompliant); ADC089093 (April 27, 2013) (multiple MARs completed incorrectly at Yuma La Paz and Dakota); ADC088742 (April 4, 2013) (many MARs at Florence incomplete or filled out incorrectly).

I reviewed historic MARs in the medical records I read as well as active MARs in the different medical treatment areas of the facilities I visited. As suggested by the monitoring reports, I found that they are a documentation disaster. For example, in the chart of [redacted], whom I discussed above, I counted eight different MARs for August 2013. Each of the MARs contained some of his ordered medications, but each one was different from the rest by one or two medications. I was unable to figure out what medications he was actually supposed to be on because the MARs overlapped so much and there were no orders in the chart to use as a reference. It is no wonder the patient complained about not getting all of his HIV medications; clearly, nobody knew what to do.

I also saw examples of obvious nursing disregard for medication orders. [redacted] is a Florence patient who is on court-ordered treatment for injectable long-acting Haldol Decanoate via a Psychotropic Medication Review Board (PMRB) order. There was an indication in the MAR that the patient was due for his shot on October 23, 2013. I visited the facility on October 25 and the nurse in that unit indicated that she did not know if the medication had been given since it was not properly recorded. We found the medication on the shelf unused. Similarly, [redacted] was ordered Haldol Decanoate to be administered on October 18, 2013, by PMRB order indicating that he "can't refuse." Nobody could determine whether he had received his critical medication because a temporary nurse had been on shift that day and none of the nurses knew how to contact her to determine whether she gave the

medication or not. The issue remained unclarified for at least a week prior to my October 25 tour and nobody was able to resolve the issue and provide me an answer as to whether this critically mentally ill patient had been treated.

Another example of medication misadventure is the case of [redacted] who is currently being treated with Enbrel, a Tumor Necrosis Factor inhibitor that is quite expensive. He saw the specialist and an order was written on October 9, 2013, to change his Enbrel dosing to a new dose. The nurse made a notation in the MAR that the new dose was not to start until November 1 despite the fact that the medical order in the physician's written order section of the medical record clearly states that the new dosing was to begin October 9. The nurse overruled a specialist's medical management of a fragile patient in clear violation of scope of practice and medical oversight, but undetectable in this system unless someone is looking closely.

Also not surprisingly, ADC has major backlogs for provider chart review. See, for example, ADC154226 (September 27, 2013) (0 of 11 Phoenix charts reviewed showed that consult reports were reviewed by the provider within 7 days of receipt); ADC137360-61 (July 29, 2013) (Tucson Whetstone had 106 charts awaiting provider review, with serious backlogs also at Winchester, Cimarron, Rincon West Medical, Catalina, Manzanita, and Santa Rita); ADC137395 (July 29, 2013) (Tucson has backlogged charts needing review); ADC137369-71 (July 26, 2013) (Tucson Rincon, Catalina, Manzanita, and Santa Rita each have dozens of consult reports awaiting review); ADC137309 (July 26, 2013) (Perryville San Carlos and Santa Maria have provider review chart backlogs); ADC137236-37 (July 14 and 30, 2013) (most reviewed Florence South, Central, and North charts not timely reviewed by provider); ADC137236 (July 14, 2013) (Florence prisoner's 5/4/13 hospital discontinued orders were not reviewed as of 7/11/13); ADC137259 (July 30, 2013) (every Florence unit except Kasson has 70+ charts waiting to be reviewed); ADC088943 (April 30, 2013) (at Perryville, the medical director is providing direct care to inmates in addition to her other

responsibilities and has not been able to conduct monthly or quarterly chart reviews); ADC088746 (April 4, 2013) (Florence East charts with labs, x-ray reports, hospital notes, and consultant notes dating back to early February have not been reviewed).

In addition, there are problems at least in Perryville with getting information back from outside hospital stays, which makes post-inpatient planning, at a time when a patient is particularly fragile, very difficult. ADC 52804 ("there continues to be a delay in receiving hospital documentation, discharge information and/or recommendations. Staff are unaware who is responsible for this task"); ADC 52823 ("[t]his continues to be an issue for the provider to receive the hospital records, information &/or recommendations. It has occurred that the provider had not received these records by the time of the inmate's hospital follow up appt with the provider. It is unclear to staff, including providers – who actually is responsible for this task to be completed in a timely manner"); ADC 52782-83 ("[t]he hospital admission, care provided, tests done, discharge recommendations or follow up is not provided to the staff/providers, per staff – in a timely manner. It is unclear who is responsible for this task"); ADC 52760 ("[h]aving hospital record information, discharge information &/or recommendations is difficult to obtain in a timely manner. Staff state their frustrations with this task and it is unclear who is actually responsible for this task").

In my review of medical records areas on my tours I found many examples of records that had not yet been reviewed by providers and the data that they were supposed to review was quite old. For example, in Tucson I found entire shelves of medical records that contained loose filing that was over a month old waiting for providers to review. I reviewed the records myself and found many abnormal lab results and radiology findings that had yet to be acted upon. In addition, I found fifty-six lab results and radiology results in a file that indicated that the charts could not be found. As such, the abnormal results were just sitting there with no place to be filed and no action taken on the abnormalities.

3. Use of nurses as primary care providers

Patients are denied a clinician's professional medical judgment if nurses or other staff are called upon to make decisions that standard of care – and sometimes professional licensing requirements – reserve for primary care providers. This happens all too often in the Arizona system. See ADC137397 (Tucson infirmary patients are not being seen every 72 hours by doctor or mid-level provider, as policy requires, but are instead seen by LPN, CNA, or RN). In Yuma, I saw extensive evidence of this practice: LPNs doing RN work and RNs doing primary care provider work that should only be done by physicians, physicians' assistants, or nurse practitioners. My review of medical records for [redacted] in the Dakota Unit ([redacted]) provides one example. [redacted] experienced horrible follow-up after a hospital stay for three days with gastro-intestinal bleeding at the end of May 2013. The day after his return, he complained of chest and abdominal pain. He was seen only by an LPN, with no provider follow-up. (He was frequently seen by an LPN, including for chronic care appointments).

Other Arizona prisons also have this problem. I saw RNs reviewing labs and ordering treatment for end stage renal disease patient [redacted], in Florence. My review of medical records of [redacted] at Yuma showed multiple violations of nursing scope of practice. [redacted] has end-stage AIDS and he is a very complicated patient. He has been seen multiple times by LPNs for healthcare and the LPNs have diagnosed him and treated him for problems such as upper respiratory infections and a chronic rash. I requested to see this patient and it is clear that the LPNs' and RNs' management of him is medically incorrect, as described in more detail in Section II.C.4. They are well outside of the scope of their practice and they are far over their heads in even trying to assess a patient of this complexity. Sadly, he has suffered serious harm as a result of their mismanagement, all as a result of nurses attempting to practice medicine.

The dialysis program is essentially run by a nurse on a day-to-day basis. I reviewed all of the dialysis charts (approximately 12) at Florence and a nurse orders the labs, interprets the labs, decides on what changes need to be made on the dialysis prescription, and writes orders for post-dialysis management. This is boldly beyond the scope of practice for a nurse. The nephrologist overseeing the dialysis care within the system has inappropriately delegated prisoner dialysis treatment to a nurse and technicians.

Another example of nurses practicing beyond their scope is the nurse who attempted to provide postoperative management to Shawn Jensen (032465), who underwent a robotic radicle prostatectomy on July 15, 2010, and discharged on July 18, 2010, with instructions to follow up in three weeks for Foley removal. On July 20, 2010, and July 31, 2010, Mr. Jensen submitted two HNRs reporting leaking from his catheter site. He was finally seen on August 1, 2010, at which time the nurse offered him pads. He was again seen the following day, and instead of referring the patient to the provider for appropriate post-operative management of an indwelling catheter in a surgical site the nurse attempted to complete what she believed to be a Foley irrigation by "twist[ing] the catheter, manipulate[ing] the catheter, push[ing] it in further" in order to "try[] to get it to drain better." No improvement was documented. Fortunately, Mr. Jensen was already scheduled to be seen by the urologist on August 5, 2010, at which time he reported to the hospital with no urine in his leg bag and "soaked towels in his perineal area [in an attempt] to keep himself dry"; the urine had leaked through the towels into his orange jumpsuit. The cystogram completed at the hospital showed that the catheter was "located anterior and outside the bladder," and his urine had been leaking into his abdominal cavity. As a result of this botched procedure by the nurse, Mr. Jensen required emergency surgery to repair the tear in his bladder neck and remove the Foley from his abdomen. Mr. Jensen has continued to experience severe complications, and require a

number of operations, as a result of the nurse's inappropriate manipulation of an indwelling surgical drain.

Another example of nurses practicing beyond their scope is the case of Charlotte Wells (247188). On February 20, 2010, days after Ms. Wells received heart surgery to address her blocked artery, she complained of chest pain again at 7:15pm. ADOC0005180-81. At that time, she was seen by a nurse who treated her based on phone conversations with Dr. Enciso, the covering doctor that day. *Id.* She was never examined and appropriate diagnostic assessments were not completed. Her pain reportedly improved with treatment and she was sent back to the yard. *Id*. Medical standards of care indicate that patients who have recently received a stent are at high risk for getting a blood clot and having a heart attack post-procedure. Thus, any chest pain in a recently stented patient is usually very concerning and should be evaluated thoroughly by a medical provider instead of a nurse.

I found another dramatic example of nurses practicing outside of their legal scope of practice in the chart of [redacted]. There is a remarkable note in his chart dated July 12, 2013, indicating that telephone orders supposedly written by the Family Nurse Practitioner at 0430 the previous day were not written by or given by the Family Nurse Practitioner. It appears that the nurse on call decided to give this patient prescription medications without appropriate provider orders and she forged the order in the chart. When I looked at the provider orders, there were no orders in the chart corresponding to this incident, suggesting that someone had removed them from the record.

In general, these practices not only violate licensing requirements but they can all too easily result in bad outcomes. They also provide evidence of poor staffing in the Arizona system.

The following nightmarish example details how such a practice can seriously injure patients. [redacted] is a patient I chose to interview randomly in

the infirmary in Tucson. He related the following history, which I confirmed from a review of his healthcare records. On July 20, 2013, this previously healthy 42-year-old patient complained of neck and back pain and was seen by an LPN. He had a fever of 99.1 and the LPN did not examine him or consult anyone about him. She determined that he was OK and sent him back to his unit. It was a violation of the scope of practice for this staff member to make decisions about his care, and indeed the LPN made a drastically poor decision to provide no follow-up. Two days later, the patient again complained of back and neck pain and was again assessed by an LPN, who failed to take his temperature and decided to give him an injectable non-steroidal pain medication (Toradol). It was again a violation of the LPN scope of practice to assess this patient. This time, he was scheduled to see a provider on the following day. At that time, the RN found he had a temperature of 100.0 degrees and gross neurological deficits. He was sent to an outside emergency room, where it was found that he has an abscess of his neck muscles and epidural spinal abscess. He was sent to University Hospital for surgery and then transferred to St. Luke's Hospital for several months and then returned to Tucson IPC, where I saw him bed-bound, with no physical therapy and no prevention from complications of bed rest, foot drop on the left leg, fixed flexion contractures in the left hand, and an indwelling Foley catheter that had been in place for weeks. This case is a tragedy across the board. The fact that the healthcare system used LPNs out of scope virtually guaranteed a delay in diagnosis. LPNs are not taught to do physical examinations; they are not taught pathophysiology; and they have no experience assessing sick patients, developing a plan to work up the problem, and pursuing a proper diagnosis. As a result, [redacted] likely suffered much more significant neurological damage than necessary because of the delay in diagnosis.

[redacted] is now experiencing a different type of neglect. He is bed-bound, no care is rendered to him to help him gain strength and range of motion, and he is slowly and needlessly dwindling physically. The nursing staff have placed a Foley catheter into

his bladder; in my experience and based on the factors he presents, this decision was likely made because they grew tired of helping him urinate into a bottle. This places him at unnecessary risk for developing additional infections, all because there are not enough staff to help him with basic bodily functions. He also returned from the hospital with a hard cervical collar in place, which is a very unusual long-term intervention and it runs significant risk of causing long term impairment. I asked him if any of the physicians had seen him to discuss his need to wear the C-collar and he replied that nobody had discussed any plans with him in the six weeks that he has been back. I reviewed his chart and could find no clinical indication for continued use of a hard C-collar. This case is a tragedy of errors. Even now, given all that has happened, he could still make a modest recovery and retain the ability to perform activities of daily living, but he is being completely ignored in his bed by the staff and quickly losing what remains of his physical capabilities. I was so moved by his neglect that I called his case out to Corizon Arizona Regional Medical Director Dr. Williams and the attorneys for the State and Corizon in the hope they would intervene on his behalf.

4. Specialty care

The exercise of professional judgment sometimes requires more in-depth knowledge than primary care providers possess. In these cases, the provider must be able to refer patients for specialty consultations. This essential step often does not happen in Arizona. Haldane Depo - Perryville, 204:19-205:4, 45:13-46:2 (referrals have been an "issue of noncompliance," "pretty much . . . every month"); Sharp Depo, 47:18-48:2 (concerns with specialty referrals that have "loomed larger with time" and continue to present). Patients are harmed as a result.

I saw numerous examples of people whose cases clearly required input from specialists or a more advanced understanding of their complex needs but yet they were not referred for that care. For example, [redacted] in Yuma's La Paz Unit, has end-stage liver disease, with very little liver function left. He is very fragile and has a

complex case that is being mismanaged. When I saw him in early August 2013, he needed to see a hepatologist urgently. He never had, although he had been in ADC for more than three years.

Similarly, [redacted] is HIV positive and housed in the Tucson complex. His medications are not renewed regularly, resulting in gaps of up to a month without them (a grievance I saw in his file dated December 4, 2012, signed by Director Ryan, agrees he went without HIV medications for 30 days). As I discussed earlier, HIV medication management has to be done correctly and patients need to receive all of their HIV medications every day without gaps or the virus can mutate and further damage the immune system. [redacted] CD4 count (a common measure of the strength of his immune system) dropped dramatically due to the medication mismanagement. If the virus has become resistant, the medications might need to be entirely changed. Despite his poor care and obvious deterioration, he has never been seen by an HIV specialist.

[redacted] housed in the Manzanita Unit IPC in Tucson, is an extremely fragile 31-year-old patient with lupus and multiple sclerosis; the intersection of these two major diseases makes him an extremely complicated patient in need of specialty care. He has been seen by a rheumatologist on telemedicine, but not enough, and some of the recommendations of the specialist have been ignored. In a well-functioning system he would be seen regularly by multiple specialists and have regular labs to measure the effect of the medications. He is not getting such care and as a result, his life expectancy will be shortened and he will likely become debilitated.

Another example, [redacted] is a patient who has lupus. It had initially been incorrectly diagnosed as Sjogren's disease in 2007. He saw a rheumatologist via telemedicine in 2011 who diagnosed lupus, but he did not see a rheumatologist again (by telemedicine) for two years, which is far too long.

Even when referrals are actually made, they are all too often delayed so long as to place the patients at serious risk of harm. I addressed the case of [redacted]

[redacted] earlier in the report in relationship to nurses attempting to manage his end-stage AIDS. The complexity of his case allows me to make additional points with respect to the failure to have him treated by an HIV specialist. At the point in time that I saw him his CD4 count was 64 and he was suffering from a horrible whole-body rash. When the LPNs finally gave up trying to manage his rash they referred him to the facility doctor. The facility doctor felt he was allergic to his Atripla (combination medication containing efavirenz, emtricitabine, and tenofovir). To deal with his rash, she decided to switch him to Truvada (combination medication of emtricitabine and tenofovir). Her decision-making is just nonsensical. Not only did she not eliminate the medications that she thought he was allergic to by switching him to Truvada, she put him on sub-therapeutic dosing of HIV medications by prescribing only Truvada. As such, she placed him at grave risk for the development of drug-resistant virus and for the acceleration of his decline. She obviously does not understand basic HIV management or the medications used to manage this disease. Additionally, because his CD4 count is so low and his immune system is so compromised, he absolutely must be on prophylactic antibiotics to prevent opportunistic infections. Under her management he has received none of the appropriate antibiotics, which is a complete violation of the standard of care. I interviewed [redacted] and saw that his rash, a direct result of his low CD4 count, is actually quite serious. The mismanagement of his HIV within the prison system has contributed directly to his decline and he is in desperate need of management by an HIV specialist. On May 23, 2013, an infectious disease consult was ordered, but it was never done. This failure is catastrophic for [redacted]; the deficiencies in care that he has experienced in ADC are life-threatening.

[redacted] has basal cell cancer (a skin tumor). He was given a definitive diagnosis in a biopsy on May 1, 2012, and at the same time a consultation was appropriately requested for dermatology, plastic surgery and a CT scan of his neck. The CT scan was not done until February 5, 2013, and the dermatology and plastic surgery

consultations have never happened. A repeat order for a dermatology consultation was written on July 22, 2013. Although the biopsy removed some of the growth, cancer cells remained in the margins and if they are not removed, the cancer will continue to grow and metastasize. If left untreated this condition is potentially fatal and can cause deformity and pain.

I met Shawn Jensen (032465), a class representative in this case, in ASPC-Tucson. He had been waiting for a CT scan for an aneurysm in his heart that was first ordered in July 2010; it was finally done the day before my tour. Fortunately, there were no significant negative findings, but the delay of more than three years for this test placed Mr. Jensen at unreasonable risk of harm and caused him prolonged and unnecessary distress.

[redacted] in Florence has newly diagnosed significant rectal cancer. He had a consult written to oncology on September 24, 2013, for initial evaluation. This consult is essential for his care, but as of October 16, 2013, I saw no evidence in his file that it was approved, scheduled, or completed. Similarly, [redacted], also at Florence, has a large hepatic cyst. He had received excellent care prior to incarceration and his physician wrote a letter on July 8, 2013, outlining the care plan for the patient's multiple significant problems. That care plan included a cardiology consult and a general surgery consult to evaluate his large hepatic cyst for surgical treatment. A cardiology consult was written by a physician's assistant within the prison on September 3, 2013, but he did not write a general surgery consult despite the fact that it was recommended in the same letter. Both specialty consults are essential for his care, but as of October 16, 2013, I saw no evidence in his file that the cardiology was approved, scheduled, or completed and the general surgery consult had been completely disregarded and never initiated.

Referrals do not appear to be tracked in any meaningful way. Mielke-Fontaine Depo – Florence, 251:9-251:19 (no list of urgent consultations at a facility; only way to

find out is to look at the file for each consult ordered). Corizon Arizona Regional Medical Director Dr. Williams, along with one colleague, reviews all utilization management requests, including for off-site specialty care. Deposition of Winfred Williams, October 10, 2013 (Williams Depo), at 16:7-16:13. The requests are entered into a computer system, as are approvals and denials, and appointment schedulers at the prisons are informed of the approvals. *Id.* at 84:6-84:15, 85:25-86:5, 90:7-90:19.

An effective healthcare delivery system requires more, however: it must have the capacity to track referrals with a time line for completion and provider notification. The time line is essential because time frames vary: some referrals need to go immediately, others must be completed quickly but are not immediate, and still others can be completed on a longer time line or can happen when there is room in the schedule. Referrals must also be tracked so that cancellations, which are an unfortunate reality in correctional medicine due to factors such as court dates and institutional emergencies, are minimized and referrals are rescheduled promptly as needed. I see no evidence of these essential measures in the Arizona prisons.

Neither ADC nor Corizon requires that providers who make specialty referrals be notified about whether the referral was approved. Williams Depo, 87:3-14; Responses 257 and 259, Defendants' Responses to Verduzco's First Set of RFAs (all healthcare staff referrals to outside contractors must be reviewed and approved by a committee of healthcare and ADC administrative staff , but ADC policy does not require the committee to notify the referring healthcare staff whether the referral was approved or denied); Responses 260 and 262, Defendants' Responses to Verduzco's First Set of RFAs (Corizon policy requires all healthcare staff referrals to outside specialty contractors be reviewed and approved by a committee of healthcare staff, but Corizon policy does not require the committee to notify the referring healthcare staff whether the referral was approved or denied). Not surprisingly, the primary care providers are not in fact always notified of the status of referrals. Sharp Depo, 71:19-72:4, 72:5-24 (physician who

practiced at Eyman, Florence, and Perryville testified he would not always be notified whether a specialty referral was approved and this was a "concern about adequacy of care"). This is a problem because it is the job of the primary care physicians to track the continuity of care for patients under their care. They are expected to manage the patient up to the point of the referral, assess the new information obtained from the referral, and then implement a new care plan for the patient based on the referral. If they don't know the status of a referral, how can they reasonably manage their patients in this chaotic resource-limited environment?

Even when notified, providers often do not review referral reports in a timely manner. ADC154105 (September 30, 2013) (13 of 42 Florence files reviewed show consultation reports were not reviewed by the provider within seven days of receipt); ADC137428 (July 29, 2013) (5 of 9 Yuma La Paz charts reviewed do not have consultation reports reviewed by provider within seven days of receipt).

Although referrals are not effectively tracked, ADC monitors have catalogued extensive delays that serve to bolster my opinion that this aspect of care in Arizona prisons is completely broken and just missing in many cases. See, for example, ADC137629 (August 29, 2013) (Tucson prisoner's 7/11/13 urgent orthopedic consult request for foreign body in knee with repeated infections has not been addressed); ADC137628 (August 29, 2013) (Tucson prisoner with basal cell cancer not scheduled to go out for treatment despite numerous HNRs requesting such); ADC137365 (July 31, 2013) (Tucson prisoner submitted an emergency HNR for chest pains on 6/15/13 and was not seen until 7/9/13); *id.* (July 31, 2013) (Tucson prisoner with an aortic aneurysm measuring 4.2 cm on 6/16/11 and 4.7 cm on 10/25/12 had an urgent cardiology consultation dated 5/28/13, but apparently had not been seen as of 7/10/13); ADC137238 (July 30, 2013) (Florence prisoner had an urgent surgery requested on 5/30 and had not been seen as of 7/25); ADC137236 (July 30, 2013) (Florence prisoner had an urgent consultation written on 5/30/13 and was not seen as of 7/25/13); ADC137425 (July 23,

2013) (a Yuma provider's telephone order for two prisoners with abscesses was not "signed" as of 7/15); ADC137369 (July 11, 2013) (Tucson prisoner received a cardiology consult on 6/6/13 for syncopal episodes, was referred for a walking EKG and follow-up appointment with cardiology, but was not sent for an EKG; another Tucson prisoner's cardiology follow-up approved 2/7/13 but not seen by 7/3/13; a third Tucson prisoner with testicular mass and urethral stricture seen by urology on 1/30/13, consults submitted 3/26/13, but not yet seen/scheduled; a fourth Tucson prisoner's urgent colonoscopy consult was written 12/31/12, approved 3/13/13, but not yet scheduled); ADC137322 (July 8, 2013) (an urgent consultation for a Phoenix prisoner was written on 5/15/13, entered on 5/24/13, and had not been scheduled as of 7/8/13); ADC088863 (April 30, 2013) (Florence North prisoner who was exposed to HIV positive blood on 4/24 had no progress note or SOAPE note documenting the incident nor an indication that the prisoner was seen by medical after exposure); ADC089013 (April 29, 2013) (an urgent cardiology consult for a prisoner at Tucson Whetstone written on 6/7/12 was not reviewed by a provider until 3/8/13); ADC088858 (April 27, 2013) (prisoner's recommended left heart catheter/angiogram was not addressed at Florence South); another prisoner delayed in beginning radiation therapy for prostate cancer at Florence North); ADC088856 (April 27, 2013) (prisoner at Florence North with urgent oncology request on 2/25/13 was not seen until 4/10/13, with consult re-written on Corizon form on 3/29/13); ADC088746 (April 4, 2013) (Florence Central appears "out of compliance for scheduling specialty care appointments"); ADC037152 (October 2012) (Tucson prisoner had "urgent cardiology written 8/16/12 approved 9/14/12 not scheduled as of 10/1/12"; another "[i]nmate was seen by cardiology on 3/28/12 requested 2D Echo and adenosine stress test. If these test[s] are abnormal consider cardiac catheterization, otherwise f/u in one year. Dr. DeGuzman has ordered Consult urgent on 4/30/12. Inmate has not been seen [as of October 2012 review]. There is no indication the studies have been approved to be done"); ADC 52782-83 (November 2012) (Perryville prisoners are not being

referred out in a timely manner for specialist reviews, and outside medical consultations are not reviewed in a timely manner by prison healthcare providers, including "consult report dated 09/27 and was signed on 11/13/12").

Urgent consults are often not seen as required within 30 days. See, for example, ADC154103 (September 30, 2013) (8 of 10 urgent consults at Florence noncompliant); ADC154226 (September 27, 2013) (2 of 3 Phoenix urgent consults noncompliant); ADC137428 (July 29, 2013) (5 of 9 Yuma La Paz charts reviewed noncompliant).

In my review of the medical records across all of the facilities I visited, the failure to schedule consult appointments in a timely fashion was rampant in the charts. On the whole I found the on-site physician consultation requests to be medically appropriate and it is clear that the breakdown is at the system level with delays, obfuscations, alternate treatment plans, and frequently total disregard for the consultation requests. In most of the cases I reviewed, the failure to accomplish the consultation was a clear violation of the standard of care for the disease being treated.

5. Substandard care decisions

To this point, I have discussed the exercise of professional judgment in terms of what is needed to get the patient in front of the provider and to get the provider the tools needed to make treatment decisions. There is another element, however: those treatment decisions must be consistent with community standard of care. In the Arizona system, all too often the providers make treatment decisions that are clearly substandard and endanger their patients.

Because human error is a reality of life, a responsible healthcare delivery system builds in methods to find and correct such problems.[9] A rigorous quality assurance

[9] The fact that human error is inevitable does not make it excusable. The errors and omissions I describe in this section are serious and harmful; some, in my opinion, are actionable. My point here, however, is that because people are fallible, particularly in chaotic systems such as I have seen in Arizona, a responsible health care system must be prepared to find and address mistakes before they impact patient care.

program, a functional patient feedback loop (such as through HNRs and grievances), and high-quality staff who communicate well with one another and are supported by a responsive system that delivers assistance in the form of appropriate diagnostic testing and timely specialty referrals are all essential elements to correct for the known factor of human error. As discussed elsewhere in this report, Arizona lacks all of these elements. The results, for some of the many patients who are placed at severe risk, are described below.

[redacted] at Perryville experienced terrible medical judgment in wound care. She told me she was returned to the prison on June 12, 2013, after delivering by a Caesarian section in an outside hospital. She reported that she noticed her wound was leaking and infected after only a few days and she asked for attention at the medical unit several times but was sent away each time, finally being told, by an officer, "if you come back again without an appointment, we'll write you a ticket." As a result, she said she was on the yard for two weeks with an open incision (she was later told it was more than an inch deep.) Finally, she was taken to the infirmary, where the wound started to heal. As of July 30, when I saw her, medical staff were packing the wound with sugar -- the kind of packets you use for coffee. This treatment was documented in her medical records. I have never anything like it in my years practicing medicine and it definitely does not conform to the standard of care.

At ASPC-Phoenix, I saw the healthcare records for [redacted] whose name had appeared on the HIV chronic care list. The chart clearly stated that he is not HIV+, and that he had purportedly lied about that status in 2008. However, test results in the file that were several years old showed that he has an active case of syphilis, and there was no indication in the file that anyone had done anything about his illness.

[redacted], in Yuma, urgently needs wound care that works; his current inadequate treatment has transformed a treatable infection into a huge, gaping wound that requires immediate plastic surgery and reconstruction on his leg. This patient

has lost his ability to walk as a result of a year's worth of mismanagement of a simple wound and inept treatment. When I spoke with him on August 2, 2013, his wound was being treated with silvadene, which is silver in a cream, typically used for initial burn treatment. It is a ridiculous choice for this purpose and its chronic use does not conform to the standard of care.

Also at Yuma, I interviewed and reviewed the charts for [redacted] a 69-year-old with hypertension. On June 10, 2013, at 1:15 a.m., he complained of chest pain. An RN evaluation by L. Sanders told him to "drop HNR" and "return[] to dorm." At 7:50 a.m., he complained of chest pain again, and this time RN A. Gutierrez appropriately sent him to the emergency room. He had a heart attack. In sum, medical staff lost six and a half hours during this patient's heart attack through RN error and lack of effort. Fortunately, he lived, but the risk of injury or even mortality was high.

[redacted] also in Yuma, has out-of-control diabetes. In December 2012, in county jail, he was found to have a very low blood platelet count, possibly as a result of medication he was given (Depakote). At that time, it was 62, which is an alert to medical staff. On March 5, 2013 (after he had arrived in ADC), it was at 49 and his white blood cell count was at a critical low. His liver function was normal on that date. These test results were not reviewed for five days, which is far too long for such abnormal findings, and nothing was done even after they were reviewed. On May 17, 2013, his lab values had changed radically and he had substantially high liver enzyme readings. These results were not read until June 6, an even longer and less excusable delay, and again, nothing was done as a result. These abnormal lab results showed serious liver dysfunction and dysfunction in the production of the cells of the blood system and should have been quickly addressed. In addition, he has lost vision in his eyes due to his diabetes but no retinal exam has been completed, his blood sugars are routinely out of control with no attempts at management, and he is not on an ACE inhibitor to protect his kidneys, which is a clear violation of the standard of care. [redacted]

[redacted] case is error compounded on error, with critical physical exam findings and critical lab values that as of August 2, 2013, were unaddressed, and routine chronic disease management that has been poorly designed and implemented.

[redacted] in Yuma's Cheyenne Unit, has a severe case of Crohn's Disease, which is fistulizing: his bowel walls are breaking down and fecal matter leaks out into other areas, which is life threatening. He is an extremely fragile patient, at serious risk, who requires constant vigilance. He was admitted to the hospital with a significant fistula and abscess where he was stabilized and then transferred to Florence where he recovered. The hospital started him on Remicade (a tumor necrosis factor inhibitor) which is the standard of care for management of fistulizing Crohn's Disease. By his report he received two doses. However, when he was transferred back to Yuma, Corizon declined to continue his Remicade and switched him to asacol. Since starting the asacol he has decompensated several times and ended up back in the hospital. The cardinal error in this case was stopping the Remicade, apparently because of a central office utilization review decision. Remicade is a unique medication that is the standard of care for this patient's disease and the only thing that really works to reduce the development of fistulas. Once it is started, it must be maintained since it is usually not possible and medically dangerous to restart Remicade in patients because of extreme risk of allergic reaction upon re-exposure to this medication. As such, it is very unfortunate that the poor decision-making within the system probably has eliminated as a treatment option the only medication that really works by exposing him to Remicade for a couple of doses and then stopping it.

In Tucson, [redacted] complained of swelling in his chest for more than a year. He was told repeatedly by medical staff that it was only a cyst, but when it was finally biopsied in March 2013, it was found to be Stage IVB Hodgkin's Lymphoma. No care was pursued until May 2013. The cancer is now untreatable because it is so far advanced.

[redacted] in Tucson, is 17 years old. He has shotgun pellets in his knee and a plate in his femur that is probably infected. His infections have been partially treated through antibiotics and dressing changes, but the underlying problem is the plate, which clearly needs to be removed. He was seen by an orthopedic surgeon at the hospital, who ordered that he be seen again on September 19, 2013. As of October 24, he did not have an appointment. He has only 10 degrees range of motion in his knee, and will likely be disabled at a young age because of this failure to provide adequate care.

[redacted] also in Tucson, has heart problems, but there is not a single EKG in his healthcare records. He has an artificial heart valve which requires anti-coagulation medication. He is on a high dose of Coumadin which has failed to produce an appropriate amount of thinning of his blood. His treatment plan was not changed for over a year even though there is ample lab evidence in the chart that his plan is failing. He is also on ibuprofen, which is contraindicated with Coumadin.

Desiree Licci (150051) suffers from a prolapsed uterus, Stage III cystocele, and Stage III rectocele, and a hysterectomy was recommended by Dr. Irving. ADC122691, ADC122684. However, since Ms. Licci does not objectively fit the classic criteria for a hysterectomy, her subjective complaints and reports of pain were not considered.

Ms. Licci has a history of breast and ovarian cancer. In late 2010, she began to experience a series of symptoms, including fatigue, pain, and congestion, and she also began to feel multiple masses on her arms, breasts, eyelid and mouth. In November 2010, her provider attributed her symptoms to Hepatitis C. In February 2011, her provider noted that the question of whether her symptoms indicated a reoccurrence of cancer was a question for experts. ADC005459. Ms. Licci continued to experience symptoms that were increasing in severity. She submitted a number of HNRs requesting care. See, e.g., ADC0010810, 0010808, 0010799. On May 14, 2011, in response to her HNR regarding the lump in her arm, she was told that the "Hep C issue" would be addressed first. ADC005905. In response to another HNR submitted May 14, 2011,

regarding a visit with oncology, the response notes "all in good time. You have multiple problems. Consult to oncology written on 5/18/11." ADC005906. After a number of attempts to get treatment for her symptoms and lumps, she finally received a properly administered CT scan in September 2011 which revealed numerous masses in her reproductive system. ADOC0010633-34. Ms. Licci then received an MRI in March 2012 which confirmed multiple masses in her reproductive system. Ms. Licci was finally seen by an oncologist in February and May 2012, who concluded that she had a "simple cyst," without conducting any type of biopsy in this cancer survivor. She needs be evaluated by a gynecologist for proper management of her reproductive system issues.

D. Delivery of care that is ordered

The third major component of an adequate medical care system is the right to treatment. Patients must not only be seen by appropriate clinicians and given appropriate diagnoses and treatment orders; they must actually receive the care – medications, labs and other diagnostic tests, special diets -- that is ordered. Teamwork, communication, and good documentation are essential to ensure that care that is ordered is actually provided to patients. I have observed multiple barriers in the Arizona system that interfere with care delivery.

1. Providers' orders

Orders written by providers must actually be carried out. Throughout the Arizona system I saw a consistent pattern of ordered care – medications, labs, nursing care, follow-up appointments, specialty referrals – not getting done. This is another symptom of a badly understaffed medical care system.

In Florence North and East, I was also struck by the divide between nursing and medical staff in terms of orders not being carried out. For example, I talked with [redacted] a patient with MRSA and multiple episodes of serious staph infections. There were orders to medical staff to call him in for a wound check to see if he had healed from his infections, but he was never brought in to be seen.

[redacted], in Tucson, has prostate cancer that was partially treated. His doctor appropriately recommended that his prostate be reduced chemically with Casodex to allow him to function normally without a Foley catheter, which he has had for 14 months. The recommendation was denied, which subjects this patient to needless pain and suffering.

[redacted] housed in the Manzanita IPC in Tucson, is an extremely fragile 31-year-old patient with lupus and multiple sclerosis; the intersection of these two major diseases makes him a very complicated patient in need of specialty care. Some of the recommendations of the specialist he has seen have been ignored.

[redacted] is housed in the Florence infirmary because he has very aggressive multiple sclerosis (MS). He has been evaluated by an outside neurologist (Dr. Ales Hlubocky) who described his situation as "very active MS, disease is aggressive impacting ADL's significantly." On August 13, 2013, Dr. Hlubocky recommended Tysabri infusions because of the severity of the disease and because of its aggressive appearance on neurological imaging. So far the Tysabri has not been approved and there is a notation in the patient's record that Corizon is seeking to find a second neurologist to seek an alternative to the Tysabri treatment that has been recommended. As of October 15, 2013, no Tysabri has been administered to the patient, no follow-up has occurred with his neurologist, no appointment has been scheduled with the second neurologist, and the patient is bed-bound. His disease continues to progress without any treatment and he has now lost the ability to feed himself because his hand tremor is so severe that he cannot get food into his mouth. The other prisoners on his unit help feed him because the IPC where he is housed is so short-staffed with nurses that this is his only option despite the fact that in my understanding it is technically against ADC policy. Without treatment he will continue to lose function, lose vision, lose the ability to sit and care for his basic body needs, and his life span will be significantly shortened.

Throughout my chart reviews it was common to see labs ordered but never done, medications ordered but not approved, medications ordered but not administered by the nurses, ADA accommodations ordered but not provided, consults ordered but never approved or scheduled, follow-up appointments requested by providers but never scheduled, and medical diets ordered but not received. In the Arizona prison system prisoners invest a tremendous amount of time, effort, money, and suffering into finally getting to see a provider; it is such a tragedy that when those providers do order appropriate healthcare interventions, the system is all too often not accurate, expeditious, or motivated to ensure that the care is delivered.

2. Medication administration and monitoring

Prescribed medications must be provided to patients in a timely, consistent manner. Medications must be renewed regularly and without interruption, and prisoners must be able to transfer housing locations without medication interruptions. The system must ensure appropriate monitoring of efficacy and side effects. Arizona fails in all these areas, as high-level administrators acknowledge. Robertson Depo, 143:23-144:9 (ADC's Medical Program Administrator describes gap in delivery of medications under Corizon, including the delivery of HIV medication); Gross Depo, 61:20-62:2 (ADC Assistant Director over the Health Monitoring Bureau notes that ADC has identified problems with medication management, including refill, reordering, and dispensing), 62:22-63:4 (there are problems both with the pharmacy refilling the medications and because doctors aren't rewriting prescriptions as needed); Williams Depo, 54:6-54:25, 56:21-56:24 (Corizon Arizona Regional Medical Director admits to problems with Corizon's pharmacy services, with "some discrepancy between the expiration report and the patients actually being on medications").

The ADC monitors' reports show that administration of prescription medication is frequently delayed or missed. ADC154207 (September 26, 2013) (16 of 24 Perryville MARs showed unreasonable delays in prescription medication distribution); ADC137255

(July 30, 2103) (Florence prisoner hospitalized after not receiving antibiotics following surgery); ADC137432 (July 30, 2013) (prisoner at Yuma Cheyenne presumably went without psych medication when his 5/28/13 HNR was not addressed until 6/19/13); ADC137443 (July 29, 2013) (31 of 50 Yuma charts reviewed have missing initials on dates indicating that the medicine was not administered); ADC137390 (July 29, 2013) (Tucson prisoner went 20 days without medication despite filing HNR alerting staff to upcoming medication expiration dates) ADC137294-5 (July 24, 2013) (pill line delays at Perryville); ADC137293 (July 24, 2013) (boxes of undistributed medications were found on multiple occasions at Perryville); ADC137264 (July 14, 2013) (Florence prisoner (163888) had an order for intravenous Primaxin [antibiotic] upon discharge from the hospital, and although this was brought to the attention of nursing staff on 7/5/13, there was still no medication as of 7/8/13); ADC137305 (July 5, 2013) (at Perryville San Carlos, three inmates who were prescribed antibiotics did not receive them); ADC089051 (April 30, 2013) (Tucson prisoner's (15141) Rifaximin marked not available from 4/1/13 to 4/24/13); ADC088880-81(April 28, 2013) (8 of 10 reviewed MARs at Florence North had multiple blank dates indicating medications not administered); ADC088880-81 (April 28, 2013) (6 of 10 reviewed MARs at Florence Kasson had multiple blank dates indicating medications not administered); *id.* (April 28, 2013) (10 of 10 reviewed MARs at Florence East had multiple blank dates indicating medications not administered); ADC088880-81 (April 28, 2013) (8 of 10 reviewed MARs at Florence Central had multiple blank dates indicating medications not administered); ADC088973 (April 21, 2013) (multiple prisoners at Phoenix Aspen did not have medications for April); ADC088744 (April 4, 2013) (MARs at Florence Kasson listed medications that were not available to prisoners for multiple days in a row in March); ADC088742 (April 4, 2013) (minimum of 47 patients in Florence East who were consistently absent from "watch swallow" medication line).

Corizon policy requires prisoners to file an HNR to request that chronic care prescription medication be refilled (Response 31, Defendants' Responses to Verduzco's First Set of RFAs), a practice that practically guarantees patients will face medication interruptions. They do: prisoners consistently reported to me that it takes a week or more to get refills. At Tucson, I saw many HNRs for medication renewal that were over a month old; they had not been reviewed by a prescriber so they were not refilled.

The ADC monitors have documented extensively that prescriptions are commonly allowed to expire before being reordered or renewed and expired medication continues to be distributed. ADC154137 (September 30, 2013) ("[m]edications are not being ordered prior to expiration on any unit on Florence complex"); ADC154333 (September 30, 2013) (Tucson staff reordered 0 of the 140 formulary prescriptions reviewed either on or prior to expiration, and only 5 after expiration); ADC137603 (August 29, 2013) (only 66% of chronic care medications in Phoenix are being reviewed prior to expiration); ADC137576 (August 20, 2013) (medicine renewal compliance is 67% at Perryville); Winland Depo, 129:6-129:11 (127 prescriptions identified as expired in Phoenix); ADC137339 (July 19, 2013) (Phoenix Aspen notes 64 expired medications cards in with current administered medications); *id.* (July 31, 2013) (multiple units at Phoenix document currently using medications that have expired); ADC137256 and ADC137240 (July 30, 2013) (51 of 375 Florence prescriptions were renewed after expiration); ADC137395 (July 29, 2013) (medications are not ordered, filled, or refilled on time at Tucson); ADC137240 (July 29, 2013) (medications are improperly refrigerated and not timely renewed at Florence); ADC137306 (July 29, 2013) (71 of 165 Perryville prescriptions expired prior to renewal date); ADC137430 (July 25, 2013) (a "more diligent approach to filling and refilling expired medication must be adopted" in Yuma); ADC137333 (July 25, 2013) (52 of 103 prescriptions reviewed at Phoenix expired prior to renewal date); ADC137323-29 (July 24, 2013) (64 expired medicine cards from April 2013 to July 2013 are in the currently used bins at Phoenix); ADC137313-14 (July 12 ,

16, and 19, 2013) (expired medication in use in KOP and DOT bins at Perryville San Pedro, Lumley Santa Cruz, Santa Rosa, Santa Maria, and Piestewa); ADC137306 (July 15, 2013) (at Perryville, 86 of 154 prescriptions reviewed expired prior to their renewal date and 20 of 154 prescriptions ran reviewed out of medication prior to their renewal date); ADC137306 (July 15, 2013) (review of Perryville July 1-8 stop date report showed chronic condition medication expiration dates were not being reviewed prior to expiration); ADC137259 (July 30, 2013) (medications at Florence are expiring before being reordered); ADC088890 (April 15, 2013) (numerous medications in the "Man Down" bag at Florence were expired, some for over one year); ADC089106 (April 27, 2013) (many delays in receiving medication at Yuma); ADC088947 (April 22, 2013) (43 of 112 reviewed mental health and chronic care prescriptions at Perryville were expired without renewals).

Some of the medication delivery problems are caused by staffing deficits. For example, Corizon slashed in half the number of pharmacy technicians at Tucson. AGA_Review_00001704-1705. This has caused problems such as those documented above in this Section. It has also led to problems not monitored in the MGAR process: for example, as of March 28, 2013, pharmacy staff at Tucson were unable to ensure prisoners are provided medications on release. AGA_Review_00009347 -9349.

3. Labs, imaging, and other tests

Diagnostic tests are an essential part of any medical care system. Arizona fails all too often to provide labs, x-rays, CT and PET scans, and other tests that are ordered by providers as crucial diagnostic tools.

Some tests that are ordered are simply never done. In Florence, I noticed in the chart of one patient with Hepatitis C ([redacted]) that there was no record of his current viral load even though there was an order to draw that lab on August 19, 2013. When I asked for any records indicating his current viral load, I was told by Corizon Arizona Regional Medical Director Dr. Williams that there were no results in the file

because it had not been done. It is important in treating Hepatitis C patients to understand their viral load because it correlates with the severity of the disease and determines the success of treatment. In Tucson, [redacted], who is HIV positive, had appropriate labs ordered but never drawn (as confirmed by the Corizon attorney on the tour), so his providers know nothing about where he is in the disease process and cannot effectively treat him. He is admitted into the Inpatient Care Unit where he has had a number of medical complications that have required care but the medical doctors do not even have the basic healthcare information about his underlying condition even though it is prominently listed as an active problem in his chart. This is just bad healthcare.

Another Tucson patient, [redacted] has basal cell cancer (a skin tumor). He was given a definite diagnosis in a biopsy on May 1, 2012, and at the same time an order was placed for a CT scan of his neck. The CT scan was not done until February 5, 2013. If left untreated this condition is potentially fatal and can cause deformity and pain.

Even if lab tests are done, they are sometimes not timely filed or reviewed, which renders them useless for patient care. In the clinic at Santa Rita unit in Tucson, I saw a great deal of loose filing of lab results and consult results and x-ray reports which were upwards of four to six weeks old and had clearly never been looked at by anyone – they were not organized into the patients' files and there were no signatures indicating review or any follow up. Such delays can be dangerous to patients: I looked at many of the unreviewed lab reports and found significant abnormal levels. If lab results are not reviewed promptly, they do the patient no good – they might as well not have been ordered. These errors speak to lack of staff and provider availability.

My findings are bolstered by the testimony of ADC's own staff. See Sharp Depo, 54:21-56:5 (according to Perryville physician, it currently takes 2-4 weeks to get x-ray reports from radiologist; such delays can and have posed a serious risk to patients);

ADC137319 (July 31, 2013) (no regular medical provider line in Phoenix, resulting in untimely review of laboratory results); ADC088856 (April 14, 2013) (review of imaging and lab results at Florence Globe was delayed, including an x-ray result that was received on 2/27/13 and not reviewed until 4/5/13 and an abnormal lab dated 3/14/13 and still not reviewed as of 4/5/13). See also Maryann Chisholm (200825) for delays in reviewing lab work and consult orders.

4. Special medical diets

Medical diets are necessary as part of the overall care plan for some patients. Healthcare providers order these special medical diets just like medications because in many instances a proper medical diet is more efficacious at treating a problem than prescription medications. As such, I always pay attention to making sure that certain types of patients receive appropriate diets because it is so essential to successful disease management. I was shocked to discover that Arizona prisons have extremely limited disease-specific diets. The most common special diet in a correctional facility is a calorie-controlled diabetic diet. This does not exist in the Arizona prison system. I pulled diet binders that listed the diets available, I pulled diet order forms that were used for ordering diets, I pulled lists of medical diets that the kitchen was preparing for individual patients and not a single mention of a diabetic diet was found. This is inconceivable to me as a clinician as it eliminates one of the most important variables in managing diabetics—moderating the amount of sugar (carbohydrates) they consume.

Florence's Deputy Warden for Operations, Julie Jackson, attempted to explain the medical diet issue to me and indicated that a few years ago medical diets were eliminated in favor of a universal "heart healthy diet" in the ADC. She explained that the heart healthy diet was used for almost all medical diets regardless of condition and it has greatly simplified the process of producing food in the prisons. She informed me that the diabetics were all given the heart healthy diet and they did just fine on it. Based on her assertions I sought to find evidence of the universal diet's effectiveness. I reviewed

blood sugar logs for diabetic patients, chronic care notes for diabetics, and standard diabetic laboratory monitoring results in the medical records. What I discovered, not surprisingly, is that while the universal heart healthy diet may be convenient for corrections, it is not effective in managing diabetic patients. A very high percentage of the insulin-dependent patients had sugar levels that were poorly controlled. For example, when [redacted] came into the system, his Hemoglobin A1c level (an indicator of long-term blood sugar control covering about 90 days of time) was 7.6%, which indicates that he was in reasonably good control prior to incarceration. After he moved to Florence and began the heart healthy diet plan, his finger stick blood glucose readings jumped up consistently to the 300 to 400 range and his Hemoglobin A1cs increased to 10.3 and 10.6 on respective tests. As determined by the objective evidence he went from being a well-controlled diabetic to a very poorly controlled diabetic, at risk for severe disease complications.[10] The insulin was the same and the patient is the same; the primary variable that changed was the diet. I saw many examples of this phenomenon and while I did not have the time in the prisons or access to the documentation I need to examine the entirety of the medical diet dilemma, I see it as a major issue that deserves more study since I believe that the inappropriate diet issues in the prison contribute dramatically to the disease issues that I did study in detail.

E. Protection from preventable negative outcomes

Healthcare administrators know that a significant number of negative outcomes can be prevented through carefully implemented quality assurance, patient feedback, and

[10] Another breakage in the system is that if a blood sugar goes above 400, nursing staff are ordered to call a medical doctor so that action can be taken. I routinely saw blood sugars over 400, up to 500, with no notes, no assessment, and medical staff simply giving insulin and calling it good treatment with no provider involvement despite medical orders to call. I saw no indication that anyone had called a provider about [redacted] blood sugar readings.

screening mechanisms. I saw no evidence that any of these measures have been meaningfully implemented in the Arizona system.

1. Quality assurance

People make mistakes. This is an unavoidable fact of human nature. In order to find and correct errors before they harm patients, healthcare administrators establish quality assurance mechanisms.

An effective quality assurance process requires structured and systemic review of healthcare processes throughout the whole system. This is typically done by identifying a problem to be investigated, developing a hypothesis, performing a review of a statistically significant number of charts by a qualified individual or group to assess the evidence of care, calculating appropriate statistics to prove or disprove the hypothesis, formulating proposed action plans to improve the item being reviewed if necessary, developing policy and procedure to implement the new action plans, and then re-assessing the results of the changes in the future to determine that the identified problems have actually been corrected.

I saw no evidence that such system exists in ADC, which does an inadequate job of providing this essential aspect of healthcare delivery. The MGAR monitoring system is no substitute for a true quality assurance program. It is merely an incident reporting tool with no analysis of cause and effect and it simply is not an adequate tool to assess healthcare quality in any way.

Dr. Winfred Williams, the Corizon Arizona Regional Medical Director, oversees and supervises doctors in the system, including peer review based on chart reviews. Williams Depo, 9:1-9:4, 12:20-13:5. He looks at "clinical outcomes data," including information about patient HIV viral loads and insulin levels and the like, from the laboratory database to measure performance. *Id.* at 17:25-18:6, 20:16-20:22, 21:22-23:4.

Corizon also conducts quality assurance studies with review performance measures analogous to the MGARs.[11] *Id.* at 24:23-26:1.

From Dr. Williams's own description of his processes, however, it is clear to me that they are not an adequate quality assurance mechanism. For one thing, he does not have enough information. He has only seen a few MGAR reports, he does not receive official reports from medical directors, and he does not receive any reports that review delays in patient care. Williams Depo, 16:17-16:21, 15:11-15:17, 21:2-21:10. Weekly conference calls with providers (*id.* at 15:18-16:6) and occasional trips to the field (*id.* at 14:1-14:6) are no substitute for methodical information-gathering. Nor is a review of lab numbers in a database: such data give you some information about patient health, but they do not pinpoint deficits with quality of care. (If a patient's numbers are subnormal, is the problem in delayed access to care? Medication delivery? Interaction with other medications?) Without reviewing patient charts, it is impossible to tell whether the medical care delivery system is working and if not, where the problem lies. Moreover, without reviewing additional data and performing thorough reviews at the site, it is impossible to tell what these numbers are missing. For example, how many patients should have had labs drawn but did not? The answer cannot be found in reviewing lab results.

The fact that Dr. Williams is unaware of serious care delivery problems in the system he oversees demonstrates the inadequacy of any quality assurance mechanisms currently in use. Although he believes he can determine the rate at which chronic care patients are timely seen by assessing the computerized lab data (*id.* at 46:16-50:18), his belief is clearly misplaced: as of October 2013, he did not know that in June 2013, some

[11] I was not provided with any of these studies. My understanding is the Corizon has not produced them in this litigation. I would be happy to review any such studies, but I am confident, based on the evidence I have seen and documented in this report, that any quality assurance measures Corizon is taking are ineffective.

chronic care appointments at Eyman were overdue by many months – and several for over a year. *Id.* at 57:6-58:2, 59:24-60:4. He did not know that in July 2013, 68% of chronic care appointments at Eyman were late. *Id.* at 60:6-64:14 (actual question and response at 64:1-64:14). Most chillingly, Dr. Williams is either unaware of or unpersuaded by the serious staffing deficits I cataloged in Sections II.A.3 and II.B.2, above: he believes that Corizon currently has adequate providers to meet chronic care guidelines: "from what I've seen when I've been out to the sites, I notice that the patients are being seen and provider lines are being done. And patients are scheduled." Williams Depo, 45:9-45:23. *See also* Bybee Depo, 8:13-8:16, 24:24-25:12 (Corizon vice president of operations for Arizona believes that Corizon has enough providers to see patients 7 days after nurse's line).

2. Grievance process

Patient grievances are an important source of information for healthcare administrators and practitioners. They are another essential element of quality assurance programs in correctional settings. Of course, patients file many meritless grievances, but the meritorious ones make the process worthwhile: in any system, people can slip through the cracks and the grievance process affords an opportunity for them to be heard, for errors to be corrected, and for oversights to be addressed.

The healthcare grievance process does not work in Arizona prisons. For one thing, neither ADC nor Corizon tracks grievances electronically. Responses 38 & 39, Defendants' Responses to Verduzco's First Set of RFAs. Without that capability, the feedback loop cannot be effective, and staff and administrators cannot learn from their mistakes. An effective grievance process relies on statistical analysis of patterns to uncover issues that need to be addressed. Extracting any meaningful quality data from grievances is simply not possible without any tracking, categorization, or analysis of the grievances as an overall data set. In Arizona, problems conveyed on grievances come in one by one, unit by unit, prison by prison and they are addressed individually without any

sense of the larger healthcare delivery process within the Arizona Department of Corrections.

The grievance system also is unreliable when responses are significantly delayed. I have seen some evidence of delays in Arizona. ADC036793 (ASPC-Perryville Grievances Performance Measures: "[a]s of October 15, 2012, there were 260 informal grievances [and] 7 formal grievances that had not been answered. Of the informal grievance, only 23 were compliant with this standard" requiring a response within 15 working days of receipt per Department Order 802); ADC089042 (April 27, 2013) (7 past due inmate grievances and 28 overdue incomplete inmate letter responses to date at Tucson); ADC088938 (April 29, 2013) (10 of 32 informal grievances due by 4/29 at Perryville were not answered within the allotted time and approximately 60 informal grievances awaiting site managers signatures).

3. Screening

Correctional healthcare systems must have an initial screening process to catch urgent or emergent needs (for example, major injuries from the arrest process) and then a secondary, more thorough screening that is an actual clinical encounter to address medications, infectious disease control, and the like.

Arizona's intake screening process, which takes place for male prisoners at the Phoenix facility, is faulty. ADC's Phoenix monitor has repeatedly told Corizon of intake compliance problems. Valenzuela Depo, 108:7-108:21. These problems include physical exams not occurring in a timely fashion. ADC088954 (April 28, 2013) (5 of 10 charts reviewed at Phoenix C area had not had a physical examination completed by a medical provider by the second day of the intake process); ADC088998 (April 29, 2013) (as of 4/29/13, 8 minors at Tucson Rincon Minors yard had not had a physical exam by a provider completed within two days of the intake process); AGA_Review_00009556 (as of March 31, 2013, 14 Phoenix intake charts show no timely physical exam).

Another problem involves lab testing: "lab results are not consistently transferred with the inmate in his medical records to his permanent yard in a timely manner creating a situation of unavailability of laboratory results to medical staff at the inmate's permanent facility." AGA_Review_00009559-9560 (listing multiple lab results not filed or not reviewed by provider) (emphasis in original).

Perhaps the main constraint on intake processing is that the space set aside for it -- Alhambra Unit at Phoenix -- is very small. Since Alhambra can house only a limited number of prisoners awaiting transfer, when new buses arrive there is serious pressure to move people out as quickly as possible, as documented on a series of frantic emails I reviewed between ADC and Corizon staff in June 2013. AGA_Review_00021332-21333 ("Alhambra only has a capacity of 336 beds. Intake continues to be extremely high. As of right now we are negative 90 inmates, with only 17 ready to move. We need at least 48 more scheduled out for today. Medical has 190 roll overs and tomorrow we have 103 arrivals putting Alhambra at almost 130 negative"). As one staff member put it, "We can not operate intake this way." *Id.*

ADC ascribes the hold-up to Corizon: "[m]ovement out of Alhambra is being impeded by the current medical process. Inmates are getting backed up there without bed space to house them." AGA_Review_00021381-21382 (also noting large numbers of prisoners awaiting medical processing; "it's like this almost daily"). As a result, prisoners are rushed through the process and it is not always adequately completed. For example, physicians' orders are substandard: Dr. Robertson, ADC's Medical Program Administrator, determined that "notes are scanty and some are even copied for a pre-signed progress note and place[d] in chart with minor modifications. (This is unacceptable.)" AGA_Review_00018506. I agree. Dr. Robertson also points out that other providers do not trust Alhambra's intake labs, a "serious" issue that "needs to be looked at." *Id.* Untrustworthy labs could be another symptom of rushed processing.

These are problems of long standing. Dr. Fisher from Wexford found that transfer summaries coming out of Phoenix for men were "grossly incomplete," with many sections left completely blank. Deposition of Neil Fisher, October 8, 2013 (Fisher Depo), at 16:18-17:8, 88:21-89:16; WEXFORD000023. Transfer summaries from Perryville for women were "better, but still challenged." WEXFORD000023. This meant that providers lack a patient's full medical and social history. *Id.* at 107:19-108:17. Wexford detailed extensive deficiencies in the screening process in November 2012, including the failure to implement a proper intake screening process and the failure to provide tuberculosis testing and preventive care. WEXFORD000023-25.

Corizon has not cured all of these deficiencies. According to the ADC monitor for Phoenix, Corizon has been notified repeatedly of problems but has not addressed them in a meaningful or lasting way. ADC118026 ("[t]he health services intake process is problematic in medically processing inmates and entering the information on a timely basis resulting in a serious delay of ADOC inmates being moved or transferred out to other facilities. Corizon upper management at the Phoenix Complex have been previously and currently made aware of this on several occasions and were provided with suggestions for making improvements. They have shown a momentary attention to address the problems with the intake process; however, it is temporary with limited to no follow up to assure correction"). In sum, "[i]t seems there exists an attitude of ignoring the ineffective current medical intake process combined with a non urgency to maintain timely intake medical inmate processing." *Id*

III. Conclusion

Medical care in Arizona prisons is simply inadequate to meet the basic needs of many of the prisoners who experience illness and injury while in custody. Throughout my investigation, I found evidence of a system in disarray: poor management structure and lines of authority; systematic violations of policies and procedures as well as omitted policies that are necessary for patient care; staff spread far too thin to provide for

patients' needs; malfunctioning sick call process and consequent significant barriers to care; dangerously inadequate chronic care patient management; serious concerns regarding emergency and inpatient care; signs of custody interference with care; disturbing waivers of treatment at least in the Tucson infirmary; a widespread failure to provide patients with appropriate provider medical judgment due to chaotic and disorganized medical records, nurses acting outside of the scope of their licenses, denial of specialty care consultations, and substandard decision-making; inability to provide patients with medically necessary medications and diagnostic tests; and the inability to self-correct or to address known risks of harm through quality assurance, grievance, and screening mechanisms. All of these problems are chronic but also current. All of them harm patients.

My follow-up experience with two patients I met during my tours is symptomatic to me of the system's failures. I discussed the case of [redacted] in Section II.C.5 on substandard care decisions. He is the Yuma patient in urgent need of wound care: his inadequate treatment had transformed a treatable infection into a large pus-filled gaping wound that required immediate vascular surgery with reconstructive plastic surgery on his leg. After I interviewed him on August 2, 2013, I arranged for [redacted] to show his wound to Corizon's Arizona Regional Medical Director Dr. Williams as well as the lawyers for the State and for Corizon on the tour and I described for them why the current long-standing wound management for him was incorrect and what steps need to be pursued quickly to address this treatable problem.

I understand that [redacted] wrote to the Prison Law Office in September and again on October 23, 2013, reporting that he still had not received meaningful care for his wound. According to the copy of the grievance I was shown, dated October 22, 2013, [redacted] was taken on September 17 to Yuma Regional Medical Center where he was given an IV drip and other aggressive treatment and told by a plastic surgeon that he would require several surgeries. This finding is consistent with what I would expect if

the wound I saw in August continued to be incompetently treated to that point. According to [redacted], three days after arriving at the hospital he was moved to the Tucson prison, where he was denied any treatment for several days and was then returned to Yuma, where he is once again on the same inadequate treatment regimen: bandage changes three times a week.

I have not been able to review [redacted] healthcare records because they have not been produced by the State, although they were requested after my tour, so I cannot verify his account. If what he relates is true, however, it is outrageous and demonstrates deliberate indifference to his serious medical needs. What started off as a manageable problem has turned into a catastrophe for this patient as a result of a year of incompetent wound care management. Without adequate treatment, there is a very real possibility that he may require amputation to control the infection.

The second patient is [redacted] whom I discussed in Section II.C.4 regarding failure to provide him with specialty care. [redacted] has end-stage AIDS and is a very sick and fragile patient. After I met with him and reviewed his chart at Yuma, I told Dr. Williams and the attorneys for the State and for Corizon that his case was being seriously mishandled by the facility providers with a treatment plan that fell well short of the standard of care. He needed urgently to see an HIV specialist to correct fundamental treatment errors and omissions. I pointed out that on May 23, 2013, an infectious disease consult had been ordered, but it had never been completed.

I have been provided with a copy of [redacted] medical chart through October 7, 2013. From the documentation, I see that he was in fact seen by an HIV specialist on August 19, 2013, several weeks after I informed Dr. Williams of his dangerously mishandled care. The specialist confirmed my initial findings and ordered a panel of diagnostic tests necessary to evaluate the patient in light of his failed treatment and to reset the treatment plan as best as possible. A follow-up appointment with the HIV specialist one month later was also ordered. As of October 7, only two of the

medical tests ordered have been completed. Additionally, the consults ordered by the HIV specialist have not been completed. [redacted] life continues to be at great risk due to horrendous care.

I mention these two cases because to me they represent the extraordinary depth of indifference to serious medical needs manifested in the medical care system in the Arizona prisons. I am an expert for the plaintiffs in a major lawsuit over treatment, and I pointed out these cases of prisoners who are dying due to substandard care to the attorney representing the State and to the doctor who oversees medical care in Arizona prisons. Months later, the patients continue to receive dangerously poor care. These are routine correctional medical cases where the standard of care is unequivocal and should be obvious to any competent physician. Furthermore, the path forward to treat these patients adequately is easily accomplished with a very high likelihood of success. If the State cannot fix these two cases, in the glare of litigation, how can it be trusted to provide decent care for those thousands of patients whose care does not come under outside scrutiny?

After touring the facilities, talking with patients, reading well over 100 charts, and reviewing the abundance of evidence in this case, it is clear to me that medical care in Arizona prisons is dangerously bad. The care I have seen in ADC is as poor as I've ever seen in a correctional setting, and certainly worse than Maricopa County at the time I testified in the *Graves v. Arpaio* case. It is true system failure.

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

Executed this 8th day of November, 2013, at Salt Lake City, Utah.

Todd R. Wilcox, MD, MBA, CCHP-A

Appendix A to Confidential Expert Report of Todd Randall Wilcox

Todd Randall Wilcox, M.D., M.B.A., C.C.H.P.-A.

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EMPLOYMENT:

Chief Executive Officer, Wellcon, Inc.
May 1996 to present

Medical Director, Salt Lake County Jail System
May 1996 to present

Attending Physician, After Hours Medical
August 2001 to present

Senior Consultant, Phase 2 Consulting
January 2003 to December 2009

Medical Director, Maricopa County Jail System
November 2004 to February 2006

Attending Physician, Wasatch Physician Services
July 1996 to January 2000

Attending Physician, State of Utah Department of Corrections
August 1997 to January 1999

Staff Physician, Salt Lake County Jail
June 1994 to May 1996

EDUCATION:

M. B. A.
University of Utah David Eccles School of Business
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Residency in Orthopaedic Surgery
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Internship in General Surgery
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BOARD CERTIFICATIONS: American Board of Urgent Care Medicine

ADVANCED CERTIFICATIONS: American Academy of HIV Medicine (AAHIV Specialist)
Advanced Certified Correctional Health Care Provider (CCHP-A)

FACULTY APPOINTMENTS: Medical School Admissions Committee, University of Utah School of Medicine
Faculty Instructor, Correctional Crisis Intervention Team Academy, Salt Lake County, UT
Adjunct Instructor of Medicine, University of Utah School of Medicine
Adjunct Professor of Chemistry, Salt Lake Community College
Faculty Instructor, University of Utah School of Nursing

PROFESSIONAL APPOINTMENTS: President-elect, Society of Correctional Physicians, 2013
Chairman, Physician Certification Committee, National Commission on Correctional Health Care, 2012-2013
Board of Directors, National Commission on Correctional Health Care—Certified Correctional Healthcare Professional Board
Chairman, Electronic Medical Records Taskforce for the National Commission on Correctional Healthcare, 2002

Treasurer, Society of Correctional Physicians, 2012
Medical School Admissions Committee, University of Utah School of Medicine, 2012-13

HONORS:

Medical Director for National Commission on Correctional Healthcare Facility of the Year, 2001
Angier B. Duke Memorial Scholarship
Boettcher Foundation Scholar
Jostens Foundation Scholar

PROFESSIONAL MEMBERSHIPS:

American Medical Association
American College of Emergency Physicians
American Jail Association
Society of Correctional Physicians
American Correctional Health Services Association
American Academy of Urgent Care Medicine
American Academy of HIV Medicine

CORRECTIONAL CONSULTING:

American Jail Association
National Institute of Corrections
California Department of Corrections
Maricopa County Correctional Health Care, AZ
Pima County Department of Institutional Health, Tucson, AZ
Santa Clara County Jail System, CA
Washington County Jail, UT
Utah County Jail, UT
Seattle-King County Jail System, WA
Mississippi Department of Corrections
National Commission on Correctional Healthcare

PUBLICATIONS:

Wilcox TR. Critical Commandments in Correctional Health Care: Part 1. CorrectCare. Chicago: National Commission on Correctional Health Care, Spring 2013. 27:2, 20.

Wilcox TR. Developing an Effective Alcohol Withdrawal Protocol. Correctional Health Care Report. Civic Research Institute, Inc., May 2003: 49-50, 63-64.

Goble EM, Kane SM, Wilcox TR, Doucette SA. Meniscal Allografts. In: McGinty JB, ed. *Operative Arthroscopy*. Philadelphia: Lippincott-Raven Press; 1996: 317-31.

Goble EM, Kane SM, Wilcox TR, Olsen RE. Advanced Arthroscopic Instrumentation. In: McGinty JB, ed. *Operative Arthroscopy*. Philadelphia: Lippincott-Raven Press; 1996: 7-12.

Wilcox TR, Goble EM. Indications for meniscal allograft reconstruction. *American J of Knee Surgery* 9: 35-6, 1996.

Wilcox TR, Goble EM, Doucette SA. Goble technique of meniscus transplantation. *American J of Knee Surgery* 9: 37-42, 1996.

Goble EM, Downey DJ, Wilcox TR. Positioning of the tibial tunnel for ACL reconstruction. *J Arthroscopy* 12: 415-18, 1995.

Wilcox TR. Treatment modalities in infected total joint arthroplasties. {In prep}.

Morris JA, Wilcox TR, Reed GW, et al. Safety of the blood supply: surrogate testing and transmission of hepatitis C in patients after massive transfusion. *Annals of Surgery* 219: 517-26, 1994.

Wilcox TR, Morris JA, Green NE. Case report: Pediatric ankle fractures. *Tennessee Medical Journal*. 85: 217-19, 1992.

Morris JA, Wilcox TR, Frist WH. Pediatric organ donation: the paradox of organ shortage despite the remarkable willingness of families to donate. *Pediatrics* 89: 411-15, 1992.

Morris JA, Wilcox TR, Noreuil T, and Frist WH. Organ donation: a university hospital experience. *Southern Medical Journal* 83: 884-88, 1990.

Cogbill TH, Moore EE, Feliciano DV, Wilcox TR, et al. Conservative management of duodenal trauma: a multicenter perspective. *Journal of Trauma* 30: 1469-75, 1990.

Morris JA, Moore EE, Feliciano DV, Wilcox TR, et al. Post-traumatic renal failure: a multicenter study. *Journal of Trauma* 31: 1584-90, 1991.

Wilcox TR, contributing author to The Admissions Essay by Helen W. Power and Robert DiAntonio. Lyle Stuart, Inc., Seacausus, NJ, 1987, pp. 116-7, 197, 206-8, 219-20.

PRESENTATIONS:

National Commission on Correctional Healthcare Jail Standards Course
Chronic Disease Management in Correctional Facilities
Pain Management in Correctional Healthcare
Alcohol Withdrawal Syndrome
Drug Withdrawal Syndromes
Effective Correctional Medical / Mental Health Intake Screening
Endocrine Emergencies
Excited Delirium and Sudden In-Custody Death Syndrome
Hematologic Emergencies
Safe Restraint and Intensive Medical Management Practices
Medical Effects of Mental Health Medications
Neurological Emergencies
Effective Nursing Triage in Correctional Settings
Orthopedic Emergencies
Point of Care Laboratory in Correctional Healthcare
Managing Hypertension in Correctional Healthcare
Seizure Assessment and Treatment
How To Work Well with EMS
Effective Wound Care Practices in Correctional Healthcare
14-day Assessments in Corrections
Electronic Health Records for Institutional Medicine

EXPERT PANELS:

Rand Corporation Expert for Modified Delphi Process to Determine Quality Measures for Correctional Healthcare—June 2009

American Jail Association / National Institute of Corrections Expert for Mental Health in Jails Focus Group and National Satellite Broadcast—June 2009

PATENTS:

United States Patent 5,681,289
Chemical Dispensing System
Issued October 28, 1997

United States Patent 5,891,101
Chemical Dispensing System Methodology
Issued April 17, 1999

United States Patent 5,895,375
Chemical Dispensing System Components
Issued April 17, 1999

Appendix B to Confidential Expert Report of Todd Randall Wilcox

Deposition/Trial testimony in the last four years

2009
Rohrbaugh v. Prison Health Services
Combs v. Prison Health Services
Turner v. CorrectHealth / Dekalb County, GA

2010
Williams v. Gamble

2011
Thomas v. Arizona
Williams v. Gamble

2012
Dawkins v. CHS, NJ
Turpen v. Graham, GA
Cady vs. Cumberland, ME
Braillard v. Maricopa County, AZ – Diabetes
Sumers-Eskridge v. Kaschubeck et al.
Brooks v. San Joaquin County

2013
Marcum v. Scioto County
Galambos v. Cumberland
Siple v. Columbia County
Baires v. USA

Publications authored in the last 10 years

Wilcox TR. Critical Commandments in Correctional Health Care: Part 1. CorrectCare. Chicago: National Commission on Correctional Health Care, Spring 2013. 27:2, 20.

Wilcox, TR. Critical Commandments in Correctional Health Care: Part 2. CorrectCare Chicago: National Commission on C0rrectional Health Care, Summer 2013. 27:3, 19.

Wilcox TR. Developing an Effective Alcohol Withdrawal Protocol. Correctional Health Care Report. Civic Research Institute, Inc., May 2003: 49-50, 63-64.

Compensation

I am compensated for my services on this case at a rate of $225 per hour, or a daily rate of $1800 for out-of-town work.

Appendix C to Confidential Expert Report of Todd Randall Wilcox

Deposition Transcripts

12.08.23	Helena Valenzuela, Ph.D
12.09.19	Richard H. Rowe, MD
12.10.09	Jeffrey Alan Sharp, MD
13.05.20	Daniel L. Conn
13.05.21	Karen D. Mullenix
13.08.26	David W. Robertson, DO
13.08.27	Vanessa Headstream, RN
13.09.09	Arthur Gross
13.09.10	Marlena D. Bedoya
13.09.11	Kathleen Campbell, RN
13.09.17	Anthony N. Medel
13.09.18	Martin J. Winland
13.09.18	Mark T. Haldane, JD
13.09.20	Jenny Mielke-Fontaine
13.09.23	Juliet Respicio-Moriarty
13.09.23	Kathleen Campbell, RN
13.10.08	Neil A. Fisher, MD
13.10.10	Vickie Bybee
13.10.10	Winfred D. Williams, MD

Documents Produced by Defendants

ADC000001-000286	Medical Records - Chisholm, Maryanne, 200825
ADC004375-005078	Medical Records – Jensen, Shawn, 032465
ADC005375-005967	Medical Records – Licci, Desiree, 150051
ADC006565-007144	Medical Records – Wells, Charlotte, 247188
ADC010648-011234	Health Services Technical Manual
ADC024171-024221	[redacted] - Death Investigation
ADC024949-024988	[redacted] - Death Investigation
ADC025079-025109	[redacted] - Death Investigation
ADC025079-025139	[redacted] - Death Investigation
ADC027829-027931	Numerous documents including full ADC Cure Letter to Wexford and Wexford Response
ADC027854-027876	12.09.21 ADC Cure Letter to Wexford
ADC027941-027943	12.10.01 Wexford Response to ADC Cure Letter
ADC035204-035295	Florence Compliance Reports – September 2012
ADC036993-037228	Tucson Compliance Reports – October 2012
ADC040550-040573	DO 912 Food Service System
ADC040574-040609	Diet Reference Manual
ADC048247-048250	12.09.24 Wexford COO Conn email to ADC Director Ryan
ADC049045-049055	12.09.27 Wexford Vacancy Report
ADC049377-049480	ADC Employee Reprimands

ADC050749-050764	Medical Records – Jensen, Shawn, 032465
ADC051013-051256	Medical Records – Jensen, Shawn, 032465
ADC052422-052564	Florence Compliance Reports – November 2012
ADC052718-052839	Perryville Compliance Reports – November 2012
ADC052840-052896	Phoenix Compliance Report – November 2012
ADC053118-053171	Winslow Compliance Reports – November 2012
ADC053285-053285	Yuma Compliance Reports – November 2012
ADC054007-054020	Perryville Weekly Executive Meeting Minutes July-Nov. 2012
ADC067540-067690	Florence Compliance Reports – October 2012
ADC068031-068239	Perryville Compliance Reports – October 2012
ADC068240-068321	Phoenix Compliance Reports – October 2012
ADC068893-068940	Winslow Compliance Reports – October 2012
ADC068941-069143	Yuma Compliance Reports – October 2012
ADC069300-069401	Florence Compliance Reports – December 2012
ADC069514-069597	Perryville Compliance Reports – December 2012
ADC069598-069643	Phoenix Compliance Reports – December 2012
ADC069824-069863	Winslow Compliance Reports – December 2012
ADC069864-69947	Yuma Compliance Reports – December 2012
ADC070136-070270	Florence Compliance Reports – January 2013
ADC070399-070478	Perryville Compliance Reports – January 2013
ADC070511-070570	Phoenix Compliance Reports – January 2013
ADC070792-070841	Winslow Compliance Reports – January 2013
ADC070842-70948	Yuma Compliance Reports – January 2012
ADC071361-071393	Medical Records - Chisholm, Maryanne, 200825
ADC071574-071678	Medical Records – Licci, Desiree, 150051
ADC071920-071950	Medical Records – Wells, Charlotte, 247188
ADC073108-073149	Medical Records – Jensen, Shawn, 032465
ADC074716-074959	Medical Records – Jensen, Shawn, 032465
ADC074960-074972	Medical Records – Licci, Desiree, 150051
ADC084399-084406	Florence Compliance Reports – February 2013
ADC084407-084416	Perryville Compliance Reports – February 2013
ADC084417-084424	Phoenix Compliance Reports – February 2013
ADC084439-084446	Winslow Compliance Reports – February 2013
ADC084447-084453	Yuma Compliance Reports – February 2013
ADC084454-084700	Medical Records - Chisholm, Maryanne, 200825
ADC084701-084878	Medical Records – Jensen, Shawn, 032465
ADC088742-088755	Florence Monitoring Reports – March 2013
ADC088763-088770	Perryville Compliance Report – March 2013
ADC088771-088779	Phoenix Monitoring Report – March 2013
ADC088789-088791	Winslow Monitoring Report – March 2013
ADC088792-088795	Yuma Monitoring Report – March 2013
ADC088846-088891	Florence Monitoring Reports – April 2013
ADC088914-088953	Perryville Monitoring Report – April 2013
ADC088954-088978	Phoenix Monitoring Report – April 2013
ADC088998-089059	Tucson Compliance Reports – April 2013

ADC089060-089083	Winslow Monitoring Report – April 2013
ADC089084-089112	Yuma Monitoring Report – April 2013
ADC093959-094136	Inmates in Custody Five Years or More
ADC094265-094391	The Drug Utilization Report
ADC094932-095000	Monitor Conditions Report – Florence
ADC095053-095081	Monitor Conditions Report – Perryville
ADC095082-095087	Monitor Conditions Report – Phoenix
ADC095167-095179	Monitor Conditions Report – Winslow
ADC095180-095216	Monitor Conditions Report – Yuma
ADC095666-107477	"ORC Approval" – Referrals to Outside Providers
ADC108131	ADC Medical Transports All Complexes, Dec. 2012
ADC108132	ADC Medical Transports All Complexes, Jan. 2013
ADC108133	ADC Medical Transports All Complexes, Feb. 2013
ADC108134	ADC Medical Transports, Statewide, Dec. 2012
ADC108135	ADC Medical Transports, Statewide, Jan. 2013
ADC108136	ADC Medical Transports, Statewide, Feb. 2013
ADC108208-109790	Executive Report, 2012 Emergencies
ADC108208-109790	Executive Reports – Medical 2012
ADC109791-110429	Executive Report, 2013 Emergencies
ADC109791-110429	Executive Reports – Medical 2013
ADC110442-114357	Executive Reports – 2011 to 2013-06-13
ADC116148-116159	Phoenix Medical Grievances
ADC116937-117042	Winslow Medical Grievances
ADC117051-117063	Yuma Medical Grievances
ADC122669-122681	Medical Records – Licci, Desiree, 150051
ADC122682-122697	Medical Records – Licci, Desiree, 150051
ADC122698-122706	Medical Records – Licci, Desiree, 150051
ADC122704-122836	Medical Records – Licci, Desiree, 150051
ADC122867-122895	Medical Records – Wells, Charlotte, 247188
ADC122896-122920	Medical Records – Wells, Charlotte, 247188
ADC123280-123340	Medical Records – Jensen, Shawn, 032465
ADC123341-123378	Medical Records - Chisholm, Maryanne, 200825
ADC123379-123383	Medical Records – Jensen, Shawn, 032465
ADC130309-130328	Medical Records – Jensen, Shawn, 032465
ADC130329-130339	Medical Records – Jensen, Shawn, 032465
ADC134802-135377	Medical Records – Wells, Charlotte, 247188
ADC137229-137267	Florence Compliance Reports – July 2013
ADC137289-137315	Perryville Compliance Reports – July 2013
ADC137316-137340	Phoenix Compliance Reports – July 2013
ADC137360-137401	Tucson Compliance Reports – July 2013
ADC137419-137450	Yuma Compliance Reports – July 2013
ADC137497-137524	Florence Compliance Reports – August 2013
ADC137558-137582	Perryville Compliance Reports – August 2013
ADC137583-137609	Phoenix Compliance Reports – August 2013
ADC137626-137669	Tucson Compliance Reports – August 2013

ADC137684-137716	Yuma Compliance Reports – August 2013
ADC153777-153793	13.07.29 Corizon Contract Staffing Percentage Report
ADC154095-154146	Florence Compliance Reports – September 2013
ADC154182-154218	Perryville Compliance Reports – September 2013
ADC154219-154257	Phoenix Compliance Reports – September 2013
ADC154279-154346	Tucson Compliance Reports – September 2013
ADC154369-154421	Yuma Compliance Reports – September 2013
ADC155202-155417	Medical Records - [redacted]
ADC156083-156324	Medical Records – [redacted]
ADC156723-157010	Medical Records – [redacted]
ADC158650-159525	Medical Records – [redacted]
ADC160076-160427	Medical Records – [redacted]
ADC160811-161109	Medical Records – [redacted]
ADCPROC010933-011016	Corizon Supplemental Proposal
AGA_Review_00001704	
AGA_Review_00001721	
AGA_Review_00004833	
AGA_Review_00006398	
AGA_Review_00007168	
AGA_Review_00007170	
AGA_Review_00009347	
AGA_Review_00009556	
AGA_Review_00013126	
AGA_Review_00017516	
AGA_Review_00018434	
AGA_Review_00018506	
AGA_Review_00021332	
AGA_Review_00021381	
AGA_Review_00037462	
AGA_Review_00038450	
AGA_Review_00074092	

Documents Produced by Plaintiffs

PLTF-PARSONS-000165-000220	Medical Records – Jensen, Shawn, 032465
PLTF-PARSONS-000221-000385	Medical Records – Jensen, Shawn, 032465

Documents Produced by Wexford

WEXFORD000001-000131 - 12.11.07 Powerpoint

Other documents

12.03.22 Complaint (Parsons v Ryan)
12.11.06 Jensen Executed Declaration

13.06.11 Def Ryan's Response to Plt Verduzco's 1st Set of RFAs and ROGs
13.10.28 Doc 707-1 Exhs 1-8 to Defs' Reply
13.10.11 Medical Grievance filed by prisoner, [redacted]

Prisoners' healthcare records reviewed during tours

Florence

[redacted]

Perryville

[redacted]

[redacted]
Chisholm, Maryanne, 200825
[redacted]
Licci, Desiree, 150051
[redacted]
Verduzco, Christina, 205776
Wells, Charlotte, 247188

Phoenix

[redacted]

[redacted]

Tucson

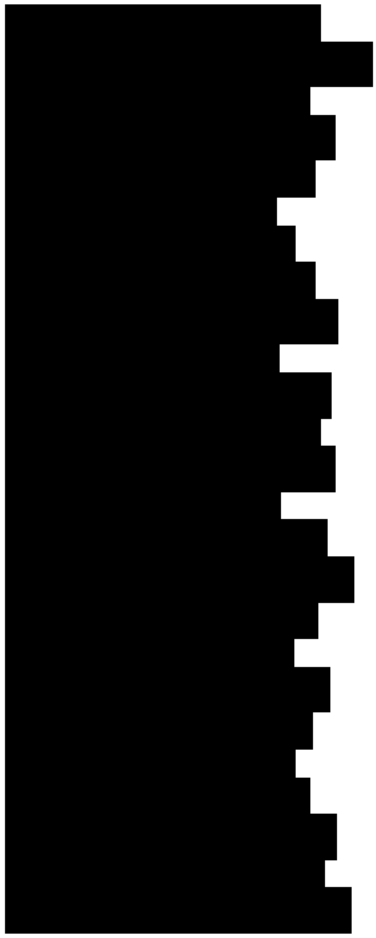
[redacted]

Jensen, Shawn, 032465

[redacted]

Yuma

[redacted]



APPENDIX D

ADC INSTITUTIONAL CAPACITY COMMITTED POPULATION

	8-Nov-13		OPERATING CAPACITY									INMATE COMMITTED POPULATION							
			RATED			TEMPORARY			SPECIAL USE			RATED		TEMPORARY			TOTAL	INSIDE	OUTSIDE	GRAND
Custody	UNIT	USE	G.P.	M/MH	TOTAL	T/G.P.	T M/MH	TOTAL	S.U.	T/S.U.	TOTAL	G.P.	M/MH	T/G.P.	T M/MH	TOTAL	S.U./T.S.U	TOTAL	TOTAL	TOTAL
	ASPC-DOUGLAS																			
MIN	Gila	GP	632		632	203		835			0	632		124		756	0	756	0	756
MED	Mohave	GP	803		803	124		927			0	803		100		903	0	903	17	920
	Complex Detention	DET			0			0	45	44	89						68	68	4	72
MIN	Eggers	GP	240		240			240			0	237				237	0	237	0	237
MIN	Papago	GP	250		250	90		340			0	250		87		337	0	337	0	337
	TOTAL		1925	0	1925	417	0	2342	45	44	89	1922	0	311	0	2233	68	2301	21	2322
	ASPC-EYMAN																			
MED	Cook	SO	796		796	657		1453				796		637		1433	0	1433	11	1444
MED	Meadows	SO	796		796	330		1126				1123				1123	0	1123	5	1128
	Meadows Detention	DET			0			0	40	40	80						69	69	0	69
MED	Rynning A42	SO	400		400			400				397				397		397	3	400
CLOSE	Rynning A37	SO	400		400			400				377				377		377	3	380
MAX	Rynning A46	SO				80		80						68		68		68	0	68
MAX	SMU I	GP	328		328	56		384	7		7	328		20		348	0	348	8	356
MAX	SMU I EAST	SO	176		176	64		240				176		51		227	0	227	1	228
MAX	SMU I P.C.	PC	352		352	72		424	1		1	352		17		369	0	369	9	378
	SMU I Detention	DET			0			0	96		96						57	57	0	57
MAX	SMU I M/H Watch	MH		8	8			8					8			8	0	8	0	8
MAX	Browning Unit	GP	596		596	110		706				596		42		638	0	638	18	656
MAX	Browning D/Row	DR	132		132			132				112				112	0	112	6	118
MAX	Browning M/H Watch	MH		20	20			20					14			14	0	14	1	15
MAX	Browning BMU	MH		20	20		10	30					12		0	12	0	12	0	12
	TOTAL		3976	48	4024	1369	10	5403	144	40	184	4257	34	835	0	5126	126	5252	65	5317
	ASPC-FLORENCE																			
MAX	Central Unit	GP	712		712			712				684				684		684	17	701
MAX	Central Unit Phase III	GP	156		156			156			0	133				133	0	133	1	134
MAX	Central Unit CB 1 MH	MH		120	120			120					105			105	0	105	2	107
	Kasson Detention	DET							64		64						48	48	3	51
MAX	Kasson MH	MH		64	64			64	8		8		47			47	15	62	3	65
MAX	Housing Unit 8	MED		22	22	20		42			0		21		0	21		21	1	22
MAX	Health Unit	MED						0	15		15						12	12	0	12
MED	East Unit	GP	600		600	80		680			0	600		68		668	0	668	8	676
MIN	North Unit	GP	972		972	124		1096			0	972		106		1078	0	1078	1	1079
MED	South Unit	SO	544		544	421		965			0	544		420		964	0	964	5	969
MIN	Globe	GP	250		250	52		302				250		8		258	0	258	0	258
	Globe Detention	DET							9		9						0	0	0	0
	Tempe St. Lukes								26		26						11	11	0	11
	TOTAL		3234	206	3440	697	0	4137	122	0	122	3183	173	602	0	3958	86	4044	41	4085
	ASPC-PERRYVILLE-F																			
MED	Santa Cruz	GP	768		768			768	2		2	679		0		679	0	679	11	690
CLOSE	Lumley Unit	GP	480		480			480			0	206		0		206	0	206	2	208
MAX	Lumley SMA	GP	108		108	24		132			0	81		0		81	0	81	0	81
MED	Santa Maria WTU	MH		24	24			24			0		20			20	0	20	0	20
CLOSE	Lumley Watch Cells	MH		12	12			12					9		0	9	0	9	0	9
MAX	Recp&Asmnt	GP	96		96	48		144			0	71		0		71	0	71	0	71
CLOSE	Minors Unit	GP	22		22			22	3		3	2				2	0	2	0	2
MIN	San Pedro	GP	432		432			432	2		2	424		0		424	0	424	4	428
MED	Santa-Maria	GP	360		360			360	2		2	305		0		305	0	305	6	311
	Complex Detention	DET							26	16	42					0	12	12	1	13
	Perryville IPC	MED							7		7					0	3	3	2	5
MIN	Piestewa Unit	GP	260		260			260			0	260		0		260	0	260	0	260
MIN	Santa Rosa Unit	GP	390		390			390			0	387		0		387	0	387	2	389
MIN	San Carlos	GP	1250		1250			1250				1233		0		1233	0	1233	8	1241
	TOTAL		4166	36	4202	72	0	4274	42	16	58	3648	29	0	0	3677	15	3692	36	3728
	ASPC-PHOENIX																			
MAX	Reception	GP	207		207	129		336			0	207		130		337	0	337	4	341
MIN	Inmate Worker	GP	30		30	25		55			0	30		25		55	0	55	0	55
MAX	B-Ward	MH		40	40		8	48			0		27		0	27	0	27	0	27
CLOSE	Flamenco Ida Ward- M	MH		25	25			25			0		21			21	6	27	0	27
CLOSE	Flamenco Ida Watch M	MH		15	15			15					5			5	0	5	0	5
CLOSE	Flamenco John PS- M	MH		30	30			30	7		7		22			22	0	22	0	22
MAX	Flamenco King - M	MH		35	35			35					27			27	0	27	0	27
CLOSE	Flamenco-F	MH		20	20			20	2		2		12			12	0	12	0	12
MED	Aspen/SPU	MH		150	150			150			0		146			146	0	146	1	147
	TOTAL		237	315	552	154	8	714	9	0	9	237	260	155	0	652	6	658	5	663
	ASPC-LEWIS																			
CLOSE	Morey	GP	800		800			800	16		16	792				792	15	807	10	817
	Morey Detention	DET			0			0	80		80						79	79	1	80
CLOSE	Rast	PC	356		356			356				350				350	0	350	0	350
MAX	Rast PC	PC	48		48			48				25				25	0	25	1	26
	Lewis Medical	MED			0			0	13		13						14	14	0	14
MED	Stiner Level G.P.	GP	800		800	300		1100				800		276		1076	0	1076	11	1087
	Stiner Detention	DET							70		70						70	70	2	72
MIN	Bachman PC	PC	300		300	76		376				300		41		341	0	341	2	343
MED	Bachman PC	PC	300		300	76		376				300		43		343	0	343	5	348
	Bachman Detention	DET							80		80						80	80	3	83
CLOSE	Buckley PC	PC	800		800			800	16		16	788				788	21	809	3	812
MED	Barchey PC	PC	400		400	150		550			0	400		121		521	0	521	3	524
MED	Barchey PC	PC	400		400	150		550				400		140		540	0	540	4	544
MIN	SUNRISE	GP	100		100			100				98				98	0	98	0	98
MIN	EAGLE POINT	GP	300		300			300				297				297	0	297	2	299
	TOTAL		4604	0	4604	752	0	5356	275	0	275	4550	0	621	0	5171	279	5450	47	5497
	ASPC-SAFFORD																			
MIN	Fort Grant	GP	588		588	160		748				588		40		628	0	628	0	628
	Miles Detention	DET						0	25	24	49						35	35	0	35
MIN	Graham	GP	615		615	96		711			0	615		64		679	0	679	1	680
MED	Tonto	GP	250		250	60		310				250		56		306	0	306	7	313
	Tonto Detention	DET							6		6						0	0	0	0
	TOTAL		1453	0	1453	316	0	1769	31	24	55	1453	0	160	0	1613	35	1648	8	1656

ADC INSTITUTIONAL CAPACITY COMMITTED POPULATION

	8-Nov-13		OPERATING CAPACITY									INMATE COMMITTED POPULATION								
			RATED			TEMPORARY			SPECIAL USE			RATED		TEMPORARY			TOTAL	INSIDE	OUTSIDE	GRAND
Custody	UNIT	USE	G.P.	M/MH	TOTAL	T/G.P.	T M/MH	TOTAL	S.U.	T/S.U.	TOTAL	G.P.	M/MH	T/G.P.	T M/MH	TOTAL	S.U./T.S.U	TOTAL	TOTAL	TOTAL
	ASPC-TUCSON																			
CLOSE	Cimarron	GP	288		288			288				253		0		253	0	253	2	255
MED	Cimarron	GP	384		384			384			0	347				347	0	347	4	351
	Cimarron Detention	DET							48	48	96					0	114	114	2	116
CLOSE	Rincon MH Watch	MH		55	55			55			0		32			32	0	32	0	32
CLOSE	Rincon BHU	MH		56	56			56					41			41		41	1	42
CLOSE	Rincon Medical	MED							50		50					0	25	25	2	27
CLOSE	Rincon S.N.U.	MED		16	16			16					14			14	0	14	0	14
CLOSE	Rincon Transitory	TRANS				30		30			0			18		18	0	18	1	19
CLOSE	Rincon	GP	512		512			512			0	474				474		474	10	484
CLOSE	Minors	GP	146		146			146				38				38	0	38	0	38
MAX	Minors	GP	36		36			36	16		16	12				12	5	17	0	17
MED	Santa Rita	GP	768		768			768				740		0		740	0	740	13	753
MED	Manzanita S.N.U.	MED		25	25		20	45			0		25		13	38		38	2	40
MED	Manzanita	GP	309		309	179		488	0		0	309		146		455	NA	455	12	467
	Manzanita Detention	DET			0			0	12	11	23						20	20	2	22
MED	Winchester	GP	400		400	336		736				400		308		708	0	708	14	722
	Winchester Detention	DET							12	12	24						17	17	0	17
	Complex Detention	DET			0			0	40	40	80					0	75	75	1	76
MIN	Catalina	GP	360		360			360			0	343		0		343	0	343	14	357
MIN	Whetstone	GP	1250		1250			1250				1223		0		1223		1223	3	1226
	TOTAL		4453	152	4605	545	20	5170	178	111	289	4139	112	472	13	4736	256	4992	83	5075
	ASPC-WINSLOW																			
MIN	Coronado	GP	492		492	136		628			0	492		50		542		542	2	544
MED	Kaibab	GP	400		400			400			0	365				365	0	365	7	372
CLOSE	Kaibab	GP	400		400			400			0	385				385	0	385	1	386
	Complex Detention	DET			0			0	20	19	39					0	23	23	0	23
MIN	Apache	GP	334		334	80		414			0	334		13		347	0	347	0	347
	Apache Detention	DET							12		12						0	0	0	0
	TOTAL		1626	0	1626	216	0	1842	32	19	51	1576	0	63	0	1639	23	1662	10	1672
	ASPC-YUMA																			
MED	Cheyenne	GP	800		800			800				795		0		795		795	5	800
	Cheyenne Detention	DET			0			0	40	39	79						70	70	0	70
MIN	Cocopah	GP	250		250	80		330			0	250		77		327	0	327	2	329
CLOSE	Dakota	GP	800		800			800	16		16	763				763		763	6	769
	Dakota Detention	DET			0			0	80		80						66	66	0	66
MED	Cibola	GP	1250		1250			1250				1164		0		1164	0	1164	28	1192
MIN	La Paz	GP	1250		1250			1250				1244		0		1244	0	1244	11	1255
	TOTAL		4350	0	4350	80	0	4430	136	39	175	4216	0	77	0	4293	136	4429	52	4481
	TOTAL IN-STATE		30024	757	30781	4618	38	35437	1014	293	1307	29181	608	3296	13	33098	1030	34128	368	34496
	CONTRACT BEDS																			
MED	CACF - GEO	SO	1000		1000	280		1280	40		40	1000		267		1267	10	1277	6	1283
MIN	Phx. West- DWI - GEO	DUI	400		400	100		500	20		20	400		93		493	3	496	6	502
MIN	Flor. West- RTC - GEO	RTC	200		200	50		250	4	4	8	200		7		207	1	208	0	208
MIN	Flor. West- DWI - GEO	DUI	400		400	100		500	10	7	17	400		91		491	7	498	0	498
MED	Kingman MTC- Hualapa	GP	1400		1400	108		1508	73		73	1400		15		1415	62	1477	26	1503
MIN	Kingman MTC- Cerbat	GP	2000		2000			2000	80		80	1904				1904	68	1972	15	1987
MIN	Marana - MTC	GP	500		500			500	8		8	488				488	2	490	3	493
MED	Navajo County Jail	PC	50		50			50				50				50	0	50	0	50
	TOTAL CONTRACT		5950	0	5950	638	0	6588	235	11	246	5842	0	473	0	6315	153	6468	56	6524
	TOTAL IN-STATE		30024	757	30781	4618	38	35437	1014	293	1307	29181	608	3296	13	33098	1030	34128	368	34496
	TOTAL CONTRACT		5950	0	5950	638		6588	235	11	246	5842	0	473	0	6315	153	6468	56	6524
	GRAND TOTAL		35974	757	36731	5256	38	42025	1249	304	1553	35023	608	3769	13	39413	1183	40596	424	41020
	TOTAL STATE MALE		25858	701	26559	4546	38	31143	970	277	1247	25533	567	3296	13	29409	1015	30424	332	30756
	TOTAL CONTRACT MALE		5950	0	5950	638	0	6588	235	11	246	5842	0	473	0	6315	153	6468	56	6524
	TOTAL MALE		31808	701	32509	5184	38	37731	1205	288	1493	31375	567	3769	13	35724	1168	36892	388	37280
	TOTALSTATE FEMALE		4166	56	4222	72	0	4294	44	16	60	3648	41	0	0	3689	15	3704	36	3740
	GRAND TOTAL		35974	757	36731	5256	38	42025	1249	304	1553	35023	608	3769	13	39413	1183	40596	424	41020

STATE MALE	TOTAL OPERATING CAPACITY	POPULATION	VACANCIES
MINIMUM CUSTODY	9335	8953	382
MEDIUM CUSTODY	13458	13651	-193
CLOSE CUSTODY	4729	4800	-71
MAXIMUM CUSTODY	3285	3011	274
RECEPTION -MAX	336	341	-5
TOTAL	31143	30756	387

CONTRACT MALE	TOTAL OPERATING CAPACITY	POPULATION	VACANCIES
MINIMUM CUSTODY	3750	3688	62
MEDIUM CUSTODY	2838	2836	2
TOTAL	6588	6524	64
TOTAL MALE	37731	37280	451

STATE FEMALE	TOTAL OPERATING CAPACITY	POPULATION	VACANCIES
MINIMUM CUSTODY	2332	2331	1
MEDIUM CUSTODY	1152	1023	129
CLOSE CUSTODY	534	234	300
MAXIMUM CUSTODY	132	81	51
RECEPTION-MAX	144	71	73
TOTAL	4294	3740	554
GRAND TOTAL	42025	41020	1005

COMMUNITY SUPERVISION OFFENDERS	
Arizona Parole Prior TIS	78
Interstate Parole	544
Work Furlough	0
Home Arrest	15
Truth In Sentencing (TIS)	5072
SACRC Community Corrections Center	55
Daily Total	5764

COUNTY JAIL INTAKE	Male	Female	Both
County Jail Intake 11/08/13	56	23	79
County Jail Transfers Pending	0	0	0
Inside Count	36892	3704	40596
Outside Count	388	36	424
Offical Daily Count	37336	3763	41099

RATED BEDS PLUS TEMPORARY BEDS = OPERATING CAPACITY (R+T=OC).

CURRENTLY THERE ARE NO FEMALE INMATES IN CONTRACT BEDS.

SPECIAL USE BEDS ARE NOT INCLUDED IN THE OPERATING CAPACITY.

INMATES TEMPORARILY ASSIGNED TO SPECIAL USE BEDS ARE INCLUDED IN THE TOTAL POPULATION COUNT AND ARE REFLECTED IN THE TOTAL OPERATING CAPACITY VACANCIES. THEREFORE THE BED VACANCY NUMBER CAN BE NEGATIVE WHEN THE NUMBER OF INMATES IN SPECIAL USE BEDS EXCEED THE VACANCIES IN OPERATING CAPACITY.