Expert Report of Brie Williams, M.D., M.S.

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

November 8, 2013

I. INTRODUCTION

I have been retained by the ACLU National Prison Project to visit three Arizona Department of Corrections (ADC) prison complexes, interview prisoners, inspect the housing units and other areas to which prisoners have access, and review selected medical files. I have been asked to provide my opinion about the risks of isolated confinement on physical health, especially for older adults. For the purposes of this opinion, isolated confinement is defined as being confined to a prison cell nearly all the time with access to an exercise enclosure approximately 6-7 hours per week. In this report I have been asked to concentrate on a subset of persons for whom such isolated living conditions pose a particularly high risk of present and future harm.

This report sets forth the opinions I have reached in this matter to date. My opinions at this point are necessarily preliminary, as I understand from plaintiffs' counsel that many relevant documents, including some of the medical records I have requested, have not yet been produced. I reserve the right to modify and supplement these opinions as additional information becomes available.

II. QUALIFICATIONS

I am a licensed and practicing physician in the state of California and am board certified in Internal Medicine, Hospice and Palliative Medicine, and Geriatrics. I received a B.A. from Wesleyan University, an M.D. from the Mount Sinai School of Medicine, and an M.S. in Community Medicine from the City University of New York and the Mount Sinai School of Medicine. I served my Internal Medicine internship and residency at the University of California, San Francisco (UCSF). Upon completion of residency, I was a hospitalist physician at Marin General Hospital until joining the UCSF faculty as a Clinical Instructor in Internal Medicine in late 2002. As UCSF faculty, I managed a primary care clinic of adult patients and precepted medical students and residents in clinic. From January 2004 through December 2004, I was a UCSF clinical fellow in Geriatrics. From January 2005 through July 2007, I participated in the UCSF Fellowship in Aging Research funded by the National Institute on Aging. I also worked as a consultant Physician Reviewer at Lumetra, a Medicare Quality Improvement Organization.

From August 1, 2007 until now I have been on faculty in the UCSF Division of Geriatrics, Department of Medicine. Currently, I am an Associate Professor of Medicine. The majority of my time is spent conducting aging research with a focus on the health of prisoners; directing the Geriatrics Clinic at the San Francisco VA Medical Center, serving as associate director of the UCSF Program for the Aging Century; and attending on the ACE (Acute Care for Elders) Unit at the San Francisco VA Medical Center.

I have visited and assessed medical care in several prisons and jails nationwide. In July 2005, I was hired as part of a consultation team by the California Department of Corrections and Rehabilitation through a contract with Lumetra to describe and assess the needs of the California geriatric prisoner population, which led to our report "Aging Inmates: Challenges for Healthcare and Custody." I have lectured nationally and internationally about prison healthcare. In July 2007, I co-founded the San Quentin Prison Geriatrics Consultation and Teaching Service, which I directed until July 2009 and on which I attended to patients as a

consulting Geriatrician. I have written several textbook chapters about aging in the criminal justice system, and have served as an expert or consultant in various legal cases. Details of these activities, including all of my publications in the last 10 years and all of the cases in which I have testified in the last 4 years, are set forth in my Curriculum Vitae, attached hereto as **Appendix A.**

III. COMPENSATION

I am being compensated for my services at a rate of $225.00 per hour, with a daily cap of $1800.

IV. INFORMATION AND DOCUMENTS CONSIDERED IN REACHING OPINIONS

I conducted on-site inspections of the following ADC prison complexes: ASPC-Florence (Central and Kasson Units) (August 14, 2013); ASPC-Eyman (SMU and Browning Units) (August 15, 2013); and ASPC-Perryville (Lumley Special Management Area (SMA)) (August 16, 2013) (hereinafter collectively referred to as the "isolation units"). At each complex I inspected housing units, exercise enclosures, and other areas to which prisoners have access. I spoke with prisoners at cellfront, and conducted interviews with some prisoners in an out-of-cell setting. I also reviewed medical records at each facility. These activities are reflected in the notes I took during my inspection tours, which are attached hereto as **Appendix B** and incorporated herein as a part of this report.

In addition to the medical records identified in my notes, I have reviewed additional documents, listed in **Appendix C**. I may use any or all of these documents to illustrate my opinions at trial.

V. OPINIONS

Prisoners of older age, with chronic medical conditions, and/or with physical disabilities are at high risk of immediate and future harm from isolated confinement as practiced in ADC. In addition, some of these prisoners are receiving dangerously inadequate medical care. Additional opinions are stated in the body of this report.

VI. LITERATURE REVIEW

The importance of deconditioning and functional impairment in older age.

Prisoners are considered "older" or "geriatric" in their 50s due to a high prevalence of chronic medical conditions and disabilities at relatively young ages.[1,2] The fundamental principle in maintaining and improving geriatric health is to avoid "deconditioning." In lay terms, deconditioning is commonly referred to as "use it or lose it," whereby periods of inactivity lead to declines in physical function.[3] Physiologically, deconditioning describes the complex process by which diminished muscle mass, decreases in muscle strength, muscle shortening, and changes in joint structure lead to deficits in important areas including mental status, the physical ability to accomplish essential activities of daily living (ADL), and continence.[4] Deconditioning is of particular importance to the health of older individuals because it leads directly to functional impairment, which poses significant physical danger to older adults. The consequences of functional impairment include falls, dependence on others to complete basic ADL (e.g. bathing, dressing, eating, transferring from a lying to a seated position), acute care use (i.e. emergency department visits and/or hospitalization), and mortality.[5,6] Falls in older adults lead to serious injury, further loss of function, hip fracture, increased health care usage, nursing home placement, and mortality.[7,8] Simply put, deconditioned older adults have a greater likelihood of sustaining injury due to falls, using costly healthcare services, requiring assistance to complete basic activities of daily living, and succumbing to acute or chronic illnesses including mortality.[9,10,11]

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[1] Williams BA, Stern MF, Mellow J, Safer M, Greifinger RB. Aging in correctional custody: setting a policy agenda for older prisoner healthcare. Am J Public Health. 2012;102(8):1475-1481.
[2] Aday R. Aging Prisoners: Crisis in American Corrections. Westport: Praeger, 2003.
[3] Cassel CK. Use it or lose it: Activity may be the best treatment for aging. JAMA. 2002;288(19):2333-2335.
[4] Gillis A, MacDonald B. Deconditioning in the hospitalized elderly. Can Nurse. 2005;101(6):16-20.
[5] Manton KG. A longitudinal study of functional change and mortality in the United States. J Gerontol. 1988;(42:S153-S161.
[6] Lipsitz LA, Jonsonn PV, Kelley MM, Koestner JS. Causes and correlates of recurrent falls in ambulatory fraily elderly. J Gerontol. 1990;46(4):M114.
[7] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Falls Among Older Adults. Last updated, 2013. Available from: http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html
[8] Tinetti ME, Kumar C. The patient who falls: "It's always a trade-off". JAMA. 2010;(303(3):258-66.
[9] Hessert MJ, Gugliucci M, Pierce HR. Functional Fitness: Maintaining or Improving Function for Elders with Chronic Diseases. Family Medicine. 2005;37(7):472-6.
[10] Cassel, 2002.
[11] Guralnik JM, Alecxih L, Branch LG, et al. Medical and long-term care costs when older persons become more dependent. Am J Public Health. 2002;92:1244-5.

Leading causes of deconditioning include prolonged bed-rest and the absence of regular physical activity. Restricted activity is among the most significant risk factors for functional decline in older adults[12] and has been shown to reduce functional ability in diverse older populations, including those that are otherwise healthy, and those that have coexisting chronic illnesses.[13] Functional impairment resulting from restricted activity and deconditioning is often permanent in older adults, who are less likely to recover function once it is lost than are younger persons.[14,15] In a study of the later-life consequences of torture experienced by former prisoners of war (POWs), solitary confinement was specifically associated with higher levels and greater severity of later life disability and medical conditions.[16] Studies have also shown that being alone and/or the perception of isolation from others are risk factors associated with rapid deconditioning, functional decline, and death.[17,18] The range of adverse health effects associated with loneliness and isolation in older adults extends well beyond deconditioning and is discussed at greater length in the next section.

Deconditioning can be avoided and sometimes minimized or reversed with regular exercise, such as distance walking.[19] Regular exercise may also help prevent secondary diseases associated with deconditioning in the context of chronic illness.[20,21] But deconditioning occurs rapidly in older adults who do not participate in regular physical exercise and for those older adults who have been deconditioned to the point of frailty, there is evidence that regular exercise may no longer improve physical performance scores or reduce fall risk.[22,23] Thus, avoiding deconditioning in the first place is essential to optimal health in older adults.

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[12] Gill TM, Allore H, Guo Z. Restricted activity and functional decline among community-living older persons. Arch Intern Med. 2003;163(11):1317-22.
[13] Stuck AE, Walthert JM, Nikolaus T. Risk factors for functional status decline in community-living elderly people: A systematic literature review. Social Science & Medicine. 1999;48(4):445-469.
[14] Gill, 2003.
[15] Covinsky KE, Palmer RM, Fortinsky RH, et al. Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: Increased vulnerability with age. Journal of the American Geriatrics Society. 2003;51(4):451-458.
[16] Hunt SC, Orsborn M, Checkoway H, et al. Later life disability statust following incarceration as a prisoner of war. Military Medicine. 2008;173(7):613.
[17] Buchman AS, Boyle PA, Wilson RS, et al. Loneliness and the rate of motor decline in old age: the rush memory and aging project, a community-based cohort study. BMC Geriatrics. 2010;10:77.
[18] Perissinotto CM, Stijacic-Cenzer I, Covinsky KE. Loneliness in Older Persons: A predictor of functional decline and death. Arch Intern Med. 2012;172(14):1078.
[19] Cassel, 2002.
[20] Hessert, 2005.
[21] Pang MYC, Eng JJ, Dawson AS, McKay H, Harris JE. A community-based fitness and mobility exercise (FAME) program for older adults with chronic stroke: a randomized controlled trial. J Am Geriatr Society. 2011;53(10):1667.
[22] Gill TM, Baker DI, Gattschalk M, et al. A progam to prevent functional decline in physically frail, elderly persons who live at home. NEJM. 2002;347(14):1068-74.

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development or worsening of deconditioning in older adults; access to an environment that affords regular physical activity and walking is important to minimize the risk of functional impairment in older adults.

The medical effects of loneliness and social isolation.

Loneliness, both actual and perceived social isolation, is an important risk factor for the development and/or worsening of many serious medical conditions.[24] Imposed social isolation has been studied in animals and has been shown to promote a wide range of adverse health outcomes including decreased lifespan, obesity and Type 2 Diabetes mellitus, increased circulating stress hormones, poor prognosis following stroke, and others.[25] In humans, studies show that social isolation has a significant adverse effect on physical and mental health, immune responses, functional ability, and important health behaviors capable of hastening the onset and course of medical illness (such as medication adherence, inactivity, and smoking).[26,27] Other studies have shown that loneliness is a significant, independent risk factor for memory impairment, including dementia and Alzheimer's disease.[28,29] One study showed that older adults reporting loneliness exhibited more rapid cognitive decline than non-lonely older adults.[30] In addition, loneliness predicts depression in older adults and has been shown to be a more significant predictor of depression than other associated factors like disability and low levels of social support.[31] This finding is important for two reasons. First, depression in older adults is strongly associated with disability, poorer outcomes from chronic illnesses, and mortality.[32,33] Second,

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[23] Faber MJ, Bosscher RJ, Paw MJC, Wieringen PC. Effects of exercise programs on falls and mobility in frail and pre-frail older adults: A multicenter randomized controlled trial. Archives of Physical Medicine and Rehabilitation. 2006;87(7):885-896.
[24] Shankar A, McMunn A, Banks J, Steptoe A. Loneliness, social isolation, and behavioral and biological health indicators in older adults. Health Psychology. 2011;30(4):377-385.
[25] Cacioppo JT, Hawkley LC. Perceived social isolation and cognition. Trends Cogn Sci. 2009;13(10):447-454.
[26] Shankar, 2011.
[27] Buchman, 2010.
[28] Tilvis RS, et al. Predictors of cognitive decline and mortality of aged people over a 10-year period. J Gerontol A Biol Sci Med Sci. 2004;59:M268-274.
[29] Wilson RS, et al. Loneliness and risk of Alzheimer disease. Arch Gen Psychiatry. 2007;64:234-240.
[30] Tilvis, 2004.
[31] Prince MJ, Harwood RH, Blizard RA, et al. Social support deficits, loneliness, and life events as risk factors for depression in older age: The Gospel Oak Project VI. Psychol Med. 1997;2727:323.
[32] Lenze EJ, et al. The course of functional decline in older people with persistently elevated depressive symptoms: longitudinal findings from the Cardiovascular Health Study. J Am Geriatr Soc. 2005;53(4):569-575.
[33] Rodda J, Walker Z, Carter J. Depression in older adults. BMJ. 2011;343:d5219.

physical activity has a proven protective effect against depression[34] and offers significant, long-term reduction of existing depressive symptoms[35] in older adults.

Loneliness also directly affects physical health through biological processes. The connection between loneliness in older adults and the onset and worsening of cardiovascular disease, including cardiovascular mortality, is well-established.[36] One study showed that loneliness predicts a significant and potentially harmful increase in blood pressure among older adults independent of other sociodemographic, psychosocial, and cardiovascular risk factors.[37] Another study found that loneliness in a population of older adults with average age 70 conferred a three-times-greater risk of heart disease, regardless of age or other chronic illness.[38] In sum, loneliness itself significantly increases older adults' risk of poor health behaviors, functional decline, cognitive impairments including dementia and Alzheimer's disease, depression, cardiovascular disease, and death.

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development or worsening of serious medical conditions; access to an environment that affords more regular social interaction is important to minimize these risks.

Memory impairment.

Memory impairment (cognitive impairment beyond the cognitive effects of normal aging) becomes increasingly important with age as such impairments in older adults can lead to falls, morbidity, poor health behaviors, high healthcare costs, and death.[39,40,41,42] In addition to the dangers for older adults associated with falls and morbidity, memory impairment is a leading predictor of advanced dementia in older adults.

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[34] Strawbridge WJ, Deleger S, Roberts RE, Kaplan GA. Physical activity reduces the risk of subsequent depression for older adults. Am J Epidemiol. 2002;156(4):328-334.
[35] Motl RW, Konopack JF, McAuley E, Jerome GJ, Marquez DX. Depressive symptoms among older adults: long-term reduction after a physical activity intervention. J Behav Med. 2005;28(4):385-94.
[36] Hawkley LC, Cacioppo JT. Loneliness matters: A theoretical and empirical review of consequences and mechanisms. Annals of Behavioral Medicine. 2010;40(2):218-227.
[37] Hawkley LC, Thisted RA, Masi CM, Cacioppo JT. Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. Psychology and Aging. 2010;25(1):132-141.
[38] Sorkin D, Rook KS, Lu JL. Loneliness, lack of emotional support, lack of companionship, and the likelihood of having a heart condition in an elderly sample. Ann Behav Med. 2002;24(4):290-298.
[39] Stark SL, et al. Preclinical Alzheimer disease and risk of falls. Neurology. 2013;81(5):437-443.
[40] Sachs GA, et al. Cognitive impairment: An independent predictor of excess mortality (A cohort study). Annals of Internal Medicine. 2011;155:300-308.
[41] Comjis HC, et al. Memory complaints; the association with psycho-affective and health problems and the role of personality characteristics: A 6-year follow-up study. Journal of Affective Disorders. 2002;72(2):157-165.
[42] Hill J, Fillit H, Thomas SK, Chang S. Functional impairment, healthcare costs and the prevalence of institutionalization in patients with Alzheimer's Disease and other dementias. Pharmacoeconomics. 2006;24(3):265-280.

Dementia is ultimately fatal and is a major driver of rising healthcare services utilization and costs.[43] In prison, dementia poses significant risks to the physical and mental health of older adults, including the risk of undue and excessive suffering in prisoners who do not understand their detention, the risk of victimization, and functional and health insults.[44,45]

Causes of memory impairment include social isolation, physical inactivity, chronic pain, and depression.[46,47,48] Sleeplessness and decreased mental activity can also contribute to memory impairment.[49] These factors are all commonly reported among persons who are living in isolated confinement.[50] One study of isolated prisoners found that common causes of memory impairment -- including depression, anxiety, physical pain (stomach and muscle), and being unable to concentrate -- were common after just four weeks of isolated confinement.[51] Moreover, physical activity has been shown to improve memory in older adults and protect against the progression to advanced dementias including Alzheimer's disease.[52,53] Engagement in social and leisure activities is also associated with decreased risk of dementia in older adults.[54] Treatments that slow the progress of cognitive impairment and help avoid functional decline in those who are impaired are primarily nonpharmacologic in nature and are at odds with the conditions associated with solitary confinement. These

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[43] Pimouguet C, Lavaud T, Dartigues JF, Helmer C. Dementia case management effectiveness on health care costs and resource utilization: A systematic review of randomized controlled trials. J of Nutrition and Aging. 2010;14(8):669-676.
[44] Fazel S, McMillan J, O'Donnell I. Dementia in prison: ethical and legal implications. J Med Ethics. 2002;28;156-159.
[45] Maschi T, Kwak J, Ko E, Morrissey MB. Forget me not: dementia in prison. The Gerontologist. 2012;1-11.
[46] Gauthier S, et al. Mild cognitive impairment. The Lancet. 2006;367(9518):1262.
[47] McCracken LM, Iverson G. Predicting complaints of impaired cognitive function in patients with chronic pain. Journal of Pain and Symptom Management. 2001;21(5):392.
[48] Aleman A, et al. Memory impairment in schizophrenia: A meta-analysis. Am J Psychiatry. 1999;156(9):1358.
[49] Ancoli-Israel S. Sleep and aging: Prevalence of disturbed sleep and treatment considerations in older adults. J Clin Psychiatry 2005;66(suppl9):24-30.
[50] Haney C. Mental health issues in long-term solitary and "supermax" confinement. Crime & Delinquency. 2003;49:124.
[51] Smith PS. The effects of solitary confinement on prison inmates: A brief history and review of the literature. Crime and Justice. 2006;34(1):441-528.
[52] Lautenschlager NT, et al. Effect of physical activity on cognitive function in older adults at risk of Alzheimer Disease. JAMA. 2008;300(9):1027-1037.
[53] Erickson KI, et al. Exercise training increases size of hippocampus and improves memory. PNAS. 2011;108(7):3017-3022.
[54] Wang HX, Karp A, Winblad B, Fratiglioni L. Late-life engagement in social and leisure activities is associates with a decreased risk of dementia: A longitudinal study from the Kungsholmen Project. Am J Epidemiol. 2002;155(12):1081-1087.

typically include increased social interaction, cognitive training, avoiding agitation, removing environmental stressors, and ensuring regular sleep habits.[55,56]

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development or worsening of memory impairment in older adults; access to an environment that affords regular physical activity and social interaction is important to minimize the current and future risk of memory impairment in older adults.

Osteoarthritis.

Osteoarthritis is the most common form of arthritis in the United States.[57] It affects 28% of persons age 45 or older living in the community, nearly 40% of those aged 65 or older, and prevalence continues to rise as the population ages before leveling off around age 80.[58] Osteoarthritis leads to considerable disability which often results in pain and functional impairment and limits individuals' ability to complete basic activities of daily living such as toileting, dressing, and ambulation.[59] The pain associated with osteoarthritis can also lead to deconditioning and gait and balance deficits which are, in turn, associated with falls.[60,61,62] Again, the risks of falls in older adults include serious injury, loss of function, hip fracture, increased health care usage, nursing home placement, and mortality.[63] The adverse effects of osteoarthritis are often made worse by comorbid conditions including hypertension and renal disease,[64] which are disproportionately common in prisoner populations.[65]

Common risk factors for osteoarthritis include muscle weakness, joint laxity, and low levels of vitamin D.[66] Joint laxity is increasingly common with aging while muscle weakness is a common feature of the deconditioning associated with limited physical activity, and vitamin D deficiency is both associated with

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[55] Willis SL, et al. Long-term effects of cognitive training on everyday functional outcomes in older adults. JAMA. 2006;296(23):2805-2814.
[56] Sadowsky CH, Galvin JE. Cognitive and behavioral problems in dementia. J Am Board Fam Med. 2012;25(3):350-66.
[57] Felson DT, et al. Osteoarthritis: New Insights. Part 1: The disease and its risk factors. Ann Intern Med. 2000;133(8):635-646.
[58] Lawrence RC, et al. Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. Part II. Arthritis & Rheumatism. 2008;58(1):26-35.
[59] Breedveld FC. Osteoarthritis – the impact of a serious disease. Rheumatology. 2004;43(1):i4-i8.
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[62] Ambrose AF, Paul G, Hausdorff JM. Risk factors for falls among older adults: A review of the literature. Maturitas. 2013;75(1):51-61.
[63] Tinetti, 2010; Ambrose, 2013; Salzman, 2010.
[64] Breedveld, 2004.
[65] Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. J Epidemiol Community Health. 2009;63:912-919.
[66] Felson, 2000.

aging and exacerbated by diminished sunlight exposure.[67,68,69] As a result, older adults in isolated confinement are at added risk for the development of osteoarthritis as well as the pain, functional impairment, and risk of falls associated with the disease. Physical activity (such as walking) is a first-line treatment for older adults with osteoarthritis because it decreases the pain associated with the disease, improves function, and improves postural and gait stability.[70,71] Physical *in*activity exacerbates disability in osteoarthritis patients.[72]

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the worsening of symptoms associated with osteoarthritis and, in turn, to the future risk of serious falls. Access to an environment that affords regular physical activity is important to minimize the current and future risk of osteoarthritis-associated symptoms and their consequences in older adults. Having only three short periods a week out of confinement impedes prisoners' opportunity to participate in regular walking and exercise which are important for reducing pain and improving gait and balance and for limiting the present and future risk of falls and associated morbidity and mortality.

Hypertension.

Hypertension, or high blood pressure, puts older adults at increased risk for end-organ damage including stroke, cardiovascular disease, heart failure, kidney disease and death.[73,74] Hypertension is the most commonly occurring chronic health condition in prisoner populations, affecting 50% of prisoners age 50-65.[75] Blood pressure control, which is essential to limit complications and reduce mortality from hypertension,[76,77] improves significantly with physical exercise and activity.[78] Indeed, the United States Preventive Services Task Force (USPSTF) lists physical exercise as the first–line therapy for the prevention,

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[67] Feson, 2000.
[68] Gillis, 2005.
[69] Janssen HCJP, Samson MM, Verhaar HJJ. Vitamin D deficiency, muscle function, and falls in elderly people. Am J Clin Nutr. 2002;75(4):611-615.
[70] Bennell KL, Hinman RS. A review of the clinical evidence for exercise in osteoarthritis of the hip and knee. Journal of Science and Medicine in Sport. 2011;14(1):4-9.
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[77] Hansson L, et al. Effects of intensive blood pressure lowering and low-dose aspirin in patients with hypertension. Lancet. 1998;351:1755-1762.
[78] Fagard RH, Cornelissen VA. Effect of blood pressure control in hypertensive patients. European Journal of Preventive Cardiology. 2007;14(1):12-17.

treatment, and control of hypertension[79] and a number of studies have shown that physical activity reduces risk by lowering blood pressure in hypertensive patients.[80] One such study found that physical activity conferred a significant decrease in mortality risk for hypertensive older adults independent of body mass index.[81] Thus, access to regular physical activity, such as walking and working, can greatly improve blood pressure and decrease the medical risks associated with poor blood pressure control.

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development and worsening of hypertension and, in turn, a future risk of end-organ damage, morbidity, and mortality. Access to an environment with less cell confinement and more access to walking would significantly improve ability to remain physically active and would help control blood pressure.

Hearing impairment.

Hearing impairment is associated with poor health and functional impairment in older adults, including higher rates of chronic illness, difficulty walking, and difficulty with important self-care functions (e.g. managing medications).[82] Hearing impairment is also a significant contributor to social isolation.[83] (Adverse health effects associated with social isolation include functional decline, cognitive impairment, depression, cardiovascular disease, and death and are described in detail in the section above on loneliness.) Even mild hearing loss can impair language processing, negatively affecting health care access and use and leading to changes in cognitive and emotional status.[84] Indeed, assessing older adults for hearing impairment and fitting impaired older adults with appropriate hearing aids are considered important health promotion interventions in preventing social isolation, loneliness, and the adverse health outcomes associated with these conditions.[85,86]

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[79] U.S. Preventive Services Task Force Recommendation Statement. Behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention in adults. June 2012. Available from: http://www.uspreventiveservicestaskforce.org/uspstf11/physactivity/physrs.htm.

[80] Whelton SP, Chin A, Xue X, He J. Effect of aerobic exercise on blood pressure: A meta-analysis of randomized, controlled trials. Ann Intern Med. 2002;136(7):493.

[81] Faselis C, et al. Body mass index, exercise capacity, and mortality risk in male veterans with hypertension. Am J Hypertens. 2012;25(4):444-450.

[82] Crews JE, Campbell VA. Vision impairment and hearing loss among community-dwelling older Americans: Implications for health and functioning. Am J Public Health. 2004;94(5):823.

[83] Heine C, Browning CJ. Communication and psychosocial consequences of sensory loos in older adults: Overview and rehabilitation directions. Disability and Rehabiliation. 2002;24(15):763-773.

[84] Agrawal Y, Platz EA, Niparko JK. Prevalence of hearing loss and differences by demographic characteristics among US adults: Data from the National Health and Nutrition Examination Survey, 1999-2004. JAMA. 2008;168(14):1522-1530.

[85] Cattan M, et al. Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. Age and Ageing. 2005;1:41-67.

[86] Heine, 2002.

Prison conditions may put older adults at increased risk of hearing impairments because exposure to high levels of occupational and/or background noise (such as fans or closing metal doors) is the primary risk factor for new and worsening hearing impairment.[87] In addition, persons with hearing impairment in isolated confinement may feel even more isolated than other inmates experiencing the same conditions of confinement, since those in isolated confinement with normal hearing may be able to have informal conversations by yelling, whereas this opportunity may not be available to those who are hearing-impaired. Since hearing impairment is independently associated with the long-term development of dementia,[88] the experience of isolated confinement may also accelerate hearing loss-related cognitive impairments.

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development and worsening of hearing impairment and, in turn, a future risk of functional and cognitive impairments including dementia and falls. A different living environment with closer contact to others would increase prisoners' ability to participate in social interactions and could decrease the medical risks associated with hearing impairment.

Insomnia and poor-quality sleep.

Difficulty sleeping is a common health-related challenge associated with aging.[89] The prevalence of insomnia in older adults is higher than in younger adults.[90] In older adults, insomnia and/or poor sleep quality can lead to depressive symptomology and poor cognitive performance, including slower response times and impairments in memory and concentration.[91,92] The connection between poor sleep and cognitive impairment has been demonstrated in multiple studies,[93] one of which showed that poor sleep predicted cognitive decline even in otherwise healthy, non-depressed older men.[94] Studies have also found a strong association between poor sleep and functional impairment in older adults.[95] In particular, poor sleep has

[87] Agrawal, 2008.
[88] Lin FR, et al. Hearing loss and incident dementia. JAMA Neurology. 2011;68(2):214-220.
[89] Ancoli-Israel S. Sleep and aging: prevalence of disturbed sleep and treatment considerations in older adults. The Journal of Clinical Psychiatry. 2005;66(Supple 9):24-30.
[90] Ancoli-Israel S. Sleep and its disorders in aging populations. Sleep Medicine. 2009;10(Suppl 1):S7-S11.
[91] Ancoli-Israel S, Cook JR. Prevalence and comorbidity of insomnia and effect on functioning in elder populations. J Am Geriatr Soc. 2005;53(S7):S264-S271.
[92] Nebes RD, Buysse DJ, Halligan EM, Houck PR, Mon TH. Self-reported sleep quality predicts poor cognitive performance in healthy older adults. J Gerontol B Psychol Sci Soci Sci. 2009;64B(2):180-187.
[93] Ancoli-Israel, 2009.
[94] Cricco M, Simonsick EM, Foley DJ. The impact of insomnia on cognitive functioning in older adults. J Am Geriatr Soc. 2001;49(9):1185-1189.
[95] Dam TT, Ewing S, Ancoli-Israel S, Ensrud K, Redline S, Stone K. Association between sleep and physical function in older men: the osteoporotic fractures in men sleep study. J Am Geriatr Soc. 2008;56(9):1665-1673.

been shown to raise older adults' risk of falls.[96] (The potential adverse health outcomes associated with falls are many and are discussed in greater detail in the section above on function.) Overall, poor-quality sleep and/or sleep disorders are associated with morbidity and mortality in older adults,[97] in one study increasing the relative risk of mortality two-fold in healthy older adults.[98]

Many factors contribute to insomnia and poor-quality sleep in older adults including environmental factors such as exposure to noise and light, pain from arthritis, cardiovascular disease, and loneliness and depression.[99] Insomnia and poor sleep can be improved with physical exercise and by amending these risk factors, including increasing light exposure during the day.[100,101]

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the development and worsening of insomnia and poor quality sleep and, in turn, a future risk of cognitive and functional decline, falls, and early mortality. Access to an environment with less cell confinement and more physical activity and daytime light exposure, and without nocturnal illumination, would significantly improve sleep.

Type 2 Diabetes Mellitus.

The profound complications of type 2 diabetes are numerous and include eye problems such as retinopathy and blindness, limb amputations due to neuropathy, renal insufficiency and failure due to nephropathy and cardiovascular disease including myocardial infarction.[102] Diabetes is a chronic health condition that is disproportionately common in prison populations, affecting 15% of those age 50-65.[103] Physical activity, alongside dietary intervention, is considered a first-line and critical treatment for diabetes because it improves glucose uptake and insulin sensitivity and thereby improves diabetes management and glucose control.[104]

In my opinion, isolated confinement as practiced in ADC poses a current and future medical risk of the worsening and poor management of type 2 diabetes and, in turn, a future risk of complications from type 2

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[96] Avidan AY, et al. Insomnia and hypnotic use, recorded in the minimum data set, as predictors of falls and hip fractures in Michigan nursing homes. J Am Geriatr Soc. 2005;53(6):955-962.
[97] Crowley K. Sleep and sleep disorders in older adults. Neuropsychol Review. 2011;21:41-53.
[98] Dew MA, et al. Healthy older adults' sleep predicts all-cause mortality at 4 to 19 years of follow up. Psychosom Med. 2003;65(1):63-73.
[99] Ancoli-Israel, 2009.
[100] Ancoli-Israel, 2005.
[101] Passos GS, et al. Effect of acute physical execise on patients with chronic primary insomnia. J Clin Sleep Med. 2010;6(3):270-275.
[102] Unzucchi SE, et al. Management of hyperglycaemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetologia. 2012;55:1577-1596.
[103] Binswanger, 2009.
[104] Segal RJ, et al. Physical activity / exercise and type 2 diabetes. A consensus statement from the American Diabetes Association. Diabetes Care. 2006;29(6):1433.

diabetes, including further disability and cardiovascular disease. Access to an environment with less cell confinement and more physical activity would significantly improve management of type 2 diabetes.

VI. FINDINGS IN THE ARIZONA DEPARTMENT OF CORRECTIONS

A. Conditions of Confinement

At every ADC prison unit I visited, I viewed the cells in which prisoners are confined. I also asked to view all the exercise enclosures to which prisoners in that unit have access. I have also reviewed the defendants' descriptions, including dimensions, of the cells and exercise enclosures in the isolation units. Defendants' Response to Plaintiff Wells' First Set of Interrogatories, No. 10, 11, 14.

While there were minor variations in the construction of the cells in the various units I visited, all of them were extraordinarily isolating. None of them were large enough to permit the kind of exercise that would mitigate the health risks of isolated confinement described above.

Similarly, the exercise enclosures were, in almost all cases, too small to permit adequate exercise to preserve physical health and prevent deconditioning. According to defendants, the exercise enclosures at the end of each pod in Eyman complex are 10'9" x 23'6". The outdoor recreation enclosures are 10' x 10'. The Stage 1 exercise enclosures at Perryville are 12' x 12', 24' x 12', and 10' x 21'. Defendants' Response to Plaintiff Wells' First Set of Interrogatories, No. 11. The 10' x 10' enclosures are not much larger than the prisoners' cells, and none of these enclosures are large enough to allow sustained walking or other adequate exercise.[105]

While a young and physically healthy person could conceivably get sufficient exercise even in these confined spaces, they are not adequate for elderly persons or those with mobility impairments, who are not able, for example, to do vigorous calisthenics or run in place. For such persons, sustained walking is the best, and in some cases the only, form of exercise to prevent deconditioning and preserve health.

I was told repeatedly on my inspection tours that prisoners in the isolation units receive two hours of out-of-cell exercise, three times a week. I was told that some prisoners may receive slightly more than this based on their behavior or their mental health status, but it is my understanding there are prisoners in the isolation units who receive only six hours a week of out-of-cell exercise, in the small enclosures described above. Such limited access to physical exercise poses a substantial risk of serious harm to older prisoners as well as those with chronic medical conditions and/or with physical disabilities.

[105] Defendants' Response to Plaintiff Wells' First Set of Interrogatories, No. 10, 11, 14. While some exercise enclosures are larger, they are not available to all prisoners in the isolation units.

Even these very limited opportunities for exercise are not consistently or realistically available to all prisoners. A number of prisoners told me that exercise is sometimes canceled because of extreme heat or for other reasons. Many others told me that they do not go to the exercise enclosure because of the extreme heat or because of the requirement to be strip-searched. My inspection of the exercise enclosures confirmed that some have no source of drinking water and some have no source of ventilation or cooling, which would exacerbate the effects of the heat. There was also sometimes no chair, bench, or any other place to sit, which makes the enclosures difficult or impossible to use for older prisoners or those with mobility impairments. I was also told that prisoners cannot ask to come in early if they find that the heat is too much for them to endure once they are outside, so some do not go out for this reason.

Some of the isolation units have 24-hour illumination in the cells. Defendant Ryan's First Supplemental Answers to Brislan's First Set of Requests for Admissions, No. 21. This would be likely to exacerbate sleep difficulties, with the negative health consequences described above.

B. Representative Cases

Based on documents I have reviewed (ADC 122656-62) there appear to be approximately 300 prisoners over 50 in isolated confinement in ADC. The following is a sample of such prisoners I interviewed and whose medical files I reviewed.

My review of these cases was focused on the physical health risks posed by isolated confinement. However, in the course of my review, I encountered several instances of these prisoners receiving dangerously inadequate medical care, which I also describe below.

[redacted], a 60 year old male prisoner in CB-7 at Florence, has a history of head and neck cancer, hypertension and a history of lower extremity edema (leg swelling). He stated that he leaves his cell to go to the shower at every chance he gets (which is every other day) but he does not go to the recreation area because it is "too hot outside." [redacted] medical chart indicates that he has uncontrolled hypertension, although at his 4/19/13 appointment when his blood pressure was elevated at 154/89, there was no plan outlined in the medical chart for medication adjustment to treat his high blood pressure. On 1/31/13 he was seen for leg edema. During the visit he was noted to have lung crackles (indicating possible fluid in his lungs). These findings, in the setting of high blood pressure, are concerning for heart failure, which is a consequence of uncontrolled hypertension, but the medical chart I reviewed gave no indication that he was being evaluated for heart failure or to identify any other etiology of his lower extremity edema. Despite the lack of a clear evaluation strategy, the treatment plan in the medical chart (1/31/13) indicated that [redacted] should exercise outside of his cell. This makes sense as part of a treatment plan, since exercise is a critical component of treatment for both hypertension and heart failure.

I viewed the exercise areas available to prisoners housed in CB-7. They are small outdoor cages that do not allow sustained walking or other kinds of exercise appropriate for [redacted]. [redacted] conditions of confinement, which do not allow for him to move around inside the prison except for the short walk to the showers every other day, put him at present and future risk of harm by having an adverse effect on his health and contradicting his medical treatment orders.

[redacted]. [redacted] is a 71 year old male prisoner in Florence-CB-7 who says he has been in lockdown for 13 years. He stated that he doesn't talk to anyone. "I leave them alone – too many rats in the prison so I stay alone. I am lonely." He says the only time he gets out of his cell is for three weekly showers. His medical notes indicate that he has dementia. Despite having dementia, he is receiving an extremely high dose of the medicine Benadryl, which is generally contraindicated in all older adults because it contributes to confusion. It is clearly contraindicated in older adults with dementia. However, according to a note from 10/29/12, [redacted] appears to be receiving four times the usual dose of Benadryl. [redacted] health is at risk because he is on a medication that is contraindicated for a person with dementia. In addition, the physical inactivity and the level of isolation he is experiencing are creating a risk of harm for worsening his dementia. The cells in CB-7 are extremely isolating, with solid steel doors. The small cages outside CB-7 do not allow the kind of exercise [redacted] needs. Access to a housing unit where he has more access to social interaction and regular exercise would mitigate this harm.

[redacted]. [redacted] is a 51 year old male prisoner at Florence-CB-7 with Chronic Obstructive Pulmonary Disease whose functional assessment form from 8/4/09 indicates that he has dyspnea (shortness of breath) with minor exercise and weakness. [redacted] stated that he used to go to the exercise yard when it was a yard, but that he stopped going in approximately 1999 when the yard was changed to a "cage;" he stated "I won't go to that cage!" Exercise is important for [redacted] health because regular exercise improves symptoms and mortality in patients with COPD. For this reason, [redacted] conditions of isolated confinement and the inadequate exercise facilities in CB-7 put him at risk for present and future medical harm by having an adverse effect on his COPD; this risk would be mitigated with access to an exercise yard.

[redacted] is a 63 year old male prisoner at Florence-CB-7 with possible prostate cancer. [redacted] appears much older than his stated age. He is very thin, frail, and very slow to transfer from his bed to a standing position. He has an indwelling urinary catheter in his penis and a urine smell could be detected through the cell door. [redacted] appears to have been approved for a urology consult on 6/25/13 but I was unable to find any documentation of a consult in the medical chart during my visit. [redacted] states that he has lost a precipitous amount of weight (from 154 lbs to 110 lbs over a year). He states that he fell while getting out of bed a few months ago and that he goes to exercise three times weekly. [redacted] is experiencing functional decline and is at risk of falls. He is at present and future risk for worsening functional impairment and falls due to the constraints on his exercise posed by his conditions of confinement. As noted, the small exercise cages available to prisoners in CB-7 do not allow adequate exercise for [redacted]. Access to more exercise time and more space where he can walk distances would mitigate this harm.

[redacted] is a 50 year old man at Florence-Kasson who has a history of a serious fall this year which resulted in 3 rib fractures and a pneumothorax. He stated that he does not always go to exercise when he has the opportunity to do so because he notes that you "have to stay out the whole time and you can't come in early if it gets hot." The exercise enclosures at Kasson Unit are too small to allow the kind of exercise [redacted] needs. [redacted] is at risk of worsening functional decline, additional serious falls, and the resulting risks posed by each condition, including mortality, because of his

conditions of isolated confinement. Access to an exercise space where he could come inside if it gets too hot and where he could have more access to regular exercise would mitigate this harm.

[redacted] is a 71 year old man at Florence-Kasson who is very hard of hearing. He stated that he cannot write so he has not been able to ask for hearing aids. He says he has been assaulted three times and at least one of these times he suffered loss of consciousness and now he no longer goes to exercise. [redacted] is experiencing present and future medical risk due to his isolated conditions of confinement. Access to hearing aids could help reduce his isolation. Access to an adequate exercise area would mitigate this harm by enabling him to get the exercise any 71 year old needs to avoid deconditioning and the adverse consequences associated with deconditioning.

[redacted]. [redacted] states his age as 60, although ADC lists his age as 53. He is housed at Florence-CB-2 and has rheumatoid arthritis, uncontrolled diabetes and hypertension, as well as diabetic neuropathy. The plan from his medical chart note on 7/29/13 included education about exercise. Lack of regular access to exercise contradicts the education given to him by his clinicians and poses a risk of present and future harm due to his uncontrolled diabetes and hypertension. Access to a less isolated living situation with more access to exercise would mitigate these risks by allowing him to access regular exercise, the first-line treatment for both hypertension and diabetes.

[redacted] is a 60 year old male prisoner at Eyman-SMU who looks much older than his stated age. He has a history of Post-Traumatic Stress Disorder with suicidal ideation. He has no windows in his cell and there are no windows in his assigned exercise area (which also has no shaded area and is open all the way around at the roof). I viewed this recreation area and it is not large enough to permit the kind of exercise [redacted] needs. However, he is in a part of the prison that is sometimes allowed to participate in outdoor recreation in a yard. He said he started this program 2 days prior to my visit. He stated, "it is better outside, you get to go outside, interact. Here you just hear voices; it could be just a tape recording. (Here you) feel destitute, poverty stricken, isolated, alone. I have no one to communicate with, I am really isolated." He also stated that when he is outside he walks; he is a fast walker and it "feels better when you are able to walk, there is not enough room in the [regular] rec area to pace. It is so small you are bouncing off the walls." He then stated "As I get older with depth perception, I can't focus as well on the ground when I am locked in the cell for so long." [redacted] is at risk for the development of worsening depression and loneliness, and the health consequences of each. This risk is somewhat mitigated by the fact that [redacted] is now allowed some outdoor exercise in an area where he can walk.

[redacted] is a 58 year old male prisoner at Eyman-SMU who uses a wheelchair. His medical records from 12/18/12 indicate that he has functional limitations with ambulation and that he has a wheelchair that he needs to use 95% of the time and that he needs assistance with ambulation. On 7/19/13 he was seen by a registered nurse for evaluation of back pain due to a fall in his cell. The medical chart indicates that the nurse was unable to assess posture or gait because the patient was in a wheelchair. The recommendations include that he needs an ADA cell or a walker in his cell. On my visit, [redacted] was housed on a tier with no ADA shower so he has to pull himself up into the shower over the shower lip on the floor, which I saw and estimate to be approximately 6-8 inches high. He states that a PA ordered a

shower chair for him in January 2013 but he still had not received it when I visited him. He stated that he has fallen multiple times in the shower and when lifting himself off of his toilet. In addition to their small size, the Eyman-SMU exercise enclosures do not have any grab bars, any place to sit or rest, or any other accommodation that would make them usable for [redacted]. His cell does not have grab bars in it, and I did not see a walker. He states "they won't give me a walker so I can't exercise like I did (with a walker) at the hospital." "I would just like to feel safe and not fall that is all." He stated that he only gets out of his cell 1-2 times per month to take a shower because he is afraid of falling. [redacted] is at current and future risk of worsening functional decline and falls and the adverse health consequences of each, which would be mitigated if he were in an ADA cell and if he had regular access to exercise so that he could practice walking, balance, and muscle strengthening.

[redacted] is a 62 year old male prisoner at Eyman-SMU who has severely uncontrolled diabetes with frequent episodes of severe dizziness, headaches and uncontrolled hypertension, and chronic renal insufficiency. He stated "if you can't do jumping jacks and push-ups there ain't nothing you can do for exercise." During one of his episodes of dizziness a clinician noted that (6/21/13) that "when he stands he is unstable, his gait is abnormal." He is at present and future risk for worsening diabetes, hypertension and deconditioning due to a lack of exercise; the exercise enclosures in Eyman-SMU are too small to allow sustained walking. This risk would be mitigated if he had regular access to an appropriate exercise venue where he could walk distances.

In addition, [redacted] has evidence of severe headaches in his medical chart since at least 11/28/12 when he placed an HNR that stated "what are you going to do about my head hurt for 3 months now. I'm a diabetes (diabetic)." On 11/29 the patient was placed on the doctor's line. He was seen on 12/20/12 (I was not able to find the note from this encounter in the medical chart when I was there.) On 1/20/13 [redacted] put in another HNR that stated "I'm taking (10) ten Tylenol a day now. Please help me. I need to see the doctor not a nurse line. Thank you I have high blood pressure and am diabetes (diabetic)." The response to the HNR stated "you have seen the provider recently we'll place you on the doctor's line again. Thank you." On 3/2/13 [redacted] again writes that he is taking 10 Tylenol per day. On 6/16/13 [redacted] appears to have been seen at his cell. His blood pressure is elevated at 160/98 and his blood sugar is elevated at 229. The note states "patient refused to get out of bed stating too dizzy to stand up and I already fell once about an hour ago. Thinks he ate something bad this morning. Very anxious feels like vomiting. Wants a shot of Benadryl." The nurse takes a voice order for a shot of Phenergan for nausea. The next day, 6/17/13, [redacted] is brought to the health unit with dizziness where he is seen by a nurse. He is in a wheelchair and too dizzy to walk. His blood pressure is very elevated at 180/94. No exam is documented. Another voice order is received for a Phenergan injection. On 6/21/13 he is again seen; this time his blood pressure is still elevated at 170/90, he states "I am very dizzy it feels like I have just gotten off a merry go round. I have fallen twice since yesterday. I have been drinking lots of water. I think I ate something bad." The notes indicate that he is again brought in by wheelchair; when he stands he is unstable, his gait is abnormal, his mucous membranes are moist. He is dizzy when he turns his head. There is no other exam noted. The physician is again called and gives a voice order for 1 liter of fluid, a Phenergan injection and to check the patient for ketones in the evening. I see no evidence of the ketones being drawn. The notes

indicate that the patient complained again on 6/30/13 of headache and again on 7/1/13. When he is seen on 7/2/13 the medical note does not mention headache or dizziness. Many of his medications for diabetes and hypertension are stopped because "patient complains on too many medications states he stopped taking them." His labs are drawn on 8/8/13 and his diabetes has worsened – his hemoglobin A1C has risen from 10.2 to 11. The note states "schedule with HCP within one week;" he is seen on 8/14/13 by a nurse. No plan appears to be made other than to follow up in one month.

The quality of care for [redacted] as outlined here falls far below the standard of care. [redacted] is a very poorly controlled diabetic with hypertension. Complaints of severe headaches need to be evaluated quickly by a clinician to ensure that they are not representing hyperglycemic or hypoglycemic episodes, hypertensive emergencies, or diabetes-related eye emergencies that could lead to blindness. Any of these could be dangerous to his health. This evaluation should be done urgently – ideally on the same day. However, [redacted] waited weeks and sometimes months for evaluation. In addition, the maximum dose of Tylenol is 4000mg per day and any dose in excess can cause liver failure and death. Although [redacted] was writing notes to medical staff indicating that he was taking 5000mg per day, still he was not seen urgently. Despite reporting that he fell from dizziness and was unable to walk, no physical exam (other than vital signs) was documented on two occasions. On the third such occasion a very rudimentary exam was performed and was limited to evaluation of his gait and mucous membranes. This is very far below the standard of care, since his symptoms could have reflected many serious, life-threatening conditions including myocardial infarction (heart attack), diabetic ketoacidosis, and stroke, to name a few. The decision to take a patient with very poorly controlled diabetes and hypertension off medications requires a long conversation about the risks and benefits of such a decision and evidence that the clinician assessed the patient's ability to understand the decision he was making. The notes do not reflect such a discussion. This also falls far below the standard of care. By the time of my visit in August 2013, there did not appear to be a plan in the medical chart to restart his medications nor to follow up on his months of headaches. [redacted] is at immediate risk of harm from medical care that falls far below the standard approach to management of a patient with uncontrolled diabetes, hypertension, and severe headaches.

[redacted] is a 60 year old male prisoner at Eyman-SMU who has diabetes. He stated that he has "been in the hole" a little over a year this time. He stated that he never goes outside because it is too hot. In addition, he has a hearing impairment and stated "the hearing is worse here because it is loud all the time, people are yelling, swearing to bother people and neighbors." Because of the noise ("it is loud all night") and incontinence, he is up 3-4 times a night and does not sleep well. He gets out of his cell to the shower 3 times per week. He states that he is in a unit where the prisoners are supposed to get out to a recreation yard twice per month but we are "lucky if we get out every three months – not to the rec pen, I mean the real outside." [redacted] is at present and future risk of worsening diabetes and its consequences, including mortality, and functional impairment. These risks would be mitigated if he had access to an appropriate exercise area and an environment more conducive to sleep.

[redacted] is a 41 year old woman with diabetes, hypertension and hyperlipidemia, housed in the Lumley SMA at Perryville. She states she has not had an eye exam with an eye doctor this year (the standard of care is an eye exam for all diabetics annually to prevent blindness). She

stated that "if I were on the GP (General Population) yards I would go outside, but here you are in cages and you can't walk away. On the GP yards I could walk away." As previously noted, most of the exercise areas at Lumley-SMA are too small to permit sustained walking. [redacted] is at present and future risk of medical harm from uncontrolled diabetes. This risk would be mitigated with access to an exercise yard where she could walk and with regular access to eye care.

C. Risk of infectious disease

While interviewing [redacted], at Florence-Kasson Unit, he told me that he sleeps on the floor because his mattress has severe cracks in it and he is fearful that this could spread disease. I observed his mattress and it was in fact severely cracked, almost shredded. Severely cracked mattresses do pose an immediate risk of transmission of infectious disease, including MRSA. I also observed cracked fabric on the chairs in the medical evaluation room at the Lumley SMA at Perryville, which pose an immediate risk of transmission of infectious disease, especially in a medical area.

VII. CONCLUSION

For all of the reasons set forth in this report, it is my opinion that isolated confinement as practiced in ADC poses a substantial risk of serious harm, including increased morbidity and mortality, to prisoners of older age, with chronic medical conditions, and/or with physical disabilities.

Dated this 8th day of November, 2013, at San Francisco, California.

BRIE WILLIAMS, M.D., M.S.

Exhibit A

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Education

1990-94	Wesleyan University, Middletown, CT	B.A. American Studies
1993	Universidad Catolica, Santiago, Chile	Semester Abroad
1995-99	Mount Sinai School of Medicine - CUNY, NY	M.S. Community Medicine
1995-99	Mount Sinai School of Medicine, NY, NY	M.D. Medical School
1999-02	University of California, San Francisco	Internal Medicine Internship and Residency
2004-05	University of California, San Francisco	Geriatrics Clinical Fellowship
2005-07	University of California, San Francisco	Geriatrics Research Fellowship
2005-06	UCSF Dept. of Epidemiology and Biostatistics	Advanced Training in Clinical Research
2007	Hartford Interdisciplinary Scholars	Communications Training
2010-13	UCSF K-Scholars Program	Additional Training in Clinical Research

Licensure and Certification

2000	Physician's and Surgeon's Certificate, Medical Board of California
2002,12	Internal Medicine, American Board of Internal Medicine
2005	Subspecialty in Geriatric Medicine, American Board of Internal Medicine
2006,12	Subspecialty in Hospice and Palliative Care, American Board of Internal Medicine

Principal Positions Held

2002-04	University of California, San Francisco	Clinical Instructor of Medicine
2004-now	San Francisco VA Medical Center	Staff Physician
2007-11	University of California, San Francisco	Assistant Professor of Medicine
2010-now	San Francisco VA Medical Center	Medical Director, Geriatrics Clinic
2011-now	Program for the Aging Century	Associate Director, Discovery & Communication
2011-now	University of California, San Francisco	Associate Professor of Clinical Medicine

Other Positions Held Concurrently

2001-05	Marin General Hospital, Greenbrae, CA	Hospitalist – per diem
2005-07	Lumetra Quality Improvement Organization	Physician Reviewer, Medicare Quality
2007-09	San Quentin Prison Geriatrics Consultation and Teaching Service	Director and Founder
2008	San Francisco Elder Abuse Forensic Center	Forensic Geriatrician
2009-now	UCSF/UC Hastings Consortium on Law, Science & Health Policy	Consortium Faculty Member

Honors and Awards

1993	The Humanities and Medicine Program, Mount Sinai School of Medicine, NY One of twenty students selected as college sophomores for early admission to medical school
1996	Patricia Levinson Summer Research Grant, Mount Sinai School of Medicine, NY
1997	Community Medicine Research Grant, Mount Sinai School of Medicine, NY
1998	The George James Research Travel Grant, Mount Sinai School of Medicine, NY
1998	Alpha Omega Alpha, Mount Sinai School of Medicine, NY
1999	Janet M. Glasgow Award, AMWA award for scholastic achievement
1999	George James Epidemiology Award, Mount Sinai School of Medicine, NY
2002	Floyd Rector Clinical Science Research Award (Best Resident Research), UCSF
2006	Presidential Poster Session, American Geriatric Society

2006 Outstanding Fellow Research Award, California Society of General Internal Medicine
2007 Hartford Geriatrics Health Outcomes Research Scholars Award
2007 Best Geriatrics Oral Abstract Presentation, Society of General Internal Medicine
2008 Brookdale Leadership in Aging Fellowship
2008 Best Health Policy/Health Services Research Poster, American Geriatric Society
2008 The Community Recognition "In the Trenches" Award, Bayview/Hunter's Point Senior Center
2009 Merck / American Geriatrics Society New Investigator Award
2010 Society of General internal Medicine - Geriatric Abstract Award (Senior Author on abstract)
2010 Mentor of the Year Award - Medical Student Training in Aging Research (MSTAR), UCSF
2010 Lieberman Scholar Award – "for work relevant to geriatrics from a multicultural perspective"
2010 UCSF Dean's Student Research Award (Senior Research Mentor for awardee)
2011 MSTAR Best Student Researcher (Senior Research Mentor for awardee)
2012 American Geriatrics Henderson Student Award (Senior Research Mentor for awardee)
2013 Best Oral Abstract, California Society of General Internal Medicine (Senior Mentor for awardee)
2013 Geriatrics Abstract Award, Society of General Internal Medicine (Senior Mentor for awardee)
2013 Best Health Policy Oral Abstract, American Geriatric Society (Senior Mentor for awardee)

PROFESSIONAL ACTIVITIES

Clinical Duties

Medical Director, San Francisco VA Medical Center Geriatrics Clinic

Duties include running a weekly trainee conference, weekly attending in clinic, coordinating patient panels and schedules of 10-15 faculty and trainees, managing distance e-consults, assessing and triaging in-person consultation requests, measuring and enhancing quality of care, developing educational opportunities for trainees

Attending, San Francisco VA Medical Center ACE Unit

I attend on the VA Acute Care for the Elderly (ACE) Unit for 2-4 weeks annually where I lead an interdisciplinary team of medical students, internal medicine residents, geriatrics fellows, nurses, nursing assistants, and physical and occupational therapists in the care of hospitalized older adults

Attending, Palliative Care Consultation Service

I attend on the Palliative Care and Hospice Consultation Service at the San Francisco VA for 0-4 weeks per year depending on division needs. Duties include working in partnership with a nurse practitioner and supervising a fellow, medical student and medicine intern, and providing consultation in a multidisciplinary palliative care team

Attending, Outpatient Clinic

I attend every other week in the San Francisco VA Medical Center Geriatrics Clinic. When I was a Clinical Instructor in General Internal Medicine I attended in outpatient primary care clinic 3.5-days/week and precepted medical students and residents in clinic 1.5-days/week

Founder and Director, San Quentin Geriatrics Consultation and Teaching Service

I created and directed this demonstration consultation service at San Quentin Prison as part of a contract between the UCSF Department of Family and Community Medicine and the California Department of Corrections and Rehabilitation. I attended on the consult service 2 days per month teaching a Family Practice Residents and medical students from 2007-2009 until the contract with the Department of Corrections and Rehabilitation ended in 2009

Attending, San Francisco General Hospital ACE Unit

I attended on the San Francisco General Hospital (SFGH) Acute Care for the Elderly (ACE) Unit for 4 weeks per year from 2007-09 where I led an interdisciplinary team of medical students, nurses, nursing assistants, and physical and occupational therapists in the care of hospitalized older adults

Forensic Geriatrician

I served as the geriatrician for the San Francisco Elder Abuse Forensic Center in 2008, a multidisciplinary effort between the District Attorney, Adult Protective Services, UCSF and the San Francisco Police Department to address likely cases of elder abuse in San Francisco (1 day/wk)

Attending, Geriatrics Inpatient Consultation Service

I attended on the Inpatient VA Geriatrics Consultation Service 4-6 weeks per year, supervising geriatrics fellows from 2005 until the service ended in 2008

Professional Organizations

Memberships

2002-now	Society of General Internal Medicine
2004-now	American Geriatrics Society
2013-now	American Academy of Hospice and Palliative Medicine

Service to Professional Organizations and Foundations

2007	The Jacob and Valeria Langeloth Foundation	External Grant Reviewer
2007-now	Geriatrics Task Force, Society of General Internal Medicine	Member
2008-09	Distinguished Professor of Geriatrics Planning Committee, Society of General Internal Medicine	Committee Chair
2009-10	Distinguished Professor of Geriatrics Planning Committee, Society of General Internal Medicine	Member
2010-now	Health in the Criminal Justice System Interest Group Society of General Internal Medicine	Member
2011	University of Utah Center on Aging Pilot Grant Program	External Grant Reviewer
2011-now	NIH Loan Repayment Program Ambassador at UCSF	Volunteer Mentorship
2012	Faculty of Medicine; University of Geneva, Switzerland	Promotions, External Reviewer
2012	Aging/Geriatrics Research, Society of General Internal Medicine	Research Abstract Reviewer
2012	Designing Clinical Research, UCSF Clinical and Translational Science Institute	External Protocol Reviewer
2012	Aging/Geriatrics Research Section, Society of General Internal Medicine Annual Meeting	Judge, Best Geriatrics Abstract
2012	United Kingdom Marie Curie Cancer Care Research Committee	External Grant Reviewer
2012	The Institute of Medicine and the National Academy of Sciences, *Workshop on Incarceration and Health*	Invited Workshop Member
2013	The Institute of Medicine and the National Academy of Sciences, *Workshop on Incarceration and Health*	Reviewer, Workshop Summary

Service to Professional Publications

2005-now	Journal of Hospice and Palliative Care	Ad-Hoc Reviewer
2008-now	Journal of Correctional Health Care	Ad-Hoc Reviewer
2009-now	Archives of Internal Medicine	Ad-Hoc Reviewer
2012-now	American Journal of Public Health	Ad-Hoc Reviewer
2013-now	Sexually Transmitted Infections	Ad-Hoc Reviewer
2013-now	Criminal Behaviour and Mental Health	Ad-Hoc Reviewer

Invited Presentations and Symposia

International Invited Presentations

2011 WHO Collaborating Centre for Prison Health International Conference on Prisoner Throughcare, Abano Terme, Italy *"The Older Prisoner: Addressing Salient Health, Functional and Social Needs of Older Adults in the Criminal Justice System and after Release"* (Keynote Address)

2012 Copenhagen Prisons Medical Department and European WHO Health in Prisons Project, Copenhagen, Denmark. *"Optimizing Healthcare for Older Prisoners"* (Invited Presentation)

National Invited Presentations

2005 The Annual Meeting of the Society of General Internal Medicine, "*Equal access to poor pain control at the end of life"* (Oral abstract presentation) New Orleans, LA.

2006 American Public Health Association Meeting "*Being old and doing time: Functional impairment and adverse experiences of geriatric female prisoners"* (Oral abstract presentation) Boston, MA.

2007 Grantmakers in Aging, *"Aging Prisoners: An Overlooked Geriatric Population"* (Invited talk and roundtable leader) San Diego, CA.

2007 California Endowment's Center for Healthy Communities: Meeting entitled *"California's Aging Prisoners: Where Do We Go from Here?"* (Invited panel discussant) Los Angeles, CA.

2007 Veterans Administration Employee Education Service/Homelessness Prevention and Incarcerated Veterans Program, *"Aging veterans in prison and after release"* (Invited Lecture) Baltimore MD.

2007 CME Correctional Medical Conference, University of Texas Medical Branch, *"Aging in prison: The fundamentals of geriatric medicine"* Houston TX.

2007 The Annual Meeting of the Society of General Internal Medicine, *"Caregiving Behind Bars: The role of correctional officers in geriatric prisoner healthcare"* (Oral abstract) Toronto, Canada

2008 Geriatrics Grand Rounds, Weill Medical College of Cornell University, *"When geriatrics and the law collide: Older adult contact with the legal system"* (Invited Presentation) New York, NY.

2008 Annual Meeting of the American Public Health Association, "*Can federal receiverships cure prison (non)healthcare?"* (Invited panel discussant) San Diego, CA.

2009 Society of Correctional Physicians Conference on Aging Inmates, *"Gaps in Knowledge Regarding Care for the Elderly Prisoner"* (Plenary talk) Orlando, FL.

2010 The Annual Meeting of the Society of General Internal Medicine, "*Wealth and the appropriate use of PSA screening among older men"* (Oral abstract presentation), Minneapolis, MN.

2011 Probate and Mental Health Institute, Center for Judicial Education and Research of the Administrative Office of the Courts *"Memory Loss in Elders and the Dynamics of Aging,"* San Ramon, CA.

2011 Leadership Symposium in Correctional Healthcare, John Jay College of Criminal Justice, *"The Crisis of Aging in Corrections"* New York, NY.

2011 The Annual Meeting of the Society of General Internal Medicine, *"The Mortality Risk for Older Adults Released from Prison"* (Oral abstract presentation) Phoenix, AZ.

2012 The Winter Series on Aging at The University of Texas, Medical Branch (Visiting Professor), *"Addressing the Aging Crisis in Correctional Healthcare*" Galveston, TX.

2012 The Dean's Lecture Series, Northeastern University (Visiting Professor), *"Criminal Justice Healthcare in the Aging Century"* Boston, MA.

2012 The Annual Meeting of the Society of General Internal Medicine (Invited Presentation and Panelist), *"Secondary Data Analysis in a Data Free Zone: Lessons Learned from Correctional Healthcare Research"* in the panel "Using Secondary Data to Study Vulnerable Populations" Orlando, FL.

2013 The Forensic Mental Health Association of California. Forensic Mental Health Across the Spectrum of the Criminal Justice System. (Invited Guest Lecturer), *"The Mental Health of Older Adults in the Criminal justice System."* Monterey, CA.

2013 The Center for Prisoner Health and Human Rights at Brown University Medical School (Visiting Professor), *"The Older Prisoner: Using research and policy to address the aging crisis in criminal justice healthcare,"* Providence, RI.

Regional and Other Presentations

2002 San Francisco General Hospital and San Francisco VA Medical Center, Internal Medicine Noon Conference. *"We are what we eat: Examining the health effects of the meat and potatoes of the American food supply"*

2005 Centerforce Annual Summit, *"Aging and Prison"* (Plenary talk) San Francisco CA.

2006 Medical Ethics Elective, College Preparatory High School, Oakland, CA. *"Medical Ethics"*

2007 UCSF Geriatrics and Public Health Interest Groups, Lunchtime Lecture, *"The public health consequences of an aging prisoner population"*

2008 San Quentin Prison, Physician CME Meeting, San Quentin, CA. *"Aging in prison: Some fundamentals of geriatric care"*
2008 UCSF Geriatrics Grand Rounds, *"When geriatrics and the law collide: Older adult contact with the legal system"*
2009 San Francisco County Jail, Healthcare Provider Education Meeting, *"What every jail healthcare provider should know about geriatrics"*
2009 UCSF Interprofessional Aging and Palliative Care Elective, *"Care of the underserved: Prison geriatrics"*
2011 San Francisco County Jail, Mental Healthcare Provider Meeting, *"Aging and mental health in the criminal justice system"*
2011 UC Hastings College of the Law, Co-Organizer and Panel Moderator, *"Prisons as Food Deserts"* part of the conference "Food Deserts: Legal, Social and Public Health Challenges"
2011 San Francisco Transdisciplinary Roundtable, *"Older Adults and Realignment: A Consideration of Potential Risks and Benefits Posed by California's New Criminal Justice Policy"* (Organizer and Main Speaker)
2011 The Prison Law Office, Attorney Training Session, Berkeley, CA. *"The Older Prisoner: Aging and Health in the Criminal Justice System"*
2011 San Francisco Police Academy, Police Crisis Intervention Training *"Aging and Health: Preparing the Police Force for the Century of Aging"*
2012 San Francisco Office of the Public Defender *"The Criminal Justice System in the Century of Aging"* San Francisco, CA
2008 Pre-trial Diversion Program *"Aging, Health and Social Services in the Criminal Justice System: Preparing for the Century of Aging"* San Francisco, CA
2012 San Francisco District Attorney's Office *"Health and Cognitive Considerations of Older Adults who are Victims or Perpetrators of Crime"* San Francisco, CA.
2012 The Dr. Benjamin Lieberman Memorial Scholar Awardee Lecture, UCSF Geriatrics Grand Rounds, *"The Older Prisoner: Addressing the Aging Crisis in Criminal Justice Healthcare"* San Francisco, CA.
2012 UCSF Center for AIDS Prevention Studies (CAPS), Panelist and Presentation in *"Aging, HIV and other Emerging Health Issues in Correctional Populations"* San Francisco, CA
2012 MSTAR - Meet the Professor, One-on-One meeting with first year medical students interested in policy-driven aging research. UCSF Division of Geriatrics, San Francisco, CA.
2012 San Francisco County Jail, Clinician Academic Meeting, *"Optimizing Health of the Older Jail Inmate"* San Francisco CA.
2012 Bay Area Clinical Research Symposium, "Evaluating a Modified Informed Consent for Older Adults in *Correctional Research"* (Oral Abstract Presentation), San Francisco CA.
2013 San Francisco General Hospital – UCSF Primary Care Internal Medicine Residency "Aging in the Criminal Justice System" (Class Lecture), San Francisco, CA.
2013 UCSF Medicine Grand Rounds at San Francisco VA Medical Center "Addressing the Aging Crisis in the US Criminal Justice System" San Francisco, CA.

Government and Other Professional Service

2005-06	Lumetra / California Department of Corrections	Geriatric Prison Healthcare Consultant
2006-08; 2013-now	Holland and Knight and Squire Sanders LLP Angola Prison, LA *Wilkerson, et al. vs. Stalder, et al.*	Expert / Geriatrics Consultant
2007	Abt Associates	Geriatric Prison Healthcare Advisor
2007	Department of Justice, Civil Right Division Seattle King County Jail	Assistant Healthcare Consultant
2008	ACLU of Southern California and the Disability Rights Legal Center, Los Angeles, CA *Johnson, et al vs. LA Sheriff's Department, et al.*	Prison Healthcare Consultant
2008	Hunton and Williams, LLP, Atlanta, GA *Miller vs. King, et al.*	Expert / Consultant

2008-10	RAND Health – Los Angeles, CA *Establishing a Sustainable Quality Measurement System for California Prisons*	Content Expert
2009-11	University of Denver Student Law Office *Silverstein vs. Federal Bureau of Prisons, et.al.*	Expert Examiner / Consultant
2009	Office of the Independent Medical Monitor, MI	Prison Healthcare Consultant
2011	Human Rights Watch, NY	Geriatrics and Prison Health Advisor
2013-now	The ACLU National Prison Project, ACLU - Arizona, and the Prison Law Office, CA *Parsons vs. Ryan*	Expert / Geriatrics Consultant

UNIVERSITY AND PUBLIC SERVICE

University Service

Departmental Service

1993-94	Senior Admissions Interviewer, Wesleyan University Admission Selection Committee
1998-99	Student Admissions Officer, Mount Sinai School of Medicine Admissions Committee
2001-02	Member, Internship Selection Committee, Department of Medicine, San Francisco General Hospital Primary Care Program
2002-04	Member, Quality Improvement Committee, Department of Medicine
2004-07	Member, Geriatrics Education Committee, UCSF Division of Geriatrics
2007-08	Member, Task Force on Incarcerated Veterans, San Francisco VA Medical Center
2008	Chair, Geriatrics Division Workload Committee
2008	Member, Geriatrics Division Administrator Search Committee
2008-10	Member, Clinical Research Subcommittee, San Francisco VA Medical Center
2009-13	Course Coordinator, Geriatrics Grand Rounds, UCSF Division of Geriatrics
2009-now	Coordinator, UCSF Division of Geriatrics Visiting Professor Program
2010-now	Elected Member, UCSF Division of Geriatrics Chief's Council
2014	Chair, Selection Committee for the Lieberman Scholar Award, UCSF Division of Geriatrics
2013- now	Member, Geriatrics Grand Rounds Curriculum Committee

Public Service

2003-04	Board Member, AIDS Legal Referral Panel, San Francisco
2005-06	Geriatric Consultant, Legal Services for Prisoners with Children, San Francisco
2006	Geriatric Consultant, Senior Ex-Offenders Program, San Francisco
2006-08	Council Member, San Francisco Safe Communities Re-Entry Council
2012-now	Parent Tour Guide, The San Francisco Day School

TEACHING AND MENTORING

Formal Scheduled Classes for UCSF Students

Academic Yr	Course Title	Teaching Contribution	Class Size
2004-07, 2009-10	N203: End of Life Care across Practice Settings (Geriatric Palliative Care)	Lecturer; 1 Lecture per year	25-40
2005-07	M170.01A: Prison Health Elective (Aging in Prison)	Lecturer; 1 Lecture per year	20-40
2004-05, 2009-now	IDS 107: Life Cycle (Ethics, Pharmacology in Older Adults)	Discussion Group Leader, 2 2-hr sessions per year and 1½ hour faculty development meeting	15-20
2009-10,13	Intersession Clinical Decision Making "Applying Clinical Prediction Rules and Finding Clinical Guidelines"	Small group leader, 1½ hour Session and 1 hour faculty development meeting	15

2009-10	Intersession Clinical Decision Making "Evaluating Evidence from Meta-analyses"	Small group leader, 1½ hour Session and 1 hour faculty development meeting	15
2009-10	170.32: UCSF Interprofessional Aging and Palliative Care Elective (Care of the Underserved – Prison Geriatrics	Lecturer; 1 lecture per year	65
2010-11	Biomedical Ethics	Small group leader and critical review of 10-15 ethical case vignettes	10-15

Pre-Doctoral Students Supervised or Mentored

Name – available upon request	Position	Mentoring Role	Current Position	Dates
RL	Medical Student, MPH Student	Research Mentor – • UCSF Dean's Summer Research Fellowship – Primary Mentor • Abstract #4 • Manuscript #23	Medical Student	2008-2011
VS	Medical Student	Research Mentor • MSTAR Primary Mentor (American Federation of Aging Research) • UCSF Dean's Student Research Award • 2010 MSTAR Best Student Researcher • Manuscript #28 • American Geriatrics Society Henderson Student Award	Resident	2009-now
CA	Pre-Med Student	Research Mentor • Manuscript #27 • Abstracts #7, #10 • NIDA Fellowship (2012, 2013): Academic and Health Policy Correctional Health Conference	Clinical Research Coordinator	2010-now
AD	Medical Student	Research Mentor • MSTAR Primary Mentor (American Federation of Aging Research) • Abstract #11 • Mount Sinai School of Medicine Student Research Day (Poster Presentation) • SGIM Geriatric Abstract Award	Medical Student	2012-now

Postdoctoral Fellows and Residents Directly Supervised or Mentored

Name	Position	Mentoring Role	Current Position	Dates
BC	Medicine Resident	Research Mentor • Abstract #6 • 1-month one-on-one research elective (2010) • SGIM Geriatric Abstract Award • Manuscript #31	Palliative Care Attending	2009-now
TS	Medicine Resident	Career Advisor Palliative Care Attending Research Advisor • 1-month one-on-one research elective (2012) • Abstract # 9 • Senior Mentor – Best Oral Abstract California SGIM	Geriatrics Clinical Fellow	2009-now

		• SGIM Geriatric Abstract Award		
AH	Geriatrics Fellow	Career Advisor Research Mentor • Abstract #5; Poster presentation in Best Clinical Vignettes Session at national meeting	Junior Faculty, Geriatrics	2009-2010
AC	Research Fellow	Research Mentor • Abstract #12	Geriatrics Research Fellow	2012-now
RB	Research Fellow	Research Mentor • Abstract #13 • Best Health Policy Oral Abstract, American Geriatrics Society	Junior Faculty, Geriatrics	2012-now

Informal Teaching

2002 – 2004 Attending, Mount Zion Primary Care Medicine Resident Outpatient Clinic (1-2 days/wk)
2002 – 2004 Attending, UCSF Medical Student Longitudinal Clinical Experience Clinic (½ day/wk)
2003 – 2004 Site Director, Family and Community Medicine, UCSF Medical School, Mount Zion Clinic
2003 – 2004 Faculty Ombudsperson, 3rd year residents, UCSF Primary Care Residency
2005 – 2006 Attending, Geriatrics Outpatient Clinic (½ day/ wk, currently backup coverage)
2005 – 2008 Attending, Geriatric Consult Service (1 month/yr)
2005 – 2011 Attending, Palliative Care Consult Service (2-4 wks/yr)
2007 – 2009 Attending and Curriculum Development, San Quentin Geriatrics Consultation and Teaching Service (2.0 days/mo)
2008 Attending, San Francisco General Hospital, Hospital Wards (2 wks/yr)
2008 – 2009 Attending, San Francisco General Hospital ACE Unit (4-6 wks/yr)
2010 – now Attending and Director, San Francisco VA Medical Center Geriatrics Clinic (1 day/wk)
2010 – now Director, Fellows Clinic Conference, VA Medical Center Geriatrics Clinic (1 day/wk)
2011 – now Attending, San Francisco VA Medical Center ACE Unit (2-4 wks/yr)

Teaching Awards

2010 Senior Mentor, Presidential Poster Session, American Geriatric Society
Senior author and mentor on Dr. Angela Hsu's abstract "*When Caring Costs More*"
2010 Senior Research Mentor, Oral Abstract and Geriatric Abstract Award, Society of General internal Medicine – for Dr. Bonnie Chen's abstract "*Self-Reported Social Standing: A simple subjective measure of SES predicts functional decline in older adults*"
2010 Senior Research Mentor - UCSF Dean's Student Research Award - for Medical Student Vivien Sun's project "How Safe is Your Neighborhood? Perceived neighborhood safety and its association with functional decline and mortality in older adults selected for the highest medical student research honor at UCSF
2010 Mentor of the Year Award - Medical Student Training in Aging Research (MSTAR), UCSF (MSTAR is the Medical Student Training in Aging Research Program supported by NIA and the American Federation for Aging Research)
2011 Senior Research Mentor, MSTAR Best Student Researcher - for Medical Student Vivien Sun's project "How Safe is Your Neighborhood? Perceived neighborhood safety and its association with functional decline and mortality in older adults" selected as the best MSTAR project 2010
2012 Senior Research Mentor, American Geriatrics Society Henderson Student Award (Senior Mentor for student awardee)
2013 Senior Research Mentor, Best Oral Abstract Presentation, California Society of General Internal Medicine for Chief Resident Tacara Soones' abstract *"My Clients Fall through Every Crack in the System": Assessing the need for geriatrics health training among legal professionals.*
2013 Senior Research Mentor, Geriatrics Abstract Award, Society of General Internal Medicine for Chief Resident Tacara Soones' abstract *"My Clients Fall through Every Crack in the System": Assessing the need for geriatrics health training among legal professionals.*

2013 Senior Research Mentor, Geriatrics Abstract Award, Society of General Internal Medicine; Medical Student Anna D'Arby's abstract *"Evaluating a Modified Informed Consent for Older Adults in Correctional Research"*

2013 Senior Research Mentor, Best Health Policy Oral Abstract Presentation, American Geriatrics Society Annual Meeting for Geriatrics Research Fellow Rebecca Brown's abstract *"Hands on the Hood, Grandpa: Assessing the Need for Geriatrics Health Training among Police"*

RESEARCH AND CREATIVE ACTIVITIES

Research Awards and Grants

Current

NIH Mentored Patient-Oriented Research Career Development Award (K23)
National Institute of Aging
"Health, function, and health outcomes of geriatric prisoners" (1K23AG033102)
Grant Term: 9/1/09 – 8/31/14; Total amount of grant: $743,266

The Jacob and Valeria Langeloth Foundation (PI)
"Designing, piloting and disseminating a model multidisciplinary geriatrics program to assess and improve the care of older jail inmates"
Grant Term: 7/1/11 – 6/30/14; Total amount of grant: $364,845

National Palliative Care Research Center Pilot Award (PI)
"The Relationship between Distressing Symptoms, Functional Decline and Emergency Services Use in Older Jail Inmates"
Grant Term: 7/1/13 – 6/30/15; Total amount of grant: $154,000

The UCSF University Community Partnerships Office (PI)
"The Healthy Transitions for Older Adults in Jail Pilot Project"
Awarded: 4/1/13; Total amount of grant: $2,500

Hartford Geriatrics Health Outcomes Research Program Mini-Grant (PI)
"Case-Based Multidisciplinary Meetings to Improve the Care of Older Jail Inmates."
Awarded 5/1/13; Total amount of grant: $1,500

Past

Lieberman Scholar Award (PI)
"Vulnerable older adults who come into contact with the legal system: A cross-cultural perspective"
Grant term: 10/1/10 – 9/30/12; Total amount of grant: $10,000

The Brookdale Leadership in Aging Fellowship (PI)
"Assessing the health, functional status and healthcare needs of older adults transitioning from incarceration to community health systems"
Grant term: 7/1/08 – 7/1/10; Total amount of grant: $250,000

Hartford Geriatrics Health Outcomes Research Scholars Award Program (PI)
"The health, functional status and health outcomes of older adults in prison and after release"
Grant term: 7/1/07-7/1/09; Total amount of grant: $130,000

UCSF Hellman Family Award (PI)
"Assessing and improving health outcomes among incarcerated older adults"
Grant term: 1/1/08 – 12/31/08; Total amount of grant: $40,000

UCSF Hartford Foundation Center of Excellence Physician-Scholar
The Hartford Foundation
Grant Term: 7/1/10 – 6/30/11; Total amount of grant: $34,633

Peer Reviewed Publications

1. **Williams B**, Lindquist K, Sudore R, Strupp H, Willmott D, Walter L. Being old and doing time: Functional impairment and adverse experiences of geriatric female prisoners. *J Am Geriatric Soc.* 2006; Apr;54(4):702-7
2. Sudore R, Landefeld C, **Williams B**, Barnes D, Lindquist K, Schillinger D. Use of a modified informed consent process among vulnerable patients: A descriptive study. *J Gen Intern Med.* 2006 Aug; 21(8):867-73
3. **Williams B**, Lindquist K, Moody-Ayers S, Walter L, Covinsky K. Functional impairment, race, and family expectations of death. *J Am Geriatric Soc.* 2006; Nov;54(11):1682-7
4. Lindner S, Davoren JB, Volmer A, **Williams B**, Landefeld CS. An electronic medical record intervention increased nursing home advance directive orders and documentation. *J Am Geriatric Soc.* 2007 Jul; 55(7):1001-6
5. Baillargeon J, Soloway RD, Paar D, Giordano T, Murray O, Grady J, **Williams B**, Pulvino J, Raimer B. End-stage liver disease in a state prison population. *Ann Epidemiol.* Aug 4 2007
6. Pollack C, Chideya S, Cubbin C, **Williams B**, Dekker M, Braveman P. Should health studies measure wealth: A systematic review. *Am J Prev Med.* 2007 Sep;33(3):250-64
7. Sudore RL, Landefeld CS, Barnes DE, Lindquist K, **Williams B**, Brody R, Schillinger D. An advance directive redesigned to meet the literacy level of most adults: A randomized trial. *Patient Educ Couns.* 2007 Dec;69(1-3):165-95
8. **Williams B**, Lindquist K, Sudore R, Covinsky K, Walter L. Screening mammography in older women: The impact of wealth and prognosis. *Arch Int Med.* 2008 Mar 10; 168(5):514-20
9. **Williams B,** Greifinger R. Elder care in jails and prisons: Are we prepared? *J Correct Health Care.* 2008;14(4):4-6
10. Sudore RL, Schickedanz, AD, Landefeld, CS, **Williams B**, Lindquist K, Pantilat S, Schillinger, D. Engagement in multiple steps of the advance care planning process: A descriptive study of diverse older adults. *J Am Geriatric Soc.* 2008 Jun;56(6):1006-13
11. Baillargeon J, Thomas C, **Williams B**, Begley C, Sharma S, Pollock B, Murray O, Pulvino J, Raimer B. Emergency department utilization patterns among uninsured patients with psychiatric disorders. *Psychiatric Services.* 2008 Jul;59(7):808-11
12. Schickedanz AD, Schillinger D Landefeld CS, Knight SJ, **Williams B**, Sudore RL. A Clinical framework for improving the advance care planning process: Start with patients' self-identified barriers. *J Am Geriatric Soc.* 2009 Jan;57(1):31-9
13. Baillargeon J, Binswanger I, Penn J, **Williams B**, Murray O, Raimer B. The revolving prison door: Psychiatric disorders and repeat incarcerations. *The Am J of Psychiatry.* 2009 Apr;166: 489.
14. Lee S, Sudore R, **Williams B**, Lindquist K, Chen H, Covinsky K. Functional limitations, socioeconomic status and all-cause mortality in moderate alcohol drinkers. *J Am Geriatric Soc.* 2009 Jun;57(6):955-62
15. Sudore RL, Landefeld CS, Pérez-Stable EJ, Bibbins-Domingo K, **Williams BA**, Schillinger D. Unraveling the relationship between literacy, language proficiency, and patient-physician communication. *Patient Educ Couns.* 2009 Jun;75(3):398-402.
16. **Williams B**, Lindquist K, Hill T, Baillargeon J, Mellow J, Greifinger R, Walter L. Caregiving behind bars: Correctional officer reports of disability in geriatric prisoners. *J Am Geriatr Soc.* 2009 Jul;57(7):1286-92.
17. Mehta KM, Stewart AL, Langa KM, Yaffe K, Moody-Ayers S, **Williams B**, Covinsky KE. "Below average": Self-assessed school performance and Alzheimer's disease in the Aging, Demographics, and Memory Study. *Alzheimers Dement.* 2009 Sep;5(5):380-7.
18. **Williams B**, Baillargeon JG, Lindquist K, Walter LC, Covinsky KE, Whitson HE, Steinman MA Medication prescribing practices for older prisoners in the Texas prison system. *Am J Public Health.* 2009 Sep 17. [Epub ahead of print]

19. Baillargeon J, **Williams B**, Mellow J, Harzke A, Hoge S, Baillargeon G, Greifinger R. Parole revocation among prison inmates with psychiatric and substance use disorders. Psychiatric Services. *Psychiatr Serv*. 2009 Nov;60(11):1516-21.
20. Baillargeon J, Snyder N, Soloway R, Paar D, Baillargeon G, Spaulding A, Pollock B, Arcari C, **Williams B**, Raimer B. Hepatocellular carcinoma prevalence and mortality in a male state prison population. *Public Health Rep*. 2009 Jan-Feb;124(1):120-6.
21. Teleki S, Damberg CL, Shaw R, Hiatt L, **Williams B**, Hill TE, Asch SM. The current state of quality of care measurement in California Department of Corrections and Rehabilitation. *J of Corr Health Care*. 2011 Apr;17(2):100-21.
22. Asch SM, Damberg CL, Hiatt L, Teleki S, Shaw R, Hill TE, Johnson BR, Eisenman DP, Kulkarni SP, Wang E, **Williams B**, Yesus A, Grudzen CR. Selecting performance indicators for prison health care. *J of Corr Health Care*. 2011 Apr;17(2):138-49.
23. **Williams B**, McGuire J, Lindsay R, Baillargeon J, Stijacic-Cenzer I, Lee S, Kushel M. Coming home: Health status and homelessness risk of older pre-release prisoners. *J Gen Intern Med* 2010 25(10):1038-44
24. Smith AK, Stijacic Cenzer I, Knight SJ, Puntillo KA, Widera E, **Williams B**, Boscardin J, Covinsky K. The epidemiology of pain over the last two years of life *Ann Intern Med*. 2010 Nov 2;153(9):563-9
25. Castillo L, **Williams B**, Hooper S, Sabatino C, Weithorn L, Sudore R. Lost in translation: The unintended consequences of advance directive law on clinical care. *Ann Intern Med.* 2011 Jan 18;154(2):121-128.
26. **Williams B,** Sudore R, Greifinger R, Morrison RS. Balancing punishment and compassion for seriously ill prisoners *Ann Intern Med.* 2011 Jul 19;155(2):122-127
27. Ahalt C, Binswanger I, Steinman M, Tulsky J, **Williams B**. Confined to ignorance: The absence of prisoner information from nationally representative health datasets. *J Gen Intern Med.* Published online early 16 Sept 2011
28. Sun V, Stijacic Cenzer I, Kao H, Ahalt C, **Williams B**. How Safe is Your Neighborhood? Perceived neighborhood safety and functional decline in older adults *J Gen Intern Med*. Epub date 14 Dec 2011
29. Smith A, **Williams B**, Lo B, Discussing overall prognosis with the very elderly. *N Engl J Med*, 2011. 365(23): p. 2149-51.
30. Chang A, Chur E, Kao H, Kawahara S, **Williams B**. Training clinicians and building systems for an aging century. *San Francisco Medicine.* In Press.
31. Chen B, Covinsky K, Stijacic Cenzer I, Adler N, **Williams B**. Subjective social status and functional decline in older Americans. *J Gen Intern Med.* 2012 27(6) 693-699
32. **Williams B**, Stern M, Mellow J, Safer M, Greifinger R. Aging in Correctional Custody: Setting a policy agenda for older prisoner health. *Am J Public Health*. 2012 Aug;102(8):1475-81.
33. **Williams B**, Goodwin J, Baillargeon J, Ahalt C, Walter L. Addressing the aging crisis in U.S. criminal justice healthcare. *J Am Geriatric Soc*. 2012 Jun;60(6):1150-6.
34. Ahalt C, Trestman RL, Rich JD, Greifinger RB, **Williams B**. Paying the Price: The Pressing Need for Quality, Cost and Outcomes Data to Improve Correctional Healthcare for Older Prisoners. *J Am Geriatric Soc*. In Press

Non-Peer Reviewed Publications and Other Creative Activities

Books and Chapters

1. **Williams B**, Abraldes R. Growing older: Challenges of prison and re-entry for the elderly. Chapter in Greifinger R, *Public Health Behind Bars: From Prisons to Communities.* Springer. NY, 2007. 56-72.
2. **Williams B**, Ahalt C, Aronson L. Aging Correctional Populations: Through the Geriatrician's Lens. Chapter in Weisburd D, *The Encyclopedia of Criminology and Criminal Justice*. Springer. NY, In Press

3. **Williams B,** Chang AC, (Co-Editors), *Current Geriatrics Diagnosis and Treatment, 2nd Edition.* McGraw Hill, In Press
4. **Williams B**, Ahalt C, Greifinger R. "The Older Prisoner and Complex Chronic Medical Care", for the textbook *The World Health Organization (WHO) Health in Prisons Project*, In Press.
5. Barry L, **Williams B**. "Understanding The Effects of Criminal Justice Involvement on Older Adults," Chapter in *Current Geriatrics Diagnosis and Treatment, 2nd Edition*. McGraw Hill, In Press.

Other Publications

1. Hill, T. **Williams B**, Lindquist K, Kobe G. Aging inmates: Challenges for healthcare and custody: a report for the California Department of Corrections and Rehabilitation. May, 2006.
2. **Williams B**. Report to the Office of the Independent Medical Monitor: Review of Duane L. Waters Health Center Services, Michigan. April 2, 2009

Selected Abstracts

1. Smith C, **Williams B**, Geer E, Rose D. *Palliative care for hospitalized patients with terminal AIDS.* (Poster presentation at 12th World AIDS Conference, Geneva Switzerland, 1999)
2. **Williams B**, Lindquist K, Moody-Ayers S, Walter L, Covinsky K. *Family expectations of death: The role of functional impairment and race/ethnicity*. (Presidential Poster Session, American Geriatrics Society Annual Meeting, Chicago IL, 2006)
3. **Williams B**, Lindquist K, Hill T, Walter L. *Caregiving behind bars: The role of correctional officers in geriatric prisoner healthcare*. (Presidential Poster Session, American Geriatrics Society Annual Meeting, Washington D.C. 2008)
4. Lindsay RG, McGuire J, Kushel M, **Williams B**. *Coming Home: Poor health status and high risk of homelessness for geriatric prisoners*. (Poster presentation, American Public Health Association, Philadelphia PA, 2009)
5. Hsu A, Sudore S, Dougan J, **Williams B**. *When Caring Costs More*. (Presidential Poster Session American Geriatrics Society Annual Meeting, Orlando, FL. 2010)
6. Chen B, Covinsky K, Conell-Price J, **Williams B**. *Self-Reported Social Standing: A simple subjective measure of SES predicts functional decline in older adults*. (Oral presentation at the Annual Meeting of the Society of General Internal Medicine, Minneapolis MN. 2010)
7. Ahalt C, **Williams B**. Paying the Price: The dearth of publicly available prison healthcare cost data. (Poster Presentation at the Annual Meeting of the Society of General Internal Medicine, Orlando FL. 2012)
8. **Williams B**, Ahalt C, Faigman D. For a Seat at the Table, Bring the Table: A Transdisciplinary Model for Aging-Related Advocacy in Non-Health Policy (Poster Presentation at the American Geriatrics Society Annual Meeting, Seattle WA. 2012)
9. Soones T, Ahalt C, Garrigues S, Faigman D, **Williams B.** "My Clients Fall through Every Crack in the System": Assessing the need for geriatrics health training among legal professionals (Oral Presentation California Society of General Internal Medicine, Los Angeles, CA 2013; Poster Presentation at Society of General Internal Medicine, Denver CO, 2013)
10. Ahalt C, Stijacic Cenzer I, Myers J, **Williams B**. "Post-Traumatic Stress Disorder in Older Jail Inmates" (Poster Presentation at the Academic and Health Policy Correctional Health Conference, Chicago IL. 2013)
11. D'Arby A, Ahalt C, Stijacic Cenzer I, Sudore S, **Williams B**. "Evaluating a Modified Informed Consent for Older Adults in Correctional Research" (Poster Presentation at Society of General Internal Medicine, Denver CO, 2013; Oral Presentation at the Academic and Health Policy Correctional Health Conference, Chicago IL. 2013)
12. Chodos A, Ahalt, Stijacic Cenzer I, Goldenson J, **Williams B.** Factors Associated with Recent Acute Care Use in Older Jail Inmates" (Poster Presentation at Society of General Internal Medicine, Denver CO, 2013)
13. Brown R, Ahalt C, Steinman M, **Williams B**. "Hands on the Hood, Grandpa: Assessing the Need for Geriatrics Health Training among Police" (Poster Presentation at Society of General Internal Medicine, Denver CO, 2013; Oral Presentation American Geriatrics Society Annual Meeting, Grapevine TX, 2013)

Exhibit B

Perryville.

Housing unit (HU) -

yard: Individual rec yards. + mirrors. + roof tops. concrete floor.
ball in each two of four units have balls.
per warden each can have a ball.
direct view through sides.

doors - can hear call out from inmate in yard through closed door.
doors are open onto yard w/ enclosures
doors solid - w/ clear window in front of door.

shower: shower w/ ~6" inch lip at entry; narrow. (P)
① temp regulation
when door is shut during shower locked in - closed in cuff port closed then shower. Window is covered. - no grab bar.

MH office + tx area: Counseling / MH center - 4 cages; linen attached.

empty cell: 2 windows narrow (LED) direct view; grille can be opened by inmate.
night light on 24 hr per Ag
central cooling although little air
MH are welded shut x death row open others are welded shut others welded shut to keep cooler per guide.

room: per prisoner sometimes used by chaplain
"catch-all".

→ in progress of welding shut. per Ag.

lower tier - "Mt watch"

no curtain or chairs in Mt watch -

Mt watch cell 2 windows (one on upstairs) Lack wall

bed on ground of mattress (~4-6 inches up from ground.

sink, toilet.

solid door (not open) + 2 windows on door. top & bottom.

⊕ restraint cell -

Medical room -

biohazard open sharps container -

? no sharps containers noted.

⊕ sink, ⊖ movable privacy screen.

No sharps in open boxes.

cracked chairs (waiting chairs).

[redacted] (death row inmate - realized at end of call-first interview).

Every time I go to Medical they see me (ask to)

on no medicines; no medical problems.

In room x 9 years -

out once per day outside - 1 hr to rec enclosures -

three rooms - if have a lot of people to get outside

rec gets canceled if too hot - not one hr often.

have lived here 5 yrs, I hate being strip-searched (not cavity) on

this. too dehumanizing. I don't want to go out & deal w that

on ⊖ day - 10-15 min; thanks for permission to leave cell

[redacted]

48 y.o. old.

can go out every other day or maybe it is every day

in SMA x 7 month.

went out last week - can stay out one hour.

always every day -

[redacted]

long h/o chronic ear infection

put in tube -

can talk to e/o then ventz.

has it been family for 4 months - h/c has gotten in trouble -

tearful talking about how she messed up but took away visits felt too harsh. 4 mnth total punishment.

[redacted]

"I have no medical problems"

talks about others who might have problems in other units - I can't understand name.

[redacted]

Amlodipine, metop, ASA, vit

In hospital recently - will finish conversation later in private.

MR

3 bunk room but now converted to 1 room

3 yrs in SMU - going home either Oct or Feb.

[redacted] 42 have DM x 24 yrs -

MR

Insulin-dep DM no eye care for ~2 yrs.

hard time seeing

HSR - Monday (today is friday)

Scheduled to see a doctor for (R) eye fixed pupil but never seen -

WD's 3:30 am insulin QD.

WE's 7:30-9 am insulin QD.

see doctor ~ every 6 mo. policy changed - we used to see every 3 mo.

saw dr recently.

special DM diet - used to get peanut butter sandwich & milk

now snack is 3 saltines.

weekend - no lunch only bfast (brunch) & dinner (5 pm).

eat in kitchen bfast/lunch/dinner if stage 3. If stage 2 bfast

stage 1 in cell.

once day x 1 hr outside - I don't want to get in trouble b/c

I am level 3 & I don't want to jeopardize it - here

no way to get out of SMU b/c I have kept arrays.

if I was on GP yards I would go outside but here you are in cages & you can't walk away. On the GP yards I could walk away.
gets very hot during day —
I bought a lamp so I can have light – no lights in cell
some people don't have their own lights.

Unit – Lumley SMA Baker Rod some are bubble beds.

[redacted] 23 y.o.
water in faucet is hot & it's so hot in here they only pass out cold H_2O once/2 x day.
HARP's for MH

[redacted]
private interview later today.

[redacted]
H_2O 2x / day

[redacted] ~ last time a/c broke throwing up from heat – supposed to be at 12^{30} but
ice ticket – 12^{30} or around 6pm 8 times out of 10 – often (1/2 time) 6:30.
we never have balls in rec – we know you are coming b/c we have balls in rec cages!! over 100° in cells to over top.

planes take off all night

[redacted]

MP haven't showered in over a week
rec on graves b/c I am allergic to bees but
graves says I am not receiving on graves.
very sweaty
but see stronger in the room —

[redacted]

no concerns except getting out in September

[redacted] 50 yo
heat problem - see Dr every 3 mos. Have a stat.
3-4x /wk session done when out of meds — not kept they come around.
fall. but head really Dizzy due to heat
1 hr 20 min out per day on the yard, very dry my observation mouth/cracked tongue.
eat in dining unless on lockdown, rec in general yard. goes to rec daily.
[illegible] H2O 7:30 am, doesn't take [illegible] since faucet H2O b/c not cold. feeling lightheaded
[redacted] (restricted content)
. 54 y.o.
waiting x 5 days for respiratory + project - on KOP made [illegible] letter, didn't have any HVR form
so gave me a different request form for medical - wrote a letter & a kite.
out 1½ weeks & go out on rec - here I can walk around.
moved from SMU in Feb
foot broken can't walk well - toe pushed under other toe.

[redacted] - received very dehydrated appearing to dr & ed/triage -
I was asked if she had put in an HVR - [redacted]

[redacted] SW 40
put in HVRs when I was sick few months ago
stomach cramps - let me lay on floor for 5 days,
still waiting to see macro - Nurse said I was on nurses
list. have to pay 4 dollars every time I put in an HVR
even if it's about the same issue.
no fall -
working & school - get rec on weekends. (1 hr)
transferred from SMH 1 year ago.
HCV - found out when arrived
I always ask when I see dr even b/c I ask for to but
never get it.
hasn't occured to her to put in an HVR about it b/c always
tells the dr. in pain

[redacted] no concern

[redacted] 63 yo. Fibromyalgia, HTN, thyroid ASTR propranolol.

takes a long time to see dr.

HTN this am it will probably be 2 weeks -

headpain, vertigo, nausea - finally put HNR in

yesterday afternoon sat in the cool air - maybe slightly better -

last visit

drinking copious amts of water -

overall care feels comparable to outside but waiting time feels longer here -

was working in education 7:30 → work → lunch → work → 3:30/3:00 pm.

moved here from SMU Nov

was in SMU for sentence related reason 2 yrs SMU

now 3 yrs "closed custody" for 3 yrs then go to medium unit -

↳ better b/c there are not even more.

asked me not to say anything to medical about HNR.

[redacted] 59 yo.

took 3 yrs to do 1st Uterine prolapse surgery.

so I have to pee putting my fingers in the up the "

I have to dig out my own poop.

December was last surgery - have put in HNRs

uses deodorant inside me & pack rags inside of me

to dry it out - it will sometimes dry up if I can keep it dry.

moved here 2

when in SMU never went to cages it took too long to get out

showered every other day but didn't get out. I just stayed in my room for 2 years - now I always get out -

they retaliate really badly

heart problems once 185/121 told me I was faking it, in cage, in outside waiting room x 2 hours - I sought for dental for very high BP.

might Be b/c the pills lapsed – I had lot then [illegible] I had
happened about 3 months ago. run out of order.
I try to keep interactions w/ medical to minimum necessary
b/c I find them mean.

Castillo 26 Vaca 15 ago

[redacted]

MR

I have kidney stones; but they wrote to me & said I didn't.
Dr. Rodriguez told me I had tumors near ovaries in 2011 but
now I got a test a week ago, I haven't heard about what it
is.
My kidneys are now bad.
fell on hip 3 months ago – on crutches of it –
but pain fel in groin area
they don't answer my grievances –
date 8/5/12

M

Confidential in-person

[redacted]

SMA

when there someone got maced next to her - came thru vent & I had to go to medical

very loud negative - one girls stay up all night. It's like a madhouse.

feces smeared on wall but the next person goes in & feces is still there on walls. they say "deal with it."

[redacted] 72 yo.

ankle & wrist shackles.

always hand cuffs whenever leave cell [station] not once why b/c she is on protective custody. leg irons when at visiting center -

have fallen once w/ ankle shackles.

out of hygienes (indigent) - friend brought a care package in January - I have toothpaste now until 3 days from now - no shampoo yet

very poor dentition

no supplement now for toothpaste at all - I will be w/o toothpaste 2 weeks of every month - get

Skin condition - better w/ a cream. if we're get sores. now it has to be bought on commissary; after 6 mo & grievances they reinstated prescription.

No major medical problems - just waiting for it to start.

→ now cancelled again 10 d. ago.

Strip searches w/ cavity before going out so a lot of us don't go out.

have to wear orange jumpsuit now - & can't exercise in it its too hot. (for Stage 1)

I am not Stage 1, I am Stage 2 so don't have to wear it.

Acker

food has diminished terribly. I weigh 108 lbs., after you eat you are still hungry.

they just got balls for your benefit (in the stage 1 cages); in the stage 2 cages they have a basketball.

often rec time is cancelled b/c of "emerges" or b/c of not getting to certain people their change of shift & forget it - but visit to dentist 6 mo ago, but not in pain now -

[redacted]

an officer wrote a report I was threatening to take NTG from my radio. But me on watch - I refused to eat 1 day.

an officer saw me & gave me a NTG. Medical took 16 mins to respond. Co yelling that my eye was bleeding

Med dept gave me me med 5 days to have been giving whole dose of methop instead of ½.

one night they gave my meds to wrong girl.

late 3 days ago Monday, I got my meds yesterday.

getting charged $16 on my books even though assigned to be charged for chronic care.

I am PC I am not SMA -

I don't get out (rarely) - ask if I want shower 1 day/shift I always.

& I get asked for rec after

but go to cage say this they get to me in a search in bathroom & then to a stage 3 yard/cage. U 6 others, but I would go if on another yard that was open would go.

they wrote that I refused the meds but they were always bringing the wrong dose it wasn't a refusal it was the wrong dose. I was scared to take the wrong dose.

The heat is horrible w/ my heat.

bring water twice a day - but tastes from faucet it tastes like iron & is very hot.

fear reprisal -

note to self - must unmask how disguised profound fear of reprisal for talking to me.

Chart review

[redacted]

HNR 12/29/12
pls renew my Excedrin for migraine headaches, also renew the calcium please I have not received either this month.
12/31/12 scheduled for drs line

1/8/13 the pharmacy has not refilled my Excedrin for migraines pls renew thank you
1/9/13 scheduled for drs line

1/10/13 pharmacy there seems to be a problem flaw in your system. pls refill my acetaminophen/caff 500. it is different from my acetaminophen it is for migraine thank you.
1/11/13 according to our records the pain reliever plus expires 1/21/13 we will try to refill it today. you will need a new Rx
1/16/13 The pharmacy wrote that my acet/caff 500 has expired something is wrong somewhere.
1/17 scheduled for drs line.

1/29/13 Medical, I have still not received my A/C/500 for migraine this is about 6 weeks now. pls respond thank you.
1/30/13 note expired 1/21/13
1/31/13 we will refer this to your provider for a new Rx.
2/4/13 seen by Orciso, MD and also write note for Excedrin for Migraine

note had been previously on 12/12 - 1/21/13 per [illegible]

HVR 2/22/13 premarin vag
2/25/13 req submitted to pharmacy (plan of action

2/27/13 The pharm has not refilled my premarin vag cream.
3/11/13 refill request sent to pharmacy

8/7/13 My estrogen ran out on the 14th. I have not been back to St. Lukes to finish my repair. Pls inquire for me, I am so uncomfortable & I am so close to a healthy life. Thank you.
8/[illegible] scheduled for f/up surgery

6/6/13 I am out of premarin cream (to be used until surgery)
I have no stool softener also
pls [illegible] on my Dr. visit stating at St. Lukes.
6/12/13 no premarin cream on profile (referral to medical [illegible]
6/16/13 your premarin cream has been discontinued, the [illegible] a replacement, [illegible] has been recorded. Per policy, you cannot know the date of your appt.
Referral to medical. Req to pharm for [illegible]

chart notes from 12/12
[illegible] - rectocele noted in chart + vag. hysterectomy repair 12/30/12
+ cystocele & bladder repair w/ vag hyst.

5/6/13 Dr encino notes Vaginal prolapse seen beyond introitus slight cystocele with enterocele. refer to Dr. Ramirez for f/up.

3/6/13 note by MD notes 155/96 ↑ lipids, ↑BP Schedule cc for recheck bp x 4 wks. notes in 4/3/13 BP's ~ 130/80 x 4 wks.

MD note 5/13/13 ~~1055am~~ 1435 pm | May 13 2013 · BP 195/109 HR 74
. ↑ BP at dentist
S: Pt. ran out of BP med
P: Rx's updated. given tabs lisinopril 20mg now + am.

Note earlier 1255 5/13/13 | S: called to dental area. Inmate c/o feeling faint, ha, nausea
stated I don't feel good & I haven't had my meds in 2 days.
they were expired so they were taken by medical.
States she doesn't want medical care & refuses to sign form
charges.
BP 180/112

P - called yard to get med but unable to get any info.
Unable.... V/O Dr. [illegible] inmate to be seen
taken to yard in WC

13:05 nursing protocol sheet states
[illegible] to yard c medication records & charts to be seen asap

8/12/13 | F/up gyn Gracia
A: Vag prolapse, cystocele, rectocele/enterocele
P: F/up referral to gyn/urology (referral made in May 2013).

[redacted]

50 yo

Last note 8/5/13

pelvic discomfort → pelvic u/s ordered. + acetaminophen

6/7/13

HNR I want off all medication b/c I'm having dizzy spells.

6/18/13 – you have been scheduled w/ ψ.

6/12/13 – psych will Php on your request.

6/16/13 I would like off all my psych meds b/c I'm having side effects.

6/13/13 you have been scheduled w/ ψ.

6/11/13 ψ will Php on your request

5/13/13 pt profile rept:

Tylenol ES 500

EMDA 101

Benztropine 1mg BID

Buspirone 15mg

Citalopram

Depakote

Lasix

Colace

haldol 10mg QHS.

HCTZ 25mg

Lactulose

Lisinopril 5M

MTF 500 BID

Omega-3

Simvastatin 40 mg

1st note in chart 6/20/13 MH sick call

Stated was going to hurt herself if they put her back in her cell.

hx of numerous self harm threats.

P 108 122/92 wt 148

Same day CP nurse noted "Ekg strip no MD eval no mention dizzy spells.

7/8/13
MD 113/76 c: dizzy, light-headed.
p 76 d/c HCTZ.

7/9 Happy Nursing encounter tool.
L felt like legs were going to give out got really sweaty hot
we for her.
dizzy, lightheaded, anxiety
N/V, weakness, HA.
~~heat not~~
pt exposed to temp > 90° etc.. marked (Y).
heat risk section - not filled out
□ Y med □ diuretic med □ elderly □ CV h
□ DM.
BP 102/68 fsbg — p 79.
dry oral mucosa clammy ~~breathing skin~~

marks urgent interaction not req.
✓ Routine interaction: increase water intake..
no med referral ret

7/15/13 RN encounter CP
pt fell 4 hit back of head (from bottom bunk)
CP assessment - no assessment for falls. Rash who bw
102/70 pulse not indicated (regular)
8/. "bump" back of head. Neuro WNL checker
no plan marked on next pg.
7/16/13 rash - gait steady, denies dizziness (after rash) walk
MD Benadryl 50 mg.
7/18/13 tx'd new dermatitis

7/23 ↓ 'wants to kill self - see full chart ACLU.
4-pt restraints.

7/27/13 dizzy again upon standing
148/76 p 88.
[illegible]
intervention ↑ fluids

7/27/13 I am feeling heart palpitations & some numbness in my
HNR left arm I feel it should be looked at as soon as
possible.

→ seen same day

[redacted]
54 40'
problem list 10/2012 GI bleed 2° NSAIDS
HNR [illegible] need to see dr for severe stomach pain. This
4/7/13 is the 3rd HNR I've filled out. Please
take a look at me. really hurts
RN ✓ 10th referral medical
RN 4/11/13 scheduled for nurses line

4/16/13 refused nursing assessment for stomach pain
reason: not in pain anymore.

1/10/12 MD note also lists h/o GI Bleed

5/7/13 arthritis - methocarbamol [illegible] BID
(years) encouraged to exercise.

[redacted]

2/4/13 refuse exam.

HNR 5/17/13

could you pls refill my Nitrostat 0.4mg 1/150 mg I have severe angina and only have 5 pills left there's no refills order on my bag. Thank you.

referred to medical by RN 20 May 2013

refill request sent to pharmacy 5/22/13

1/28/13 chronic care clinic – HTN

2/11/13 renew SL NTG KOP.

3/28/13 Rx all current

MD note has cc appt in April

4/18/13 chronic care clinic

cp – yes SOB – no palpitations – yes ankle edema – no

pt adherence w/ meds – yes with diet – yes

with exercise (not stated) 118/83 59

heart RRR

plan – refilled norvasc & enalapril

education – nutrition, exercise. . . .

meds: norvasc (amlo)

Calcium Carb

Enalapril 10

Naproxen

Ntg

Note | see no pNote indicating xfer to hospital or ...
xfr

6/5/13 - ~~6/6~~ 6/6/13
hospital - d/c dx's.

① stable angina 2° ⊕ ADA myocardial bridging. - no evidence atherosclerosis
or ACS

② HTN
"report of
③ CHF". LVED pressure 20 on ⊕ heart cath. EF 65%.

started on metop 12.5 mg BID improved sx
d/c enal & HCTZ since ↓BP.
added ASA 81
Fllup cards 2-3 wks.

→ → no indication that fllup w/ cards occurred in chart that I can find

email state 89° in cell 6/12/13

8/5/13 Nursing encounter
chest pain & SOB
also subconjunctival hematoma per Dr. [illegible]

8/7/13 nursing encounter
CP x20 min took 3 NTG 138/94 97% RA [illegible]

8/8/13
MD Fllup MD visit for CP from last night - hospital.
1 [illegible] confirmed pt [illegible]

8/15/13 angina report meds 122/80 86
cc appt schedule Oct 2013.

My ...
attorney reparing ...
charts w/ reinforcing ...

[redacted]

chronic back pain
1/3/13 xray
Minor djd of T-spine, L-spine

[redacted]

HTN, obesity, asthma - problem list HTN, obesity, asthma

~~[illegible]~~

chronic care appt 6/6/13
BP 148/90 p 58
Assessment - HTN on tx
education provided, includes exercise
no Δ BP meds. orders starts extend these 3 mos
e.c ASA, lisinopril, nifedipine 20mg BID

[redacted]

Saw RN re eye problem
today 10ws after our visit
referred to optometry.

No HNR in chart about ophtho
inmate told me this
he had HNR at eye exam.

7/18/13 ccc
eye dr DM exam. referral noted. (hasn't happened) req.

last visit in chart w/ eye doctor 1/19/12

per problem list - IDDM x 12 yrs, obese, htn, ↑ lipids

think this 6/13/13

MD note | 6/13/11 ←

not logical, ... her fears & (demands) of ... to stop BP ...

BP 178/90 wants to stop all HTN meds.

* MH please see * (...).

MH note 7/5/13

... smiling & joking w/ staff. States she is "doing good". Refuses to go to ... b/c too many calories but does eat from staff she buys from store. Stated she will likely be ... to a ... once her ... which would be around 16th of month. Asked if she was suicidal or homicidal or ... hurt self or other & she stated "no" to all.

↑ not addressing reason MD sent her to them.

[redacted]

PN - colonoscopy ... 1997
4/16/13 ↓ hearing audiology referral 7/2013

7/11/13 | notes MD
sciatica (R) ... - mod
↓ hearing (confirmed on audiogram per note)
back care ... + BID PT instr.
pt ed done.

4/29/13 CCC | note - HTN, ↑ lipids

[redacted]

HNR

problem list 9/26/08 notes bunions both feet.
5/24/12 bunions

RN encounter
7/2/13 Bunions on both feet. toes cross in (L) which has been fallen down more recently; trouble standing for long periods.
rec - chart for practicer review.

July 15 review stamp by MD.
└ no other visits or other yet.

PL obese 1/20/11
CLBpair 7/2013

HNR 6/25/13 need refill for nifedipine down to 3 pills
6/28/13 to planner
nifedipine filled 6/28/13.

7/18/13 need refill nifedipine
too soon will automatically refill
per har - given on 7/26/13 ✓

6/28/13 HNR when I got here in '11 I was seen for my bunions on my feet. I was told then that I would be ref to a specialist and then if Central agreed I would have it. I felt I need a follow-up since I haven't been seen by a specialist. The are painful.
7/1/13 scheduled for nurse visit

May 29 2013

email: definitive procedures have not been done.

(pending since Jan 2013)

1) pc [illegible] (D)

2) 3 socket [illegible] done

3) rect [illegible] adenoma

May 13 email [illegible]

palpable rect mass

↑↑ ca ↑↑ PSA

"clearly in concerning concert now"

events out of order

recd entire chart

multiple notations of ~~[illegible]~~ & contradicting commits. [illegible] not done.

Q: | FLORENCE ASP | 8/14/13

· Dialysis | Med charts 2009 ⊕
· MH eval policy in SC?
· call bells in isolation | · CB2
· Infirmary care · isolation | · Medical
· Onsite / offsite MC services | · Yard office
· refills | · CB7 (vert)

[redacted]

Dialysis · on site · 6 bed - some stay in IPC hope in gen pop
depends on health acuity
Hospice · IPC (infirmary areas).
won't answer if hospice (both attorneys did not want me to ask overtime?)

unit - 3 floor; open gated cells
3 swamp coolers.
· florescent lights.
can talk to e/o
[redacted] not in cell.
[redacted] (records wrong).
Medical terrible · staff don't know what they
one doctor - can't understand. doesn't look at your records
(Indian). Rheumatoid Arthritis - asked for prednisone
the dr. would; was taking MTX didn't work -
wasn't working - told him - not getting. dr. took
away the extra thing for breakthru - gave me

Medi for pain -- I don't want more medi. It's just a sleeping pill -- asked for top tier (is a top tier) - b/c it is warmer.

Medical every 6 mo (DMH) - new medical every unit after 1 mo. Some specialist - no issues on file.

2yrs left.

cell time: rec: we are in here constantly. need to be able to go out, play dominos in the 1990's.

This is - dorm 1 rec (2 hrs) -

Rec M, W, F - 2 hrs rec x 3 week ? + 1 hr dorm
TW - in cell except 5 1/2 hr (dorm all)

peanut butter, chips, cereal, milk. supplement w/ canteen "junk."

Can work as porter, etc. in these units - unit answer if all there or just some -

Laundry program - varies by cell size.

this tier / housing unit has open rec yard.

Infirmary unit - IPC unit. Housing unit highest level of acuity -

Medical

[redacted] – Bed #1 infirmary

79 yr old

skin cancer - when 1st told them it was nothing more than a wart - took 2 yrs to finally get surgery - was in Pinar Unit B - ambulatory resident using walker, medical attendant, Unit 9 more severe - less ill nurse.

esoph biopsy - explained eating a cracker, collapsed lung biopsied. took 12 hrs when I first saw doct at Pleasant Valley Hosp - told doctor "I can't take it any longer. Must turn" - woke up in hospital. 4 yrs ago. In infirmary 2 weeks b/c fell & broke hip - possible infection all 3 sites (wounds).

stumbled over my feet - broke hip at time

once a day getting into rec yard (fenced yard ½ size of room; covered patio, cement floor, 1 hr / day x 6 days). talk w/ others during rec only - single cells.

↓

married adult -

Bm - Room 9 in Pinar B - "old timer" & skin cancer 1 thru . he is 79 or 80 .

air cushioned unit

CB2 - no swamp cooler upper tier.

CB7 - exercise enclosure (concrete floor, 2 rows - tarp (dark green) cover

[redacted] - cancer, HCV, M3 60 (Nasal sq. cell HNY)
requires
ø rec b/c too hot outside
goes to shower QOD -

- hit on floor - food stuff -> paper packets.
chow 7.0 am (now 9.30 am).
- empty cell shut.

- Shower: 1st entry ~3 inch lip -
mid calf lip entry - cool H_2O.
no info on temp - no bars, no grab, not ADA unit.

- Everyone sleeping CB7 1 tier

- room 6 - put in med rec few weeks ago -

[redacted] 71 yrs.
no teeth - 15 days no shower w/ pepper spray -
doesn't talk to anyone - I leave them alone -
too many riots in the prison so I stay alone.
I am lonely.
no visitors - has never for 13 yrs -
never outside - b/c don't want to talk w/
anyone - 20 yrs -
never sick - never ask to see the
last dog. doc 2010, asked for teeth; asked for teeth - told I don't need them -
. O.D. shows only fine lower cell
. last dog for shower last night -

[redacted] . 57 yrs
had surgery - dental - 2012, x2
don't go to that cage I don't like that cage.
used to be an open yard in 96-98 - closed it
down in 1999 & put in cage I despised
going - lower cell - shower at sink - more
convenient -
don't have asthma inhaler - put in request for
medical last then brought more inhalers
(attempted) waiting 2 weeks - hasn't put in 2nd
request b/c afraid they will charge him x 2.

been here Aug 2 2011
arm shackles when leaves cell.

[redacted] 41 yr.
black mold on top shwr
getting hydrocortisone cream for [illegible]

[redacted] 53 yr — [redacted]
will spend all my life here.
been losing weight — have something in white cells (cancer?)
12 years locked down —
shoes have holes —
4 times in the yard over that time — always sent back
to cell · have schizophrenia
didn't want me in MH program — took my tv & radio
not allowed to have books.
sept 24th 2012 conflict w/ co —

[redacted] MH 4

Indwelling foley w/ bag
very thin
frail
very slow to transfer, limp
catheter - 10 days - Δ every month "infection"
hernia - "dr says no operation" hurts a lot
some days, not all the time.
losing weight - 10 lbs - used to be 154 lbs
1 yr ago: ; was 95 lbs in december.
I eat but not too much - prison
doesn't give much food.
Urine stench thru door -
goes out [illegible] three times a week
no visitors
fell - in a few months ago getting up -
gets shackles when out of cell to
how long here - May 2013 & but doesn't seem
to understand question -
hamburger for dinner last night

CB7: closed door, indirect sun light
(solid)

? how hot too hot to go out -
won't tell us. can't produce discovery.

[redacted] 51 yrs.
on ψ meds March 15 - 20th didn't give
me meds for 5 days - then doubled dose[?]
30 days LOP - (loss of privs).
& moved to here for indecent exposure (he states
was asking for TP while sitting on toilet).
also lost other meds at same time.
doesn't go to yard - too much chaos & political stuff
I haven't seen a[?] trouble until this date.
want move - they won't tell me when I return
"at this time they aren't referring me to go back"
is what they say.
Shaking. /tremors. 3/20/13
sweats on TIW
no visitors

[redacted]

- Surgery not getting done
  - LS spine 5.1 herniated disc unsubsiding pain; no sleep; very painful.
  - Wanted heard since 2012 about surgery.

- sleeping 1h. then get up & walks up & down & relieve cramping in leg.
  - gave general → Ibuprofen.

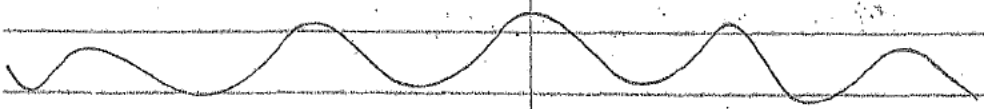
yelling thru door -

heart murmur. no treatment -
hospital - hardware removal from hand -

1-2 x per night CO: talk by
date of request to see doctor. Urgent HOPS
they never respond -
goes outside: walk it out stays in cell - always goes
(165 → 173 lbs - over 6 months.
(shoes - 1 fall in shoes - in canvas unit -
shackled on hands -
very hard to talk thru side of door.
tanks to people at rec - no visitors -
has stitches - supposed to come out yesterday & they 14 days.
has not been told when he will see them (trauma surg).

[redacted]

glaucoma specialist ; took 2 yrs to get a procedure done -
had attitude from specialist .. in sw eye clinic
b/c can be worse in orange -
3 yrs left -
as long as I send request for refills they get it to me -
dropped upper . chipped a tooth in the upper last one
only 2 yrs -
goes to rec , shoves -
10 - 10 am apart .
no visitors , talk to family out -



[redacted] CBT

[redacted] - 55 M3 2 yrs - 27 lbs wt loss)
gain weight - on pills - (Ozempic ABR
162 → 182 lbs
going outside & to shows every chance you
get . tks visitors
not bad at night -
6 1/2 months - from jail .

[illegible]

CB2 + CB1 - rec field, BB court

3 picnic tables w/ deck

pull up bar.

CB6 1 wing = MH

CB6 - no storage; doors w/ holes & windows w/ bars/covered glass.

↳ Kasen ~ MH area. (wing 1).

Smith, Randolph 52.

at work.

[illegible]

[redacted]

hernia x 2yrs.

aug 22, 2012 imaging for hernia.

in Kasen since May 2012

too tired to go out sometimes - come in all night

hot [illegible] can sleep.

TV x 4hrs.

talks to people on floor.

painful (L) hernia.

menu - hot dogs & beans last night.

2hrs x 3 per week; have to stay out whole time

can't come in early if get hot.

saw 4 2 months ago - not every month
hand cuffs behind back when leave cell.

Wing 1 - progressing in program Rec Area.
get small group activities here -
basketball or get home area
Nothing system -

Wing 1 not progressing in program to Wing 2 -
individual endorsers. ? smaller than CB7 ?

[redacted]

grievance w/ medical - old injury in spine.
keep re-aggravating; tomorrow to see Dr. asking for something
Hard of hearing. or something off pain - have a job as laundry porter
when I go back to cell hurts a lot.

getting reasons for sleep - hesitancy had time sleeping
2° pain. Sleep 4-5 hrs a night.
work 6-7 hrs as porter.
Hobbies - can't hear TV well 2° coverage in front of cell -
Has hearing aids, no visitors. Attorney contact once
to yrs. Feeling lonely "constantly".

no one my age in pod 1A high -
don't have much to say to them.
started feeling lonely - got
HOH. hears out of Ⓡ ear;
w/o TBI - in neuro hospital x 8 days before incarc.
very hard to hear when noise on tiers.
loud at night after spare b/c people get coffee.
no pillow.
asking for lower bunk it back in GI
shuffle some - hasn't fallen to ground.

[redacted] 64 yrs.
grievance waiting 41 days for fluorinated
↓ 35 lbs since April 2011 b/c don't feed us -
seized his prison legal records 8/8/2013 date.
very/hoarse -
very cracked mattress → sleeps on floor.
stuffing coming out. photo taken.
outside most times when available -

[redacted] Trans.

"[illegible]" cnvr

[illegible] 2001 incarcerated, 6 mos in this unit

. can't hear.

. 5 hrs sleeping Quiet

No friends - por que they think he is a [illegible] rats - so doesn't speak w/ anyone.

No visitors since 2004

doesn't go outside - b/c "snitches"

Showers there

can't write so can't ask for a hearing aid.

CHART . REVIEW

[redacted]

Urol. consult for ? prostatectomy
↳ 8/1/13 → 8/5/13 Consult request
wt 118 8/6/13
7/18/13 S. seen for low weight
wt 109 Review Uro consult : prostate ca.
p- wasting diet ordered.

7/3/13 - pt here d/t ↓weight
6/25/13 - arrival 5/31/13
u/o ur obstruction 2° ur ret/hydro
has foley
Consult Urol.
5/11/13 u/o "fainting spells" U/s 6/12/13
mult req. for prost surgery
5/15 req. renal U/s
6/5 Carson approved.
Med refusal 4/30/13
PSA 9.66 (ne 0-4.1) 4/8/13
[illegible] 7/11/13 Hct 39 (41-53) Hg 13.1 (13.5-17.5)

meds
7/5/13. Haldol 100mg IM Q4wks x 100d
terazosin 4mg QHS. (7 or 8/2/13)

* Need Biopsy Results
* Urology consult notes

[redacted]

7 yo.

7/23/13 - ear infection w/ pus & possible tym hole
Cefuroxime 500 mg PO BID x 10d.
recheck in 48hrs (no further notes)
BP 145/78 HR 66

8/8/12 sutures — removal for 3-7d.
9/12 BP 160+74 P102.
10/16/12 pt asking about suture removal.

altercation -
4/9/12, 6/15/2012, 8/7/12

11/24/10 - last weight recorded (166 lb).
3/15/10 note 5: lost 30#

8/5/08 - attacked by other.

8/5/08 BP 130/90 consider restarting HTN meds

11/24/10 BP 118/71 HR 82

7/26/08 BUN/Cr 34 (5-26) / 1.7 (0.5-1.5)
No BP recorded.
7/23/08 BP 148/90
5/23/07 Head trauma w/ LOC GCS 2° assault

CHART . REVIEW

[redacted]

Urol. consult for ? prostatectomy
↳ 8/1/13 → 8/5/13 Consult request
wt 118 8/6/13
7/18/13 S: seen for low weight
wt 109 Renew Uro consult: prostate ca.
p- wasting diet ordered.

7/3/13 - pt here d/t ↓weight
6/25/13 - arrival 5/31/13
U/o ur obstruction 2° ur ret/hydro
has foley
Consult Urol.
5/11/13 U/o "Fainting Spells"
Mult req. for prost surgery

5/15 req. renal U/s
6/5 Cargon approved.
Med refusal 4/30/13
PSA 9.66 (ne 0-4.1) 4/8/13
~~6/25/13~~ 7/11/13 HcT 39 (41-53) Hg 13.1 (13.5-17.5)

Meds
7/5/13. Haldol 100mg IM Q4wks ×180d
terazosin 4mg QHS. (? on 8/2/1

U/s 6/12/13

* Need Biopsy Results
* Urology consult notes

[redacted]

71 yr.

7/23/13 - ear infection w/ pus & ponible perf hole
Lamoxicillin 500 mg PO BID x 10 d.
recheck in 48 hrs (no further notes)
BP 145/78 HR 66

98/8/12 sutures — removed for 3-7 d.
9/8/12 BP 160/74 P102.
10/16/12 pt asking about suture removal.

alternative -
4/9/12, 6/15/2012, 8/7/12

11/24/10 - last weight recorded (166 lb).
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no BP recorded.

7/23/08 BP 148/90
5/23/07 Head trauma w/ LOC d/t 2° assault

4/9/10 - last labs psa 1.7 (0-4) [redacted]

8/27/08 psa 5.4 (H), cr 1.08 (nl)
7/25/08 cr 1.7 (H)

Ø current meds.

note 7/15/08 pain w/ urination & ↓ amt
7/22/08 u/s on will be scheduled.
seen 7/23/08
8/12/8 to possibly rec'v 1 month for possible needle bx
meds
↳ next visit - 9/9/08 no BP.
9/16/08 no BP
3/15/10 - BP √'d. 109/64
4/19/10 - BP 140/72

[redacted] - ordered full chart
? bloody stool w/ wt loss? 2/8/13
on waiting list ...
7/31/13 Hct 43.8 (nl)

[redacted]

h/o sq cell ca of mouth
Large portion hard palate excised - post
9/19/13 BP 154/109
(No plan re: HTN, No f/up BP ✓ since then) my notes
2/7/13 - C/o swelling legs. 130/78/55
? no w/up legs just lift?
no f/up assessment on my review
(no CXR? - my note) Labs. UNL x̄ Na 146 (148), AP 168 (166)
1/31/13 swelling legs w/ lung crackles -
advised to exercise out of cell

3/18/13
Missed pm Vicodin dose
received once on 3/21/13.

Fxl assessment from 12/10/10 - Indep ADL,
fxl limitations - can only walk short distances needs walker/cane

[redacted]

12/27/12 dx dementia 2° Syphilis"
└ last medical record in file

10/29/12 - on benazepril 10 mg QD?

2/27/12 age 70
132/92, HR 75 ← recent chart note

12/22/11 BP 134/102, HR 95
(no plan re: BP) - my note

8/4/11 141/89 HR 89.
no BP plan

11/8/12 - refused. Quarterly vital signs

3/8/07 - refuses flu & PPR.

Last ✝ notes. 2012. SMI dx dropped -
no longer on meds.

✝ meds at all.

[redacted]

8/4/09 Finished assessment from COPD
dyspnea w/ minor exacerbation Her
breathing
Lower Smirk
independent w/ ADLs

last roAP 7/13/12 -
S- flu from surgeon (fractured clavicle)
130/80 64 95% on RA
A- deferred
P- Ibuprofen.

of note - last HNR 5/29/12 for
refill Ibuprofen
(in person visit no albuterol).

7/16/12 - albuterol inh 7/6/12
per chart needs no evidence cancel albuterol?
pharm records seem not to date?

[redacted]

12/31/12 fell last pm
→ ER BP 135/90 HR 79 98% RA
1/7/13 3 rib fx w/ small pneumothx not req. chest tube
→ meds f/up CXR.

5/28/13 [illegible]
[illegible]
Benadryl 50mg PO Q4H
Phenergan IV
Naproxen.

5/17/12 BP 159/120
plan re✓ tomorrow

5/20/12 135/95
recheck 2 weeks

12/31/12 - fall 135/90 (see above.)

3/18/13 129/82
4/12/13 120/82

[redacted] cont'd

5/25/13 ALT 86 (10-35)
AST 31 (15-40)
AP 63 (53-128)

⊕ HCV 4/8/10

AST
10/27/11 48 (0-40)
ALT 109 (0-55)
ALK P 84 (25-150)

1/7/13 - request for ✓ residual PTX
2/20/12 - xray done

3/7/13 HNR "I have a burning sensation in my eyes can you put me on nurses line ASAP"

- response "will be placed on next avail nurses line" 3/7/13
3/18/13 "my eyes are dry and burning"
seen by LPN
refer to HCP
3/19/13 - dx'd dry eye syndrome
gets tears naturale oph / prn

Meds - acetaminophen 500 mg TID
chlorpromazine 50 QHS
diphenhydramine 50 QHS

Divalproex 500 QHS
Naproxen 500 BID
per note IM haloperidol + Benadryl + chlorpromazine

[redacted]

[redacted]

10/19/11 h/o perf duodenal ulcer ← (+) Dx
HTN w/ panic AT have this volume.
C diff, MRSA septicemia
pseudomal PNA
DM

7/3/13 Invasive sq. cell ca scalp (+)
(Lat.).

Sec HNR 6/14/13

HNR 5/2/13

2/2013

11/5/12

[redacted]

10/20/11 (problem list)

Sciatica (R) leg, herniated disc

2/6/12 - severe L5 radiculopathy

need referral to neurosurg for post. decompression

4/23/13 hand pain - wants hardware removed (MA)

↳ need referral

Seen 4/24/13 by PA

xray to visualize hardware.

Next note is 6/5/13 by PA

consult ordered.

6/20/13 seen in CCC

Xray (R) elbow (R) hand

"ample hx on this consult"

7/9 consult faxed

8/1/13 - came back from hospital after hardware removal

"sutures out in 7-10 days; f/u with surgeon 2 weeks"

8/4/13 - hand started landing painful RN →

8/4/13 "pt brought to the room for c/o pain - blood saturated gauze. Dressing D to (R) hand cleansed w/ NS and sterile gauze. telfa applied covering wound & 2 sterile gauze. wrapped c/ ace bandage. patient stated being painful. Fresh blood saturated noted. pt to have sutures removed 7-10 days from ER 8/11/13

8/8/13 had hardware removed 8/11/13 for ORIF 5th of UE mca ..... for f/up next week but no S.R. on I will see next week myself pt.

8/14/13 today - no other notes

Meds: dicyclomine (bentyl) 20mg tabs QID
ofloxacin 2 BID
Lactulose
methocarbamol 750mg TID
naproxyn
clonidine 0.1 mg BID (expired 4/25/13)
amlodipine 10mg QD
metop 25mg BID

7/20/12 note on problem list
11 HTN cc discontinue "

7/29/13 BP 140/93
not addressed in softnote

6/20/13 cc note 124/102 & 124/88
not addressed.

[redacted]

Rheum arthritis
7/29/13 chronic care clinic note
BP 144/97
2 hypoglycemic episodes since Lantus
↓ sensation feet
Assessment DM uncontrolled
RA pt uncooperative w/ rx/specialist.
plan- education exercise (√)
micro albumin, pred 10mg am x 3mo., podiatry eval
(pt declines MTX)

12/9/13 lost HbA1c
7/30/13 HbA1c 8.0 add glyburide 2.5mg BID
plus 1 mo

no referral form for MTX ordered in chart
? educati

Meds: ASA
Famotidine
Lisinopril 20
folic acid
Lovastatin 20mg
MTF 1000 Qam
pred long aam
Tylenol 500 BID
chlorpheniramine 4mg BID
Hctz 50 pm
Naproxyn 500mg PO BID

No ang med records in chart at all
last one from July

HNR
4/3/13 HNR for med refill request for prednisone 10mg.
4/8/13 Meds refilled.
Referral
→ I'm in need of my chronic care refills & f/u all orders... Also prednisone & naproxen.
Referral prescriptions refilled Response sent to Pt

[redacted]

consult request

7/17/13 Hep consult req for
↓ plts, ↓ hgb, ↓ WBC
" chronic likely due to Hep C & chronic liver dz"
faxed 7/18/13

1/23/13 s. labs reviewed
O - Pt Nc
A - ↓ H/H
↓ plts
P - repeat CBC, retic, INR, PO
Dr line 1/25/13 or any Hep
(later wrote in "or later")

1/30/13
1/22 labs 5.1 / 12.5 / 57.1 BX → 3.7 / 12.2 / 36.2 BO

2/5/13 - w/o ESLD

3/19/13 2.5 / 10.8 / 31.2 57,000

3/26/13 2.7 / 10.5 / 30.7 59,000

3/27/13 nurse line - very painful 2cm sore/wound on leg x 1-1.5 red around sore, edema of leg - RN calls PA orders Bactrim DS + tab BID x 10 days

& tylenol (very painful),
RN to be seen on 4/1/13 nurses line for f/up.

(no note until
6/28/13

6/28/13 lab calls w/ plts 36
put on bleeding precautions & call CO if recurs.

7/19/13 on controlled protein diet
Rice is making him throw up.

pancytopeni etiol? Hep C? other etiol?
O - liver not enlarged
A/P heme consult
w/o hepatic/ammonia encephalopathy
tylenol for dental pain, no nsaids 2° low Plts/LS

7/31 orders d/c Janoso 20 mg
Propranolol 10mg BID
Spironolactone 25 mg BID
Lactulose
7/20 tylenol 325 mg 1-2 po BID
folic acid 1 mg qd for megaloblastic anemia
heme consult

7/10/13

glucose 61 (70 - 105)

BUN 25 (7-18)

cr 1.38 (0.7 - 1.3)

AST 145 (15-40) ALT 91 (10-35)

TP 7.5 (6.0 - 8.3)

LDH 311 (100-190)

globulin 4.4 (2.0 - 3.9)

albumin 3.1 (3.5 - 5.5)

plt 45 (150-400)

WBC 3.52 (4.0 - 10)

ANC 1.58 (1.56 - 8.10)

HCT 39.7 (41-53)

hb 3.7 (4.41 - 5.57)

MCV 107.3 (80-105)

6/27/103

2.96 > 11.7 / 37.6 < 105.4

TIBC 343

Perr (D)

ANC 1.49 (1.56 - 8.10)

3/21/13 2.7 > 10.5 / 30.7 < 59 (calc) ANC 1.2 (1.8 - 7.8)

3/14/13 2.5 > / 31.2 < 57 ANC 1.1

LDH 286 AST 152 ALT 77 TBR 1.3 (0-1.2)

2/14/13 TBR 1.5 (LDH 287 (53) 71, ANC 1.7 (1.8 - 7.8)

7/14/13
My back is hurting so bad I can't
get out of bed
I can't sit too & watch TV or read my
holy bible book place help me out
doctors & nurses have a blessing day.
7/20 Nurses line

7/29 Seen HCP.

7/19/13 - emergency dental appt
for HVR on 7/14/13.
refer to dentist 7/18/13

gum decay - can't take tooth out
b/c of lab -
will flux w/ medical & extract as soon
as we can.
Temp 99.6 (medical)

Last MD note 7/19/13 — 102/66
heme consult — 61
99.6
Wt 176.

2/1/13 wt 162
2/7/13 161
2/13/13 154
3/7/13 156.6 (7/19/13 wt 176)

[redacted]

Ⓛ knee pain - ortho (chronic)
1/7/12 p̄ ORIF - TIB - TIB.
back pain
hip pain

FEYMAN

1B no windows
cell front has a circle opening multiple

[redacted] 60 y

Looks older than stated age

taking classes - mind over mood, painting etc..

here 30 yrs. TBD w/o SI

Hx

(R) foot problems - life long issue, cramping

went out 2 days ago for 2 days; haven't been for over 2 months. Have spent months in here - 6 months stretch in '05.

1 hr a day - rec center; 2 days ago started a new program of rec outside -

better outside - get to go outside, at least here you just hear voices, could just be a tape recording.

feel destitute, poverty stricken, isolated, alone -

I have no one to communicate w/ - I am really isolated..

1-2 hrs TNW

no cleaner / smells bad anymore in showers, they just painted this so nice here - smells like Sugar often. Seattle is cold

getting older here: eye trouble, leg problems, dizzy when I stand up,

walk 2 hrs when outside - pacer / fast walker; - feels better when able to walk

not enough room in rec area to pace so small bouncing off walls;

as I get older, depth perception, can't focus as well on ground when I am locked in cells for so long -
haven't been allowed to have clip-on sunglasses.
haven't been reimbursed for any of my medical & legal wasn't even though I have smi & am not supposed to be billed.
they don't allow us to have jobs to pay for anything
my mother sent $200 they took it all - I couldn't buy anything -
they took away my extra blanket; but policy says 2.

---

exercise yard: no shaded area, open all around at roof; no window - high grey walls no way to see over them, concrete floors

---

Brian Carter

[redacted] 56 yrs - knew we were coming
since Oct 2012 - trying to get to program w/ MH;
numerous kites, HNRs, personal letters - no response -
asking for MH help. if don't program don't get computer -
MH told this is an honor pod, but I can't speak to MH
© arm - 2010 bad infection in arm from bullet p arrest kept trying to see medical - got life flighted out to hospital - now
22 operations - over 60 days to get medical attn - septic shock -

since last jail visit to Ogle; Yesterday a guy was out there 4-6 hrs, then forgot about us. by the time his bro w/ rec get down there I go on else goes. what happened to my floor what happened to my rec — shower free together TAV. ask" shower or rec, shower or rec" in combo 3 yrs.

[redacted] 50 yr

Renal pt on dialysis > 5 yrs.
less than level 3 inmate - here s/c dialysis d/c from PS.
fed movement diet - my albumin below 4 "substandard" for years except 1 month -
Another kid here he is on dialysis - now he in detention b/c on dialysis -
I have been here 3 hrs — no attempts at reasonable accomodation to dialysis at central unit -
direct sunlight bad w/ my meds; try to go out to exercise but no shade -
1-2 x per week out of cell to do porter work - but after dialysis sometimes too tired to work.
Untreated HTN -> dialysis.
Only way to get my albumin up is to eat peanut butter then my K goes up to 6.1
No real renal diet - white rice, white bread.

Restricted ltd card. renal diabetic,
am, mid day + bedtime snack.

[redacted] 60 yo

had spinal damage + deformed spine – lost use legs + most organs
got MRSA – now better – few months out of a wk.
they dist really let us go outside – just to the
pen – there is nothing out there – bitter out there
than in ter. I never
I am legally blind – I can't have books + tape
its my right –
there is nothing for us as older guys – they push
you aside –

124 lbs → 178 lbs.

on hospital supplements for wasting syndrome expires
w/ 3/13/14.

SMH – 2 yr –

Double bandage in same size

[redacted] - throat & neck thing - keep doing different ads
Just work -

[redacted] 60 yrs.

asthma - not many mold - dirt need them.
... don't use toilet ex. room - too hot, no bathroom.
but use it month use another facility of many
years + the whole pod goes out

have to use bathroom 5-6 times per night.
programming once/week - gang substance abuse -
showers 3 times/week out of cell - tiny gym. (all in cages.

light comes on at 6 am turn off at 10[30] -
use to for light after that - I have no money
to buy night light for store -

Pepo - Baker.

[redacted] 58 yrs. in WC -
need handrails so I can stop falling.
fell 7 times in Mar, 5x in cell -
fall when getting off toilet -
have been asking for rail for, shower chair, handrails anything
that will help.
had TDA shower w/ shower chair in phoenix but not here.
they never respond to me - have asked Medic many
times w/ letter.

In WC from CSN.
have been trying to schedule a surgery from NOV 2009
- it was cancelled when they looked into medical condition
then it was okid but got worsened soon after.
Statin - I get every night, sometimes every other
night, some 2-3 nights a week -
can't remember when got it every night.

hospital in Feb - Septic pna - I almost died in ICU
for 1 week -
[redacted] error
it. I had a walker I could exercise -
I was able to walk around the hospital w/
a walker but they won't give me here.
We NTG 20 x / month - for chest pain -
was supposed to have an angio - something for chest
I have told them I need a stent but they
knocked it out -
out of cell - 1-2x / month shower b/c afraid of
falling. Shower has a step up have to
walk in 6-8 inch. pulls self up w/
drawer. PA recommended I have a chair
in June 2013 & I have an authorization
date 1/21/13 - 1/9/14 special needs order
wear wide restraints

" I would just like to feel safe & not fall that's all".

fell down was pinned on floor - on floor x 3-5 hrs
nurse came down to give assistance I said need to be seen I am hurt she said by the (the staff) then didn't come back, didn't help me. It scared me - they just left me. Eventually able to pull up w/ chair (end of June 2013) -

(shower closer (locks) when shower
7½-8 inch lip entry
(with dip down once walk into shower
no bars, nothing to hold onto (3 photos).

[redacted] 62 yrs old. ("In my late 60's [redacted]
8-5-13 put in HAVP bed - finally called up yesterday but didn't do anything.
Was supposed to be out of SMH 2 months ago but I didn't know when I was out - they don't help me contact anyone. Most people will be angry by now - I read the Bible to stay sane.
I don't complain - 2 yrs in SMH.

Dinner & can go out for ½ hr but no
Among spiders don't like to go out there -
if you can't do jumping jacks & push ups
ain't nothing you can do for exercise.
January 245 lbs yesterday 225 lbs.
Yes I did eat the greasy meat & the
sweet peanut butter -
dinner - chicken fried

[redacted] - error Acute

~~breakfast~~ error
[redacted] 60 yo.
Screaming & yelling, alone by inmate & alone by staff.
I am sick - I am not supposed to get charged for
medical, but they continually charge me. They
totally ignore it - in fact I got double medical
charged for 1 visit.
No teeth - they won't give me anything -
no diabetic diet - processed baloney used to have
fresh fruit & veggies & unbreaded fish but
eliminated the low salt & soft diets.
Full - Couple times in 20 years.

have seen in "hole" a little over a year this time
never go outside - too hot
hearing not good (he thought I said do you have
a glass eye")
the hearing is worse here b/c loud all the
time, people yelling, screaming to other people
& neighbors.
loud all night - sleep very not very well -
up 3-4x / night w/ insomnia.
Only program so far is substance abuse -
problem solving skills program - did 8 of 12 weeks then
they stopped it early.
I don't have a S.A problem so nothing for me to do -
3x / week - shower.
outside - supposed to go out 2x / mo - lucky if
we get out every 3 mo (not to rec pen, I
mean the real outside).
outside for 10 seconds to go to the health unit
but otherwise 3-4 months since I have seen the day.
hand & ankle when leave unit
(when have food only hand had shackles.
I feel very unsteady in ankle shackles - I fell out of
(van getting out & knocked himself out
was ~52 yrs old

[redacted]

MH programming ~10-12 cells / single cages.
(get how long? ~ complete?)
(there are cells inmates told us go to once a week ~ every ...)
MH inmates - eligible for either group rec (voluntary)
- basketball net
- individual - 5 double cells -
I asked says too hot go out every? can't answer.
no shade / covering on group cage.
cover on individual cages but direct sun still comes thru (
④ misting system individual, not on group cage

[redacted] = 7L yo. in double bunk cell
grouped OKs on bottom bunk.
HoH.
in SMU since Aug 2012 -
I have someone I can talk to -
med problems - heart, HoH at dr 2 weeks ago my ... for legs ordered (they are swollen) - hasn't come in yet.
She wanted me to take a cane - didn't at time but I realize I do need one - haven't gotten yet but came do...
shivers - ... flu
don't use yard - what's out there that's not where? I hath... out there.
very boring before w/o a cellie - harder time w/ ... when

I didn't have a cellie - it took 45 min or more
for me to remember his name -
Sleep d/o - since Vietnam. sometimes I didn't
sleep at all. It was worse when I had
no cellie, but it still fluctuates.
have to [illegible] meds - haven't tried to [illegible] them yet.
I am nervous about walking around / I stagger a lot.
I walk from here (one side of cell) to here (other side)
for exercise.
I used to walk my dog every day.
I stress about library - they lost 2 already & then
I have to pay for them. I am an
avid reader but since that happened I
don't bother reading in for books.

"please don't get me in trouble from anything
I said here - its a closed society
pay backs are the dickens in here"

BROWNING

[redacted] 72

(R) LE BKA. fell & broke ankle, [illegible] a shot
got snapped my ankle
she (RN) gave me pills for DM it made me dizzy
& after the shot I passed out.
put boot on but bone was sticking thru the skin.
the boot was put on here & then when they took
it off
I kept saying I think my ankle is broke - nurse said
I think its a sprained knee cap.
5 days after I broke it to check it - even after
I fell again - put a boot on it even
though I am a diabetic 5 days later
it stank like something dead in my room.
Gangrene had set in —
trying to get prosthetic leg - dr ok'd it now I am
waiting 3-4 months.
When I fell I was in SMU.
in Browning since 1997 -
has [illegible] in shower & stool for shower.

very boring before w/o a cellie. harder time [illegible]

go out & play cards w/ people (level 3)
3 days per week - M, T, Th, Sa.
level 3's go into cage together -
little ↓ staff.
Loud all night - put ear plugs & TV very loud
to sleep sometimes.
sleeps 11-5
better now I can sit & talk so much better -
keeps your mind occupied.
Lights off 11 pm - 6 am
can't see - took my glasses 2 yrs ago they say
they were broken. Haven't gotten them back.
Have one from a friend but not this prescription
eye dr ~ 1 yr ago says I need glasses - still
haven't gotten them.
no refund when he retired "yr are alone when
yr get in here - yr figure it out on yr
own."
girls by rear toilet not rear bed.
has sores bet toes & on heal of other foot -
has weepy edema at (1) leg has white to rash at
night.

[redacted] 60yo.

denying w/ start the doctor

nurses aren't giving me my meds - when I complain they stopped giving me my dose asap

~↓ 20 lbs in 5-6 months.

supposed to get a physical - have been asking

have NTG top 8/2/13 -

8/10/13 - not getting his top meds.

↳ NTG capsule (not the one under tongue).

allowed out 3x/week -

to a cage sometimes I do go. No toilet out there, what if I have to go to the bathroom?

2 hrs

leave w locked in shoes for hours locked in either. If take a shower or get locked in.

they don't hear you if you are outside & want to get in.

group meeting once/essay other month in cage for 10-15 min.

Dirt shower

- shower chair-built in

hand bar x2 (no operating-

head shower nozzle.

[redacted]

@ leg, pain
last time I saw dr 1½ - 2 mo ago.
gave me a medicine but it doesn't help.
they usually see me every 1½ - 2 mo.
trying to get new glasses I can't read anymore -
cape - from old injury @ leg.
too hot to go outside - I might go out in the evening.
Sweats 2-3 x / week -
I'm a loner - always been like that.

yard / rec area off unit - same as Delta
Speaker / hot sun in shaded area in ceiling
no blanket - cold walk to celling.

[redacted]

took all of our medicals last week - b/c of inmate suicide
eyedrops, ear drops, cream, vitamins, ibuprofen, tylenol,
all kept -
sleeping - leg
9/12 Ammin med Monday - got at 1:15 pm
9/13 Tues - 1:00 pm
today - noon
back pain - tramadol & ibuprofen can't take 1st thing in morning

On baseline x 2 yrs. "Children are cold turkey - like hell for 20 days." now I am put back on it but >3 weeks still not getting it.

Feb 7. saw dr - ordered xrays.
14 got xrays
he wanted me back 4/5 weeks - make HNR
but it took until July to see anyone -
the 4-5 mo delay even w/ xrays, tests +
all of that make the neurons start getting older.

go outside every chance I get - to the rec pair
3 x week for 2 hrs
also extra 2 hrs for a program (as a privilege)
sweat after 2 hr rec time.
Sometimes it I have to go to the bathroom I bang
but they ignore or don't hear it.
until they walk through maybe every 45 min./1 h.

photo - door to rec yard

[redacted] -
[redacted] procedure - ventry x 3 months.
See every 3 months -
1994 I found out I had HCV - never did anything
in 2004 stopped taking blood. I didn't
find out how bad liver was until 2008
when rushed to hospital for low WBC's.
said at hospital I should get interferon
but I had already started bleeding.
bring my 1st dose at 9, 10, 11 at morning
afternoon 9:30 - 11pm 3-4pm
pm dose 11p - 2am
don't sleep b/c waiting for them -
lights on all night - sleep about 6 hrs.
too tired to go outside from hepatitis -
make me too tired.
goes out for shower 3x/week
leave you in there 45 min - 1 1/2 hrs
in summer very hot in there -
water is hot in summer, cold in winter.
I have seen people knocking on door, screaming &
hollering & they won't come.

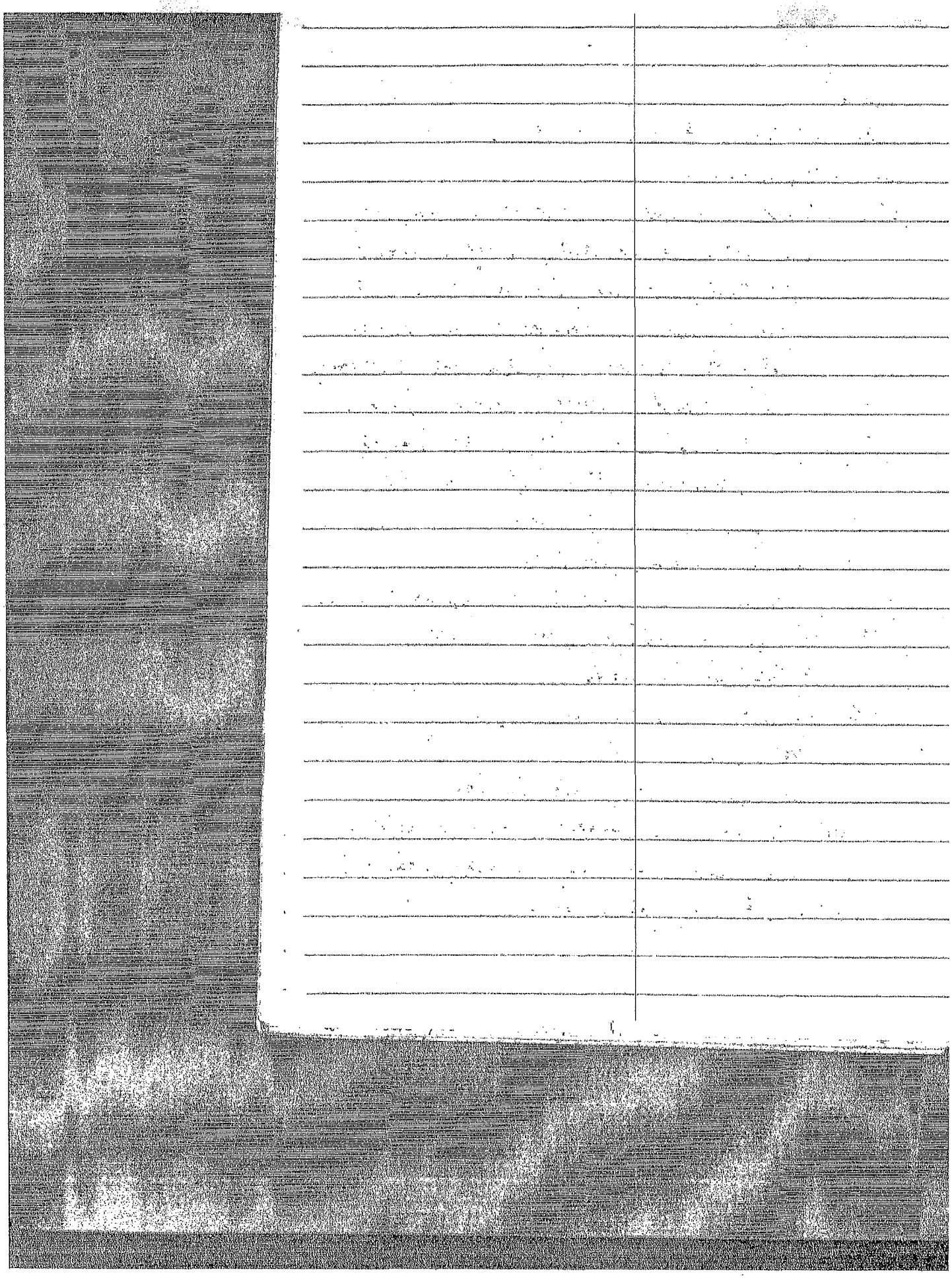

Chart Review:

[redacted]

1st chart in this chart - 4/4/12

note chronic care f/up -

p. "I have arranged for an O_2 concentrator".

1/3/13 chronic care notes:

~~Assessment~~ -

seen by nephrologist 3-4 mos gen. checkup [illegible]

-"not sure INRs or coagulation schedule is effective?"

this BPs from chart are elevated most of the time

A: note pt is requesting a time or arrow [illegible] to when he will ever get a (L) lower leg prosthesis

adjusted HTN ↑ lisinopril 10 → 20

"need to set up appt for better achieving scheduled desired results ASA.

→ req. set up another appt exclusively for this. (1/3/1..

BP 180/92, HR 80, INR 1.4 (low)

Cr 2.04 last RBS 268 HbA1c 7.4

notes no h/o prior colonoscopy brother had CA in GX.

1/22/13 INR on 1/17/13 1.5 subtherapeutic for [illegible] isch. cardiomyopathy w/ pacemaker

p ↑ Coumadin to 5mg PT/PTT weekly x 4 weeks.

1/30/13 notes last pacemaker ✓ 5/3/12
p - will need regular pacemaker ckes
Consult to pacemaker clinic for f/up
2/6/13 c/o edema x 1 week
notes leaving driving set free
wakes foot (wt) & schedule pt to see
in am 2/7/13 by ACP.
seen 2/7/13 - notes edema 120/70 68
weigh pt weekly has edema CHF need to monitor
this. (no other intervention re: edema / pain)
2/12/12 notes ↓ INRs 2/7 2.0
1/31 2.0
1/24 1.7
1/17 1.5
p: ↑ coumadin to 6
PT/PTT weekly x 4 weeks.
2/25 insulin is humulin 24u am 10u pm, ⊕ humulin sliding scale BID
3/7/13 notes no scales for non ambulatory pts.
states has DM & CHF weights are a vital part
of his medical necessity.
p.m. values averaging 300 +
→ ↑ am NPH to 28 u, instruct pt to check 2 accucheck daily
3/19 ↑ coumadin to 6.5
↑ pm insulin 12u.

4/11/13 nurses line R/t. LTVR from 4/10 that foot & leg "leaking clear water." & pain.
No weight 138/68, 97?, 69, 18, 99% RA
Lisinopril 40mg
↑ pm Lasix 80 (PA/RN).

4/15 no weight - edema going down.
Small amt weeping noted. calf palpable pulse.

4/15/cont - INR 2.9 on 3/26/13
P: ↑ pm Lasix NPH to 14u
Consult cardio f/up CHF pm
skin care w/ tech.
opto consult -
orthotic consult for prosthesis
f/up 30-60 d
renal diet.
5/8/13 RN encounter blister L Leg.
wt "W/C"
See HCP in am
5/9/13 adjust insulin
wts L leg post calf 1.5cm blood blister
↳ elevate legs. Δ dressing q3d.

5/23/13 ↓ conned c 60
↓ basin 60 → 40 mg pm Jase
5/30/13 RN note hold [illegible] until can [illegible] Levemir order on 6/3
6/3/13 starts Levemir

6/7/13 consult written for prosthesis
faxed 6/8
6/10/13 CP → hospital R/O MI
given IVS TKO, [illegible] @15 m,
EKG / [illegible]

chart very long - chart ordered.

9/17/12 HNR
"doctor I need some pain pill for my legs and arms and back. Please.

← plan of action: will set up appt (10/12/12)
9/25/12, 10/21/12 - asking about prosthesis
plan of action "HCP"
7/7/13, 7/29/13
HNR 2/5/13 My leg has been swelling up for a week now & I can't get it to go down and it hurt real bad now. I would like you to take a look at it please thank you very much.

3/7 - seen in clinic

[redacted] — HNR's 2009 - ⊖ colon

1/4/12 - HNR vista - req. ADA transfer

7/23/12

3/19 (L) leg numbness & please transfer to a ADA POD w/ ADA accessories I need a chair soon. please the numbness doesn't go away now, it's constant.

7/21 "you have seen by a provider 3/20"

12/10/12 Ext limitation ambulation

w/c - PT need to use 95% of time.

ADL (I) ō needs assist ambulation.

1/9/13 - PA cc form

P - Cardiology evaluation stress test.

shower chair, low bunk tier, w/c

2/14/13 - returns from hospital 2° resp failure 2° PNA.

cleared by cardiology

placed eff w ADA.

HCP today or next available

7/20/13

fall in cell 7/9/13

rec ADA cell or walker in cell.

HNR about fall 7/12/13

HNRs about Fall

7/8/13 "I fell again in my cell today when attempting to get off toilet. I tried to use my w/c for support but it moved on & I raked both arms, my right bloody.

7/19 - "seen"

7/12 I fell in my cell on 7/9/13 wrapping my r arm slightly on 7/11 I began pain back ... I became nauseous & vomited 7x. I asked med nurse yesterday she said put in HNR.

7/17 "seen on NC"...

7/19/13 note RN note

Nursing encounter tool back pain -

"came to clinic back pain [illegible] fall in cell on 7/8/13

pain caused by fall: aggravated old injury

[illegible] 5x [illegible] fecal [illegible].

exam filled in: posture erect in chair

[illegible] posture or gait [illegible] in w/c.

[illegible] yes for lt. leg raise [illegible]

[illegible] ada [illegible] or walker in cell.

no [illegible].

f/u in practitioner referral completed.

Not seen since then

[redacted]

8/29/12 SOAP note

71 yo ♂. ⊕ Pacemaker scar on chest.

plan - refill meds prilosec, zocor, ecasa,

low bunk / low tier, pm precautions.

schedule for PE/CC.

next appt:

10/30/12 eval for back & shoulder pain.

7/31/13 - feels off balance sometimes.

Ⓡ foot swelling. PM changed in 2003 has not seen to cardiologist since then.

plan acetaminophen — Arlene Mckamey (FNP-C)

ear lavage R/L

Flu Hep 1 mo.

consult - pm / cards

O: ambulates s̄ deficit, transfers [illegible] c̄ assistance

[redacted] a few chart notes available from 90's including:

F/U/D

5/3/95 pt desires to know status of his treatment for Hep C. Pt was told that the guidelines for tx w/ INF are very demanding

6/14/95 - LFTs again returned to NL so no Rx.

4/13. Sounded various.

4/22/13 GI consult -
Carvedilol 12.5 mg BID
U/S → AFP @ 6 mos.

↑

No evidence of U/S since then
AFP 4.7 (< 7.5) 7/16/13

Not seen since then

[redacted]

Cardiac, enlarged heart
HNRs.

See other note.

[redacted] Serious spinal problem - needs walker or w/c in past
Yoga - better now since doing yoga can walk w/o cane/walker
chronic LBP foraminal stenosis, DJD spine.
Stretching & yoga is wells

[redacted]

[illegible] start 5/29/13 - so far?
"maintain healthy habits"

Cp: Xfer hospital 5/29/13 — unclear outcome

Note 7/17/13 from FNP-C
"Maintain BP, healthy habits"

[redacted] 66 y o

BP's 210/108 230/130 at least 6 stats.

CAD

6/10/13 Acute cor syn.

ER - HTN crisis → hosp'tz | [illegible] hosp notes

HNR's - appeared to have [illegible] sepsis

10/1/12 on numerous occasions in past as I have req. refills of [illegible] prescrip have notified medical w/ HNRs & personally to wait nurses. out of atorvastatin amlodipine, atenolol, niacin, ASA; 2 days left of [illegible].
"[illegible] HNR has been sent to the pharmacy" (no date).

10/11/12 since Oct 8th continued HA's ... [illegible] 400-800 Q 6-8 hr. chronic problem w HTN have requested sp several times to no avail. since you doc sent to hosp. w/ x w/ extremely high BP since mid aug refills late + sporadic. I suspect my BP is quite high [illegible] I need to see a doc or at least have BP [illegible].
Seen on NL 10/17/13.
~~10/17/13 BP 198/106 pulse 45-48.~~

[redacted]

12/17/12 [illegible] renew BP's. Last 140/72

seen next on 5/29/13

BP 180/120 P 91 [illegible] hospitz

leg brace / cane

neuropathy

6/5/13 BP 152/90 no Δ meds.

4/8/13 [illegible]
5/6/13 160/[illegible]
6/10/13 230/[illegible]
7/14/13 [illegible]

8/14/13 BP 148/88 no Δ meds.

[redacted] - (L) knee problems, knee pain
low back, no ladder, no stairs.
Cataracts.

[redacted] -

HNR 11/20/12 what are you going to do about my head hurt for 3 month now I'm a diabetz..

11/29 DC

12/20/12 see soap.

1/30/13 My head have been hurt for 5 month now I'm taking (10) ten tylenol a day now. Please help me. I need to see the doctor not a nurse [illegible]. Thank you I have [illegible] told [illegible] I'm a diabete.

1/30 - You have seen the provider recently. Will place you on doctor line again. Thank you.

3/2/13 HA again states 10 tylenol / day
(note: acetaminophen = 500 mg @ pill.)

6/30/13 - HA
7/1/13 - HA

8/5/13 I need my blood pressure check my head hurt & I'm dizzy. Please help me I'm scary I'm afraid. I'm a diabete thank you -

8/6 referred to nurse line
8/7 blood pressure was checked 8/6/13 100/48 advised to take [illegible] 200 mg BID for HA, hydrate as well.

6/16/13 160/98, 62 BS 229

pt refused to get out of bed "I'm too dizzy to stand up" and "I already fell once about an hr ago
thinks he ate something bad this morning.
very anxious feels like vomiting
wants a shot of benadryl -
V.O. for phenergan shot for nausea.

6/17 brought to HU w/ dizziness
seen by RN
in WC too dizzy & shaky.
180/94 (L) 180/88 (R) 85 93% O2 18 93
asks for another benadryl shot -
VO from PA for phenergan
no exam.

6/21/13 Seen again by Salas LPN
170/90 78 97% RA 228 BS.
I am very dizzy it feels like I have just gotten off a merry go round. I have fallen 2x since yesterday.
I have been drinking lots of water... I think I ate something bad.....

O: brought in WC, when stands unstable, gait abl, MM pink moist
dizzy if turns head (no other exam).
P - provider called - IL TKO now, phenergan IM, UA ✓
ketones in urine (no evidence IL labs that done).

7/2/13 not doesn't weld in dizziness
pt c/o dizz on too many meds. states stopped taking insulin was making him sick.
97°, 96 pulse, 22, 150/84 / 98%
plan d/c lasix
d/c spironolactone
d/c lopressor
d/c clonidine
HCTZ 50 qam, cont lisinopril 40
check BPs weekly
glyburide 5; cont MTF
D/c levemir, d/c NPH
Insulin sliding scale
d/c pravastatin
cont ASA

cr. 1.34 (7/7/13)
Hbaic 10.2

8/8 Hbaic 11.0
cr 1.34
schedule w/ HCP w/in 1 week.

8/14/13 BP 144/82, pulse 98 ~ note stopped insulin bc he was "immune" to it.
RN sees him
F/up one month

[redacted] – no chart available.

[redacted] – no chart available.

NOTE: we are told they can't find [redacted] records, still no [redacted] records they are looking for them.
Later: told we can't find [redacted] chart.

[redacted]

80 yo DM, h/o retinopathy w/ 2 eye surgeries
took 1 month to get a shower chair
neuropathy, need tylenol 5/1/13
renewed tylenol 5/28/13
1/17/13 - note in intake that he's in meds but they didn't give me his
1/30/13 - needs to start meds
hasn't been on meds for almost 2 years.
7/11/13 order for shower chair, knee high stockings
8/8/13 HNR: "I did not receive my stool for
shower nor receive insurer diabetic socks ordered
last month by dr. that's on.
8/13/13 "has been ordered diabetic annual -
8/15/13 refused to supply coordinator -
4/17/13 hbaic 6.5
5/1/13 hbaic 7.6
7/8/13 hbaic 6.6

7/14/13 orders -

MTF 1000mg BID.

glipizide 5mg QD

GcMA 01 qD

Lisinopril 5mg QD.

[redacted]

4/29/13 there seems to be a problem getting my test strips every month. I have been out & waiting for my meds for 22 days now. So here are the strips at my meds to ready. They are supposed to come to me monthly w/o me reordering them. I am a diabetic w/ high blood pressure. I do need my meds. It seems like I get them one month then I'm off of them one month. Please get a handle on this problem.

same HNR 3/20/14

↓

2/8/13

3/19/13 - HNR 3/12/13 itchy at night w/ rash & cracked mattress ? bed bugs?

↳ RN note dx's bed bugs - box destroy or clean mattress - advised MD to send Env cell once bedding removed. Hydrocort cream

[redacted]

CAD hx on front page problem list (Cross ref).

HNRs requesting ntg:

7/3/13, 6/30/13, 4/30/13, 3/3/13, 2/20/13,
2/1/13, 10/12/12, 9/20/13, 9/27/12, 9/3/12,
8/26/12, 11/5/12, 11/9/12 (AA) . . . . .

ASA 81

Atenolol 50mg QD

Clopidogrel 600 mg

ntg CR 6mg T BID 9mg

SL NTG

2/1/13 HNR I need to get seen by the doctor! I'm on the medication "nitroglycerin" I have a chronic cardiac heart condition on file with the Arizona Dept of Corrections where I'm supposed to be given a medical check up for my chronic condition!!

Response - The HCP list is month declared. I'll put you on NL for now (RN).

Seen in CCC clinic 3/25/13

6/18/13

HNR

I have not had any meds in over a month so how can I give you the name of any meds. It is in my file.

6/21/13 we are unable to order your meds if we do not have what you want

8/7/13 HbA1c ↑↑ to 9.2% 7/29/13

9.1 5/1/13

peak ← 8.1 8/12/13

7.0 2/20/13

Exhibit C

Documents sent from plaintiffs' counsel to plaintiffs' witness Dr. Brie Williams

Depositions

- *ADC, Wexford, and Corizon Staff*
  - Deposition Transcript and Exhibits: Carson McWilliams, 9/27/13
- *Plaintiffs*
  - Deposition Transcript: Stephen Swartz, 8/22/13

Discovery Responses

- Dkt. 191: Defendant Ryan's First Supplemental Answers to Plaintiff Brislan's First Set of Requests for Admissions (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2)
- Dkt. 527: Defendants' Response to Plaintiff Wells' First Set of Interrogatories

Medical Files (non-named plaintiffs)

- [redacted]

Miscellaneous

- ADC027733: Photographs of recreation enclosures for mental health units
- ADC027751: Eyman-SMU 1 diagram showing location of mental health recreation enclosures
- ADC094573: Diagram of ASPC-Eyman-Browning Unit Typical Wing Layout
- ADC094576-77: Recreation Enclosures Dimensions Memo, dated 4/29/13
- ADC122656: Age 50+ Inmates in Identified Segregation Areas as of 7/31/13
- ADC139516-18: ASPC-Eyman-Browning Unit Activity Schedule, dated 8/1/13
- ADC139519-20: Kasson Mental Health Program
- ADC139521-23: Maximum Custody Step Matrix
- ADC139524: Perryville SMA mental health group schedules
- ADC139525-28: Mental health programming schedule, July and August 2013

Named Plaintiff Master Files

- ADC021193-816: Swartz Master File

Named Plaintiff Medical Records

- *Swartz*
  - ADC001259-396: Swartz Medical Records, 7/11/95 to 1/5/98
  - ADC001397-2288: Swartz Medical Records, 11/18/09 to 3/8/12
  - ADC018072-104: Swartz Medical Grievances
  - ADC074289-95: Swartz Medical Records, 3/16/12 to 2/12/13
  - ADC074414-6323: Swartz Medical Records, West Valley Hospital
  - ADC133730-866: Swartz Medical Records, 7/11/95 to 12-9-97
  - ADC133867-4306: Swartz Medical Records, 11/18/09 to 6/29/11
  - ADC134307-801: Swartz Medical Records, 5/10/11 to 10/23/12

Tour Photos

- *Eyman*
  - ADC153421-34- Photos - Eyman (Williams Tour) – 8/15/13 (redacted)