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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Fred Graves, et al., Plaintiffs, v. Joseph Arpaio, et al., Defendants.	No. CV 77-479-PHX-NVW

PLAINTIFFS' POST-TRIAL PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

A. BACKGROUND

1. In 1977 this class action lawsuit was brought against the Maricopa County Sheriff and the Maricopa County Board of Supervisors alleging that the civil rights of pretrial detainees held at the Maricopa County Jail were being violated. (Doc. 1).

2. In 1981, the parties entered into a consent decree that addressed conditions and operations at the Jail. (Doc. 166). In 1995, the Court entered an Amended Judgment by stipulation that superseded the 1981 decree. (Doc. 705).

3. In 1998, Defendants filed a motion to terminate the Amended Judgment pursuant to the Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626. (Doc. 755). In 2008, the Court held an evidentiary hearing on Defendants' motion, and issued its decision on Oct. 22, 2008, granting in part and denying in part Defendants' motion. *Graves v. Arpaio*, 2008 WL 4699770 (D. Ariz. Oct. 22, 2008). That day, the Court entered a Second Amended Judgment setting forth the prospective relief for those claims the Court had not terminated. (Doc. 1635). Defendants appealed the Court's decision, and the Ninth Circuit denied their appeal. *Graves v. Arpaio*, 643 F.3d 1043 (9th Cir. 2010).

4. The Second Amended Judgment provided relief in the areas of corrections/security, environmental health, overcrowding, recreation, medical care and mental health care. (Doc. 1635).

5. In 2009, the Court appointed Lambert King, M.D., Ph.D. and Kathryn Burns, M.D., M.P.H. as its experts in the fields of medical and mental health care, respectively. (Doc. 1769). Dr. King and Dr. Burns were agreed to by the parties to serve as the joint experts. (*Id.*) The experts were charged with reporting to the Court on Defendants' compliance with the Judgment, and assisting Defendants in reaching compliance. (*Id.*)

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6. Dr. King, who passed away in March 2014, was an extraordinarily distinguished physician with years of experience as a clinician and health care administrator in two of the country's three largest urban jails (Cook County, IL and Rikers Island, NY) and as federal court-appointed expert on health care services and organization in correctional institutions in Georgia, Iowa, Tennessee, New Mexico and Puerto Rico. (Doc. 1762-2).

7. Dr. Burns, who served as Defendants' testifying expert at the 2008 termination hearing, likewise has a long and distinguished career as a correctional mental health administrator. She also has extensive experience serving as a court-appointed expert charged with assessing correctional systems around the country, including facilities in the California and Massachusetts Department of Corrections. (Mar. 5, 2014 TT at 69:13-70:8, 71:9-11 (Burns)). She currently serves as the chief psychiatrist for the Ohio Department of Rehabilitation and Correction. (Mar. 5, 2014 TT at 11:22-24 (Burns)).

8. In 2012, Defendants moved to terminate the non-health care relief in the Second Amended Judgment. (Doc. 2080). Plaintiffs did not oppose the motion, which was granted. (Doc. 2093). The Court thereafter entered the Third Amended Judgment, restating the remaining health care remedies in this case. (Doc. 2094).

9. On August 8, 2013, Defendants moved to terminate the Third Amended Judgment in its entirety. (Doc. 2140). The Court set Defendants' motion for an evidentiary hearing commencing February 25, 2014. (Doc. 2192).

10. The Third Amended Judgment provides as follows:

> 2. Defendants shall provide a receiving screening of each pretrial detainee, prior to placement of any pretrial detainee in the general population. The screening will be sufficient to identify and begin necessary segregation, and treatment of those with mental or physical illness and injury; to provide necessary medication without interruption; to recognize, segregate, and treat those with communicable diseases; to provide medically necessary special diets; and to recognize and provide necessary services to the physically handicapped.

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> 3. All pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services.
>
> 4. Defendants shall ensure that the pretrial detainees' prescription medications are provided without interruption where medically prescribed by correctional medical staff.
>
> 5. Defendants will maintain records of their compliance with this Third Amended Judgment and shall provide quarterly summaries of those records to Plaintiffs' counsel.
>
> (Doc. 2094 at 2).

11. The Maricopa County Jail admits between 89,000 and 107,000 men, women, and children each year. *See* Maricopa County Sheriff's Office: Custody Operations, available at http://mcso.org/JailInformation/Operations/Default.aspx. The Jail has an average daily population of 8,200. (Feb. 25, 2014 TT at 91:22-25 (Hodges)). Some pretrial detainees remain in the Maricopa County Jails for days, and others for years. *Graves,* 2008 WL 4699770 at *25.

12. A substantial number of pretrial detainees in the Maricopa County Jails require medical treatment and/or prescription medication. (Cohen TT, *passim*, Alvarez TT, *passim*, Cohen Report, *passim*).

13. Many of the pretrial detainees in the Maricopa County Jails have alcohol and drug addictions, physical injuries, and chronic diseases, such as diabetes, asthma, hypertension, seizure disorders, and Parkinson's disease. (Cohen TT, *passim*, Cohen Report, *passim*).

14. It is estimated that 20% of the pretrial detainees housed in the Maricopa County Jails are seriously mentally ill. Many of these have schizophrenia, bipolar disease, anxiety disorders, attention deficit disorder, and other serious chronic mental

illnesses. *Graves,* 2008 WL 4699770 at *25.

15. Providing appropriate treatment and care for the large number of individuals with serious mental illness is a significant statewide problem, and state facilities and services are inadequate to sufficiently address the problem. (*Id.*)

16. Although many pretrial detainees' medical and mental health care needs could be addressed more effectively and efficiently through public services outside of criminal justice institutions, they frequently are not, and the responsibility for doing so falls upon the Maricopa County Jails. (*Id.*)

B. THE PARTIES

17. Plaintiffs in this case are a class of all pretrial detainees who now or in the future will be confined at the Maricopa County Jail. *Graves*, 2008 WL 4699770 at *11.

18. Defendant Joseph Arpaio is the Maricopa County Sheriff, and is responsible for managing the Maricopa County Jail and all employees of the Maricopa County Sheriff's Office (MCSO). (*Id.*)

19. Defendants Denny Barney, Steve Chucri, Andrew Kunasek, Clint L. Hickman, and Mary Rose Wilcox are members of the Maricopa County Board of Supervisors ("Board Defendants"). (Doc. 2221).

20. Health services within Maricopa County Jail are organized under a separately funded department of the County designated Correctional Health Services (CHS). *Graves*, 2008 WL 46699770 at *11.

21. Although not named as a defendant in this case, CHS' interests are represented by the attorneys for the Board Defendants. (*Id.*)

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C. FINDINGS OF FACT REGARDING MEDICAL CARE

Systemic Deficiencies in the Medical Care System at MCJ Place Patients at a Major Risk of Harm

22. Dr. Robert L. Cohen, M.D., was retained by Plaintiffs' counsel to provide expert opinions concerning the adequacy of the medical care provided to detainees at the Maricopa County Jail (MCJ). (Declaration of Robert Cohen (Doc. 2177-29), ¶1). He testified that MCJ's system of delivering medical care is a dangerous system for people who are seriously ill. (Mar. 4, 2014 TT at 4:22-5:2 (Cohen)). Dr. Cohen concluded:

> Taken individually and together, it is my opinion that detainees at the Maricopa County Jail do not receive adequate care to meet their serious health needs. The deficiencies that I identify in this report are endemic to the entire system; they cannot be dismissed as outlying lapses. Particularly troubling to me is that CHS and MCSO have known these deficiencies for years. Indeed, they were periodically reminded of them by Dr. King and given several years in which to remedy them. And while I credit Dr. King's assessment that CHS has made progress since 2008, the deficiencies that I discuss below continue to place patients at a major risk of serious harm – which includes pain, deterioration of health, unnecessary morbidity, and death.

(Pl Ex. 7 (Robert Cohen Medical Care Report—Nov. 18, 2013) (Doc. 2177-30) ("Cohen Report") at 4)

23. Dr. Cohen practiced medicine and served as the administrator for medical care for five years at the Rikers Island Jail in New York City. (Mar. 4, 2014 TT at 7:7-13, 10:6-7 (Cohen)). He served on the board of the NCCHC (National Commission of Correctional Health Care) for seventeen years, representing the American Public Health Association. (Mar. 4, 2014 TT at 13:22-24 (Cohen)). He has served continuously since 1989 as a federal court-appointed monitor for medical care in a number of jail and prison systems, including the medical services in the Philadelphia jail system, with a population of 9,000-10,000; for all prisoners in the State of Florida; and for prisons in New York State, Michigan, and Connecticut. (Mar. 4, 2014 TT at 8:25-9:18 (Cohen)). As court-appointed monitor, he has monitored care in order to improve it to meet

constitutional standards. (Mar. 4, 2014 TT at 11:8-12 (Cohen)). He is one of the nine members of the New York City Board of Corrections, an independent civilian board that oversees the operations and creates the rules governing the Department of Corrections including those governing medical and mental health services; these rules that have the force of law in New York City. (Mar. 4, 2014 TT at 5:6-6:23 (Cohen)). As a member of the Board, Dr. Cohen has 24-hour access to all of the jails in New York City, which have an average population of 11,000-12,000. (Mar. 4, 2014 TT at 6:5-13 (Cohen)). He served as vice president for medical operations of the New York City Health and Hospitals Corporation, a governmental agency that operated eleven public hospitals in New York City, in which capacity he was responsible for oversight of all physician services, nursing, quality assistance, and prison healthcare. (Mar. 4, 2014 TT at 10:6-17 (Cohen)). Dr. Cohen has practiced medicine in Cook County Jail and on Riker's Island. (Mar. 4, 2014 TT at 7:9-25 (Cohen)). He is a member of the faculty of the Department of Medicine at NYU School of Medicine. (Mar. 4, 2014 TT at 15:8-9 (Cohen)). "Dr. Cohen, who criticized much of SCIP's medical program, is an internist with extensive experience working in penal institutions. He is not a physician speaking from an 'ideal' perspective. We gave great weight to his testimony." *Tillery v. Owens,* 719 F.Supp. 1256, 1305 (W.D. Pa. 1989).

24. A health care system must be able to meet the serious medical needs of all detainees—both those who are generally in good health as well as those who suffer from serious or even life-threatening conditions. (Cohen Report at 2).

25. The most meaningful way to assess the care provided by a system is to look at those patients who have medical needs that require the system to function in a coordinated, efficient, and compassionate manner. (Cohen Report at 2-3).

26. Accordingly, reviewing the charts of healthy, 20-year-old patients does not permit a comprehensive assessment of access to and quality of care. (Cohen Report at 2).

27. The operative concept in assessing a health care system is to identify risks of harm, regardless of whether those risks materialized into actual poor outcomes. (Cohen Report at 3).

28. Health care in a jail, like health care in the community, is an organic system. Accordingly, it is difficult to divide it into individual, discrete components and identify distinct and separable aspects of care that are in need of remediation as many of these aspects overlap. (Cohen Report at 4).

29. In order for a health care system in a jail to provide minimally adequate care, it must have certain elements and all of these elements must work together to assure a systemic operational system. (Mar. 4, 2014 TT at 11:25-12:6 (Cohen)).

30. Taking these aspects of care together and individually, detainees at MCJ do not receive adequate care to meet their serious health needs. (Cohen Report at 4). MCJ's medical care system is a dangerous system for people who are seriously ill. (Mar. 4, 2014 TT at 5:1-5 (Cohen)). The deficiencies in care are endemic to the system. (Cohen Report at 4).

31. The systemic deficiencies at MCJ include the following general areas: intake process for people with significant acute or chronic problems, including lack of involvement of providers (Mar. 4, 2014 TT at 20:4-23 (Cohen)); lack of access to providers for patients with ongoing serious medical problems (Mar. 4, 2014 TT at 21:14-24 (Cohen)); lack of adequate care for patients with drug and alcohol withdrawals; inadequate tuberculosis control; radiology and laboratory services; medications, provider involvement in care, general clinical care, initial physical examinations ("14-day" exams), infirmary care, specialty consultations, and use-of-force assessments. Some of these areas overlap. (Cohen Report at 4).

32. There will be errors and mistakes in any system. To distinguish between a systemic problem and mere medical errors and mistakes, a process is needed whereby repetitive errors are brought to the attention of the administration and systems are

developed to find these kinds of errors and to undertake a process of improvement. (Mar. 4, 2014 TT at 12:7-13:2 (Cohen)).

33. CHS and MCSO have been aware for years of the systemic deficiencies at MCJ. CHS and MCSO were periodically reminded of several of these deficiencies by the reports of the Court's medical expert, Dr. Lambert Dr. King. CHS and MCSO have had several years to remedy them but have not done so. (Cohen Report at 4).

34. Dr. Cohen reviewed CHS's response to Dr. King's recommendations and found "most of their responses to be inadequate in that they failed to address Dr. King's concerns or cited to policies while offering no proof that such policies were ever followed in practice." (Cohen Report at 3).

35. Dr. Cohen's findings are generally consistent with those of Dr. King. (Mar. 4, 2014 TT at 15:10-15 (Cohen)). Dr. Cohen also found additional deficiencies that place patients at a risk of significant harm, including death. (Cohen Report at 4).

36. Multiple aspects of the continuum of care at MCJ are wholly inadequate. (Cohen Report at 18).

37. Although CHS has made progress since 2008, deficiencies in care continue to place patients at a major risk of serious harm, including risk of pain, deterioration of health, unnecessary morbidity, and death. (Cohen Report at 4).

38. Ameliorating the risks posed to patients is imperative and will require considerable effort and additional resources. (Cohen Report at 4).

39. Compliance with NCCHC standards is not equivalent to complying with constitutional standards. (Mar. 4, 2014 TT at 13:10-21 (Cohen)). The NCCHC standards were not developed to track constitutional standards. (Mar. 4, 2014 TT at 14: 2-3 (Cohen)).

Deficiencies in Screening and Intake

40. Intake includes screening incoming detainees for health issues, ensuring continuity of care from the community, initiating necessary health care, timely provision of indicated medications, and access to health care staff and facilities appropriate to meet identified health needs. (Cohen Report at 4).

41. CHS fails to ensure that patients presenting with serious medical conditions at screening are timely examined in person by a provider, placing patients at a risk of harm.[1]

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[1] Cohen Report at 6, 54 (Patient 44: "a failure of the intake screening process to follow up on an obvious serious abnormality – decreased vision and a swollen eye. There was a three day delay in being seen by a provider for diagnosis and treatment of an orbital fracture."), 22 (Patient 5: patient on Hepatitis C treatment), 26-27 (Patient 11: patient with diabetes and hypertension), 33 ("Medical and nursing staff knew that [Patient 20] had heart disease, but were unable to have him see a provider for three days."), 33-35 ("[Patient 21] was extremely sick at this time, and he should have seen a physician urgently… instead he was placed in a queue, for routine evaluation."), 35-36 (Patient 22: elderly patient with Parkinson's and hypertension), 36-37 (Patient 23: Patient with late-stage lung cancer that had spread to brain and adrenal glands not seen by provider until 8 days after screening), 37-38 (Patient 24: patient with cardiovascular disease including history of two heart attacks and a stroke), 38-39 (Patient 25: patient with interrupted tuberculosis medications), 39-40 (Patient 26: failure to request urgent evaluation of patient with chronic obstructive pulmonary disease (COPD) at screening contributed to "unnecessary deterioration and consequent hospitalization"), 40-41 ("It was a failure of the screening program that [Patient 27] was not referred for urgent evaluation because of his multiple serious medical problems and his advanced age"), 41 (Patient 28: pregnant woman not seen by a provider until 12 days following screening), 45-46 (Patient 33: provider contacted, but did not see patient with history of cirrhosis and esophageal bleeding and who reported vomiting blood the day of screening), 47-48 (Patient 35: patient with "life-threatening issue of bleeding esophageal varices"), 50-51 (Patient 38: patient with hypertension and history of diabetes), 55-56 (Patient 46: 61-year-old woman with hypertension, diabetes, and pulmonary disease), 56-58 ("At screening [Patient 47] said she had a bad liver. For this reason she should have had a prompt history and physical examination by a provider. This was not offered her."), 60 (Patient 52: diabetic patient with unilateral vision loss), 61-62 (Patient 54: in patient with liver disease, kidney disease, diabetes, bleeding disorder, hypertension, leg swelling and bowel problems – "The failure to provide him timely treatment represents, in the extreme, the chronic failure of intake screening to identify seriously ill patients, the failure of providers to evaluate these patients when they are aware of their serious medical needs…").

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42. A "provider" means a physician, physician assistant, or nurse practitioner. A nurse is not a "provider." (Cohen Report at 13 n.6; Mar. 4, 2014 TT at 31:1-3 (Cohen)).

43. CHS uses a screening form with questions about various medical issues. (Defendants' Statement of Facts (Doc. 2158), ¶¶ 12, 50). The screening form is very well designed.

44. However, there is more to a functional screening system than the completion of the screening form. Rather, the data obtained at screening must be used to identify patients in emergency or urgent need of medical attention and then ensure that those patients receive such medical attention on a timely basis. In addition, intake screening data must be used to continue critical medications. (Cohen Report at 5). A proper screening system includes the appropriate referral based upon the data collected at intake. (Mar. 4, 2014 TT at 26:15-21 (Cohen)).

45. The problem at CHS is that once all the questions on the screening form are answered, individuals who should be seen by a provider are not seen by a provider.

46. The intake process at MCJ fails in many, many cases to use the information collected during screening to provide access to providers when that is necessary. (Mar. 4, 2014 TT at 20:13-21:2 (Cohen)).

47. In most cases patients identified at screening as having serious acute or chronic medical conditions must be seen on an emergency or urgent basis by a provider. This is the only way that a proper plan of care can be developed and to ensure that unstable patients are not forgotten about until and deteriorate to the point of needing hospitalization—or to the point of death. (Cohen Report at 5).

48. At MCJ, however, analysis reveals many, many examples of patients who need to be seen right away by a provider not being seen. (Mar. 4, 2014 TT at 20:16-21:1 (Cohen)).

49. Although there is a provider stationed near where patients are screened, this does not result in patients receiving necessary care at intake. (Mar. 4, 2014 TT at 37:13 – 38:3 (Cohen)).

50. Systemically, prisoners in acute situations and with chronic diseases do not have access to the providers they need. (Mar. 4, 2014 TT at 23:5-10 (Cohen)).

51. In the community, a patient presenting with potentially life-threatening symptoms would never be seen briefly by a nurse and then sent back out to wait until something catastrophic occurs before seeing a doctor. Such should not happen at a jail. (Cohen Report at 5). Dr. Cohen testified that "in almost every case I reviewed, there was not a provider evaluation for people who, by the criteria that I'm describing, should have been seen on day one or day two or day three." (Mar. 4, 2014 TT at 40:15-20 (Cohen)). In general, the intake screening process "failed to use the information collected by it . . . to provide access to providers in a timely manner and when that was necessary. And that occurred in many, many cases." (Mar. 4, 2014 TT at 21: 8-13 (Cohen)).

52. Likewise, Dr. King's most recent report, submitted in 2013, cites several examples in which patients presenting with serious medical conditions at screening did not receive timely face-to-face examinations with providers.[2]

53. Dr. King recommended that "all patients with significant acute or chronic medical conditions" should have "'a hands-on' physical examination and completion of an initial assessment and plan to include the ordering of medications, pertinent labs and a scheduled follow-up specific to their needs." (King's Sixth Report (Doc. No. 1963-1) at

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[2] King 10th Report at 12 ¶3 (patient with hepatitis C and advanced liver disease), 10-11 ¶2 (deceased patient should have had a prompt and thorough provider evaluation at intake), 13 ¶5 (patient with diabetes, hypertension, and asthma later diagnosed with pulmonary fibrosis requiring oxygen treatment), 13 ¶7 (patient with diabetes, heart, liver, and kidney problems), 14 ¶8 (patient with hypertension and on multiple medications), 16 ¶15 (patient with history of myocardial infarction and hypertension).

35-36). Dr. King advised that "[t]he foregoing tasks will be completed no later than 24 hours after jail entry, and in most instances much sooner." (King's Sixth Report at 36).

54. Dr. King also recommended that all persons found to have clinically significant findings during screening should have an initial health assessment no later than 24 hours following screening. (Lambert N. King's Sixth Report at 35-36). Dr. King "worked closely with CHS' executive leaders" in making the above recommendations. (King's Sixth Report at 32).

55. Even after CHS began 24-hour provider coverage at intake, there was not "a convincing set of data documenting increased volume of face-to-face evaluations by providers of patients with serious acute and chronic medical conditions. There appear to be gaps in the degree to which clinicians are documenting their work, both with respect to entries in medical records and in recording specific types of encounters for purposes of statistical tracking and analysis." (Pl Ex. 15 (King's Tenth Report) (Doc. 2099) at 4, 19).

56. Further, there continued to be instances in which patients with complicated and serious medical needs were not being assessed and treated by physicians, physician assistants or nurse practitioners during the first 24 hours after receiving screening. (King's Tenth Report at 20 ¶ 2).

57. In his most recent report, submitted in 2013, Dr. King noted that, with regard to patients presenting with serious medical needs at intake, CHS providers needed to be "far more proactive... not only in seeing such patients but also in ordering and accessing basic laboratory tests to promptly identify patients with marginal kidney or liver function, fluid or electrolyte disorders, anemia, or infection." (King's Tenth Report at 20 ¶ 2).

58. In that report, Dr. King discussed the case of a patient with complicated medical needs who was suffering from withdrawals. The patient was never examined by a provider and no labs were ordered until two weeks after screening. The patient

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died three days later. Dr. King wrote that "this case is an example of the need to ensure that patients with acute and complex chronic illnesses upon intake are being thoroughly and timely evaluated by qualified practitioners and that timely laboratory tests are also being done." (King's Tenth Report at 10-11 ¶12). Dr. King provided other similar examples in his report.[3]

59. CHS continues to fail to ensure that necessary treatment, including labs, is initiated for patients who present with serious medical needs at intake, placing patients at risk of harm.[4]

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[3] King's Tenth Report at 13-14 ¶7 ("I believe that this patient is another instructive example of a patient who should have been seen and examined by a provider shortly after intake. Furthermore, I believe basic laboratory tests (comprehensive metabolic panel and complete blood count) should have been done at the time of intake. The purpose of doing such tests would be to timely identify significant kidney dysfunction that merited earlier medical attention."), 15 ¶11 (woman with hypertension, alcohol and opiate dependence, and possible leg abscess – was not seen by a provider and appropriate tests not ordered at intake to assess kidney function until two weeks later.), 12 ¶3 (patient with hepatitis C and advanced liver cirrhosis who did not have appropriate labs or provider visit at intake).

[4] Cohen Report at 20-21 (Patient 3: "No laboratory studies were drawn, no EKG was obtained… for this critically ill man with diabetes in severe alcohol withdrawal."), 22 ("Although she was on a complex medical regimen, requiring close monitoring of laboratory values for complete blood count, [Patient 5] was not seen by a physician, no laboratory studies were obtained, and she was not continued on her medication."), 22-23 (Patient 6: HIV patient for whom no labs were not obtained until three weeks after admission), 25 (Patient 9: patient with uncontrolled diabetes – labs not obtained until 10 days after screening), 35-36 (Patient 22: no blood pressure treatment until 10 days after booking in 71-year-old man with significantly elevated blood pressure and Parkinson's disease), 37-38 (Patient 24: failure to obtain labs and immediate EKG following screening in a patient with severe cardiovascular disease including severe cardiomyopathy), 38-39 (Patient 25: no emergency x-ray, provider examination, or isolation of a patient with interrupted tuberculosis treatment that had been started in Mexico), 45-46 (Patient 33: no labs drawn or treatment started at intake for patient with history of bleeding esophageal varices), 50-51 (Patient 38: no EKG or labs obtained in patient with hypertension, diabetes, and unstable vital signs), 61-62 (Patient 54: "No laboratory studies were ordered to determine the extent of his liver disease, his kidney disease, his bleeding problems, his diabetes, or his gastrointestinal issues."), 63 (Patient 56: no blood tests, coagulation tests, or EKG were obtained to determine if 61-year-old patient with a history of atrial flutter had a stable heart rhythm at intake).

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60. At MCJ, as at other jails, many people are released within 14 days. The purpose of screening and follow-up after screening is not to make up for failures in the system of health care in the community, or the failure of people to access healthcare in the community, but rather to make sure that people who enter the jail with urgent medical problems are seen. (Mar. 4, 2014 TT at 23:23-26:21 (Cohen)).

Lack of Adequate Care for Patients with Drug and Alcohol Withdrawals

61. Among the common serious medical needs of men and women entering MCJ are the complications of alcoholism and drug addiction, which can include life-threatening or extremely painful withdrawal symptoms that are complex to treat. (Cohen Report at 3, 49; Mar. 4, 2014 TT at 27:20-30:3 (Cohen)). Treatment of withdrawals refers to the identification, prevention, and treatment of symptoms of withdrawals from drugs or alcohol, including medical detoxification. (Cohen Report at 8). Treatment of alcohol withdrawal is a very important part of a jail's medical program. (Mar. 4, 2014 TT at 29:6-7 (Cohen)).

62. Benzodiazepines are a class of highly addictive medications that includes Valium and Xanax. Symptoms of benzodiazepine withdrawal include panic attacks, seizures, muscle spasms, and anxiety. Benzodiazepine withdrawal can be deadly. (Feb. 26, 2014 TT 58:16-59:25 (Mills)).

63. Withdrawal from alcohol is a serious and potentially deadly medical condition. (Cohen Report at 49). Symptoms include seizures, hallucinations, agitation, and increased blood pressure. (Mar. 4, 2014 TT at 27:20-30:5 (Cohen); Cohen Report at 49).

64. Delirium tremens is a complex neurological syndrome, is one of the most serious manifestations of alcohol withdrawal, and has a high risk of death. Symptoms include very rapid pulse, hallucinations, fever, and hypertension. Patients who have suffered delirium tremens in the past are at a great risk of experiencing it again when they are in alcohol withdrawal. Delirium tremens is complex to treat and requires hospitalization. (Mar. 4, 2014 TT at 28:5-24; 29:11-30:3 (Cohen); Cohen Report at 43).

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65. Mortality from delirium tremens must be managed by careful medical monitoring. (Cohen Report at 49).

66. CHS fails to ensure that complex patients suffering from withdrawals are properly managed and monitored by providers. (Mar. 4, 2014 TT at 27:20-23; 83:24-84:7 (Cohen)).

67. MCJ has protocols for managing patients in drug or alcohol withdrawal. Once identified, patients are generally housed in general population. Nurses assess them twice a day to record their vital assigns and check for symptoms using instruments such as the CIWA assessment scale. (Mar. 4, 2014 TT at 84:20-85:3 (Cohen); Cohen Report at 49). However, according to Dr. Cohen's review of medical records, patients at MCJ are not always assessed twice a day as the protocol requires. (Mar. 4, 2014 TT at 85:3-5 (Cohen)).

68. A maxim in medicine states that "if it wasn't documented, then it didn't happen." That is, if there is no evidence in a medical record that an event occurred, then the only reasonable conclusion is that the event did not occur. (Cohen Report at 5 n.2).

69. The CIWA scale measures the need for treatment of alcohol withdrawal. (Cohen report at 49). The COWS scale is a similar tool used to monitor patients withdrawing from opiates and the CIWA-B is used to monitor patients withdrawing from benzodiazepines. (Feb. 27, 2014 TT 83:16-23 (Wingate); Feb. 26, 2014 TT 60:14-18 (Mills)).

70. The CIWA scale is a good way to assess patients, but it is not sufficient. If the CIWA shows abnormalities, the patient should be seen by a provider. This does not occur at MCJ. (Mar. 4, 2014 TT at 85:10-17 (Cohen)).

71. MCJ's protocols are appropriate as outpatient tools for some patients; they are inadequate for patients with complex multisystem illnesses, and they are not designed as a substitute for the clinical judgment of a physician or mid-level provider. (Cohen Report at 8).

72. Patients withdrawing from drugs or alcohol at MCJ often fail to receive appropriate care from providers.[5]

73. CHS manages these patients in a "cookie cutter manner" without adequate in-person assessments by providers. Providers give treatment orders by phone without seeing patients. As a result, patients deteriorate. (Mar. 4, 2014 TT at 84:4-16 (Cohen)). Even when providers initially see the patient, nurses take over care and often providers are never again asked to see the patient. (Mar. 4, 2014 TT at 91:3-11 (Cohen)).

74. Dr. Cohen testified that "…giving this responsibility of managing these patients to nurses rather than expecting providers to be evaluating them is responsible for the failure in [the case of a particular patient] and the other ones." (Mar. 4, 2014 TT at 87:22-25 (Cohen)).

75. The failure of MCJ to provide adequate evaluation by providers, as opposed to by nurses, is a systemic problem in the treatment of patients with alcohol withdrawal. (Mar. 4, 2014 TT at 91: 3-23 (Cohen)).

76. CHS fails to ensure that patients at risk for severe withdrawals are placed in medically suitable housing or timely sent to the emergency room. (King's Tenth Report at 15 ¶11 (patient with hypotension and risks of alcohol and drug withdrawal); Cohen Report at 20-21 (Patient 3: alcohol withdrawal), 43 (Patient 31: "emergency hospitalization at that point, in the evening of 4/30/13, might have saved his life.")).

77. While some patients withdrawing from drugs or alcohol can be monitored in general population, patients requiring closer monitoring should be housed in the

[5] Cohen Report at 35-36 (Patient 22: 71-year-old man with significant hypertension at risk for benzodiazepine withdrawal who required prompt provider evaluation but who was managed with a protocol), 43-44 (Patient 31: poorly managed alcohol withdrawals in patient with history of delirium tremens), 45-46 (Patient 33: patient with end stage liver disease, severe alcoholism, and history of seizures not evaluated in person by provider before being placed on alcohol withdrawal protocol), 48-49 (Patient 36: patient arriving under the influence of alcohol and with history of severe withdrawals not evaluated by provider), 41-43 (Patient 30: patient not seen by provider until several days following seizure related to clonazepam withdrawal).

infirmary. Such a facility should be a medically-supported inpatient setting. (Cohen Report at 8; Mar. 4, 2014 TT at 98:7-13 (Cohen). *See also* King's Tenth Report at 20 ¶4. ("substantial compliance" with Third Amended Judgment requires that MCSO have "medically suitable beds" to house patients at risk for severe alcohol and drug withdrawal)).

78. CHS has set aside beds at its Durango facility for "some inmates who require more intensive clinical service/monitoring." (Defendants' Statement of Facts at 6 ¶ 24).

79. However, the Durango unit is not an infirmary or medically staffed unit. Only male patients classified for minimum custody are eligible to be housed there. (Mar. 4, 2014 TT at 97:20–98:13 (Cohen); Cohen Report at 8; Def Ex. 652 (Report of Kathryn Wild, RN) (Doc 2182-1, Ex. D) at 10).

80. Use of the Durango unit is not an adequate strategy to address the needs of patients who require closer monitoring. (Mar. 4, 2014 TT at 99:11-18 (Cohen)).

81. In April and May 2013, there were two deaths of patients suffering from withdrawals at MCJ. (Cohen Report at 43-44, 48-49).

82. In one case, a patient arrived at the jail on April 29, 2013 reporting that he drank heavily. He was noted to be suffering from alcohol withdrawal at screening. He had a documented history of delirium tremens that had been so severe that he required placement of a tube in his trachea. (Cohen Report at 43).

83. The patient was prescribed chlordiazepoxide (Librium) per the detoxification protocol without seeing a provider first. He became tremulous, extremely agitated, and threw himself on the floor. He was placed in a safe cell. The following day, his agitation decreased on medication and he was sent to general population. That night, his blood pressure rose to 220/120 and he was tremulous and disoriented. A provider was called by telephone and said that the patient should drink water. A

lowered dose of Librium was given and the patient was sent back to his cell with blood pressure still at 190/116. (Cohen Report at 43).

84. The next morning he began to seize uncontrollably and died. (Cohen Report at 44).

85. Dr. Cohen concluded:

> This was a preventable death… [He] required hospitalization for management of his alcohol withdrawal because of his history of epilepsy, hypertension and a prior episode of delirium tremens. The decision to apply an outpatient withdrawal protocol for a man at great risk of delirium tremens caused his death. Medical screening identified a man in alcohol withdrawal who required medical evaluation, but no medical evaluation was provided. The medical provider staff response to his deteriorating condition, his tremulousness, his disorientation, his deteriorating CIWA and COWS score (they were increasing, not decreasing), and his uncontrolled blood pressure was callous – drink more water. Emergency hospitalization at that point, in the evening of 4/30/13, might have saved his life. Failure to recognize his critical condition assured his death.

(Cohen Report at 44).

86. The second mortality involved a patient who arrived at the Jail on May 26, 2013, under the influence of alcohol. His jail health record showed a history of serious withdrawals. He was started on the CIWA and chlordiazepoxide (Librium) protocol. (Cohen Report at 48).

87. On May 29, he complained of visual hallucinations and itching, suggestive of tactile hallucinations, which prompted concern by nursing staff. The next day, he told nursing staff that he drank three 6-packs of alcohol per day. He was having tremors and was slurring his words. A provider was contacted by telephone and the patient was given Lorazepam. The provider did not examine the patient. (Cohen Report at 48; Mar. 4, 2014 TT at 94:18-23 (Cohen)).

88. The following day, the patient was noted to have unequally responsive pupils and to be stumbling. He was sent to the emergency room where he died. Causes

of death include pneumonia, pancytopenia, hepatic encephalopathy (failure of brain function due to liver failure), and sepsis. (Cohen Report at 49).

89. The patient was never examined by a provider at MCJ. (Cohen Report at 49).

90. Dr. Cohen concluded:

> Minimal treatment of alcohol withdrawal in [this patient's] case required that a qualified provider examine him in a medically supervised area on at least a daily basis… Because of [his] age and prior experience of multiple episodes of alcohol withdrawal syndrome, he was at too high a risk for severe withdrawal to be managed casually as an outpatient. His death might have been prevented had he been provided with minimal medical care, particularly frequent provider examination, monitoring of metabolic, kidney, and liver disease, and treatment in an appropriate hospital or infirmary setting.

(Cohen Report at 49).

91. Withdrawal from opiates is a serious medical need that inflicts significant suffering and pain. (Cohen Report at 3).

92. Patients with severe opiate withdrawal may suffer severe pain because they do not have access to effective therapy for their withdrawal syndrome. (Cohen Report at 8).

93. In Dr. King's third report, he wrote:

> In my First Report (section # 11, page 9), I documented that CHS does not offer continued treatment with methadone for pretrial detainees who are enrolled in community-based methadone programs for control of heroin addiction. Furthermore, the existing CHS protocol for assessment and treatment of alcohol and/or opiate withdrawal does not meet any reasonable standard of medical care for patients on a stable methadone maintenance regimen or for those who are dependent on high doses of illicit methadone alone or in combination with heroin.

(Third Report of lambert N. King (Doc. 1879-2) at 10 ¶18).

He further wrote, "[w]ithout a comprehensive evidence- based program for safe assessment and treatment of alcohol and drug (including opiates) withdrawal, CHS will

not be positioned to meet the Second Amended Judgment requirements # 6, 7, and 8." (King's Third Report at 11 ¶24).

94. CHS Medical Director Dr. Jeffery Alvarez testified that treating patients with methadone is "the right thing to do." (Feb. 27, 2014 TT at 148:5-7 (Alvarez)).

95. Dr. Alvarez further testified that:

> And I think it's wrong that we don't have the ability to give them the methadone that they were on, especially when they might have to only serve – let's say they come in for seven days. Well, you know, we should be able to keep them on that for the seven days so that when they leave, they don't relapse to heroin or other things that we're then causing an issue in a way, based on not continuing that care. So for me, it's part of the continuity of the chronic care.

(Feb. 27, 2014 TT at 148:12-19 (Alvarez)).

96. Although CHS has taken steps towards obtaining licensing to treat patients with methadone, CHS does not yet have the ability to treat opiate-dependent patients (other than pregnant women) with methadone. (Pl Ex. 123 (Joint Status Report to Court Regarding Dr. King and Dr. Burns' Tenth Reports) (Doc. No. 2128) at 5. *See also* Feb. 27, 2014 TT at 142:7–145:9, 148:20-21 (Alvarez)).

CHS' Tuberculosis Control Program Places Patients at Serious Risk

97. Tuberculosis (TB) is a disease caused by Mycobacterium tuberculosis that adversely affects public health around the world. In the United States, TB control remains a substantial public health challenge in multiple settings.

98. Tuberculosis is spread by droplets in the air produced by the sneezes or coughs of persons with active infection. (Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC (CDC Guidelines) (Doc. No. 2177-45) at 4, 49). Tuberculosis infection may be active or latent. (*Id.* at 50). Only persons with active infection may spread the disease to others. (*Id.* at 4). These droplets may remain in the air for prolonged periods of time after being released. (*Id.* at 49). Tuberculosis is

particularly dangerous in persons with HIV infection. (*Id.* at 4). Correctional facilities are prone to high rates of tuberculosis infection. (*Id.* at 3).

99. It has been known for many years that tuberculosis can spread rapidly in institutions such as prisons and jails where numbers of people are confined in close quarters. (Mar. 4, 2014 TT at 69:4-12 (Cohen)).

100. A tuberculosis control program includes screening for, diagnosing, preventing, and treating both latent and active pulmonary and extrapulmonary tuberculosis.

101. The tuberculosis control program at MCJ is a failed program. Failure of the tuberculosis control program affects everyone in the jail and everyone who has contact with the men and women who live and work in the jail. There are structural delays in screening for tuberculosis. In all the charts Dr. Cohen reviewed, PPD screening does not begin until eleven days after admission. "This is eleven days too many." (Cohen Report at 10).

102. An effective program of tuberculosis control is critical in the Maricopa County Jail. As the Center for Disease Control guidelines to tuberculosis control in correctional facilities states:

> Early identification and successful treatment of persons with TB disease remains the most effective means of preventing disease transmission [ ]. Therefore, inmates who are likely to have infectious TB should be identified and begin treatment before they are integrated into the general correctional facility population (i.e., at the time of admission into the correctional system).

(CDC Guidelines at 4; Cohen Report at 10).

103. In line with the CDC guidelines, PPD testing, or alternatively IGRA testing should be part of the intake screening process, and occur prior to housing of prisoners. IGRA is a blood test, considered by the CDC to be the equivalent of PPD testing. IGRA testing has the advantage of requiring only one encounter, when the blood is drawn. IGRA testing has been successfully implemented in large urban jail systems. (Cohen Report at 10).

104. Chest x-rays should be performed urgently for positive PPD or positive IGRA. Patients with suspect tuberculosis on admission should be housed in respiratory isolation under they have had a chest x-ray and their tuberculosis status is clarified. Medications for treatment of tuberculosis should be available at all times. Currently patients requiring tuberculosis treatment frequently wait days for therapy to begin. (Cohen Report at 10).

105. In 2011, there were four cases of active pulmonary tuberculosis identified by CHS at the Maricopa County Jails. (King's Ninth Report (Doc. 2088) at 19).

106. In 2011, the Arizona Department of Health Services identified 64 cases of tuberculosis diagnosed among patients at correctional facilities, excluding patients ages fourteen years and younger. Thus, the four cases identified by CHS that year represent 6.25% of the 64 total correctional cases. (Pl Ex. 20 (Arizona Department of Health Services, *2011 Tuberculosis Surveillance Report*) (Doc. 2177-47) at 15).

107. A study published in 2005 found that in 1999 and 2000, there were 300 cases of tuberculosis in Maricopa County. Of these, 73 cases (24.3%) had a history of being incarcerated in the Maricopa County Jail. Of those 73 cases, nine of them had been in the jail while they had active tuberculosis. The authors noted that "[effective tuberculosis control in correctional facilities requires early recognition of active cases during admission screening. Outbreaks in correctional facilities have resulted in part from the absence of adequate screening programs for early detection of active tuberculosis to prevent transmission." One of the authors of this study was a physician employed by CHS.[6]

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[6] Jessica R. MacNeil et al., *Jails, a Neglected Opportunity for Tuberculosis Prevention*, 28 AM. J. PREVENTIVE MED. 225, 225-27 (2005) (MacNeil Report) (Doc. 2177-48).

108. A person with active tuberculosis at the Maricopa County Jail can infect large numbers of people because of the close confines of the institution. (Cohen Report at 60).

109. Between January 1, 2012 and November 8, 2012, there were two cases of active tuberculosis at the Jail. A total of 246 detainees and staff were identified as having been possibly exposed to the infection. Some detainees and staff who had previously tested negative for tuberculosis subsequently tested positive. (King's Tenth 10th Report at 5).

110. The Centers for Disease Control and Prevention characterize correctional facilities as being either "minimal risk" or "nonminimal risk" for tuberculosis. To qualify as minimal risk, a jail must satisfy four criteria: (1) no cases of infectious tuberculosis at the facility within the past year; (2) the facility does not house substantial numbers of inmates with risk factors for tuberculosis, such as injection drug use or HIV; (3) the facility does not house substantial numbers of new immigrants from areas of the world with high rates of tuberculosis; and (4) employees at the facility are not otherwise at risk for tuberculosis. (CDC Guidelines at 4).

111. Any facility that does not satisfy all four criteria is a nonminimal risk facility. The Maricopa County Jail does not meet at least three criteria. Thus, the Maricopa County Jail is a non-minimal risk facility. (CDC Guidelines at 4).

112. The tuberculosis control program at the Maricopa County Jail "poses an unnecessary, unacceptable risk of tuberculosis for people who work in the jail and people who live in the jail." (Mar. 4, 2014 TT at 83:18-23 (Cohen)). According to the Arizona Department of Health Services, "Arizona has consistently ranked as one of the highest states in the nation for percentage of TB cases diagnosed while incarcerated." The Department states that "[r]outine evaluation of all inmates for TB during the intake process allows for diagnosis of both latent and active TB in this population." (Pl Ex.

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19 (Arizona Department of Health Services, *2012 Tuberculosis Surveillance Report*) (Doc. 2177-46) at 13).

113. The CDC Guidelines require that persons who do not report symptoms of active tuberculosis at screening be screened within seven days of arrival using one of three acceptable screening methods. (CDC Guidelines at 8). The seven-day timeframe is consistent with the Arizona Department of Health Services regulations governing correctional facilities. Ariz. Admin. Code § R9-6-1203(A)(3) (2013).

114. In order for the jail to appropriately manage the risk of TB, it must screen for the disease consistent with the epidemiology at the jail notwithstanding the guidelines. (Mar. 4, 2014 TT at 72:17-20 (Cohen)).

115. In Arizona, 25% of all identified cases of tuberculosis occur in correctional facilities. In contrast, the national average is 4%. (Mar. 4, 2014 TT at 31:23 – 32:1 (Cohen)).

116. Given the local epidemiology of tuberculosis, MCJ manages tuberculosis in way that is inconsistent with the safety of staff and prisoners within Maricopa County and statewide. (Mar. 4, 2014 TT at 31:15-32:10 (Cohen)).

117. Based on the prior cases of tuberculosis found in the Maricopa County Jail and the exceptionally high rate of tuberculosis in Arizona jails and prisons generally, Dr. Cohen testified that "screening should be very aggressive in Maricopa County Jail for tuberculosis." (Mar. 4, 2014 TT at 72:17-73:14 (Cohen)). Specifically, Dr. Cohen recommended that a tuberculosis test should take place at the time of initial screening. (Mar. 4, 2014 TT at 73:17-37; 76:19-20 (Cohen)).

118. There are structural delays in screening for tuberculosis at MCJ. (Cohen Report at 10).

119. At the time of filing their motion for termination, CHS did not perform skin testing until ten to fourteen days following screening. (Defendants' Statement of Facts at ¶39).

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120. CHS ties tuberculin skin testing (TST) to the detainees' initial health assessment. However, under CHS policy, two groups of detainees do not receive post-intake initial health assessments: (1) newly-arriving detainees who have had jail-administered initial health assessments within the previous year with no change in health status; and (2) detainees who have received assessments as part of a hospitalization or prenatal care visit. (Joint Status Report to Court Regarding Dr. King and Dr. Burns' Tenth Reports at 17-19).

121. In reality, by design, tuberculosis screening at MCJ does not begin until 12-14 days after admission, often longer, and sometimes does not occur at all. Because the skin test cannot be read until two days after being placed, this adds another two days of risk. (Cohen Report at 39). Delays in identifying prisoners with active tuberculosis place prisoners and staff at risk. (*Id.*)

122. The lack of a basic tuberculosis control program with PPD screening beginning at the time of admission is inexplicable. Tuberculosis is present in Arizona. There were 150 cases in the Phoenix/Mesa/Scottsdale area in 2012.

123. Dr. King identified a patient who was denied a tuberculosis screening test because he had had a health assessment during a previous incarceration four months earlier. The patient later required transfer to the ER to rule out tuberculosis. At the ER, he received a TST, which was positive. (King's Tenth Report at 13). Dr. King noted that "[t]here is also no exemption in the applicable CDC guidelines for TST testing for a readmitted inmate who has had a previous negative TST on a prior jail admission." (*Id.* at 5-6). CHS' internal audits show that a significant proportion of detainees who are eligible for an initial health assessment with TST are not TST-tested within CHS's own 14-day timeframe. As many as 7.7% of detainees across all facilities were either not tested at all or not tested within 14 days of arriving during the most recent months for which data was provided to Plaintiffs' counsel (January through July 2013). (Declaration of Gabriel Eber (Doc. 2177-42), ¶13).

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124. Concomitant HIV infection is a leading risk factor for the progression of latent tuberculosis to active tuberculosis. (Cohen Report at 23).

125. Patients with HIV infection should have a chest x-ray at intake to rule out tuberculosis. However, that is not the policy at MCJ. (Mar. 4, 2014 TT at 82:13-25 (Cohen)).

126. The CDC Guidelines require that health staff at non-minimal risk jails perform chest x-rays on patients with HIV—or who are at risk for HIV infection but whose status is unknown—during their initial intake screening. (CDC Guidelines at 8).

127. The requirement that patients with HIV receive a chest x-ray has been adopted by the Arizona Department of Health Services to govern care at correctional facilities. Ariz. Admin. Code § R9-6-1203(A)(6) (2013).

128. CHS leaves the decision to order chest x-rays for patients with HIV to nurses. (Defendants' Statement of Facts, ¶ 42).

129. CHS does not ensure that patients with HIV uniformly get timely chest x-rays to screen for tuberculosis. (Cohen Report at 22-23).

130. Patients taking medications to treat tuberculosis are subject to delays and interruptions of their treatment.[7]

131. CHS fails to ensure that patients needing chest x-rays to diagnose tuberculosis have those x-rays timely ordered, performed, and/or reviewed by a provider.[8] In one instance, there was a four-month delay in obtaining an x-ray for a patient who had a very positive tuberculosis screening result. When the x-ray was ultimately performed, the result was consistent with active tuberculosis. (Cohen Report at 59 (Patient 49).

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[7] Cohen Report at 38-39 (Patient 25), 58 (Patient 48), 64 (Patient 58).

[8] Cohen Report at 22-23 (Patient 6), 32 (Patient 19), 38-39 (Patient 25), 58 (Patient 48), 59 (Patient 49), 59-60 (Patient 51)).

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132. These failures are not new. The study published in 2005 and co-authored by the CHS physician identified “at least two missed opportunities to diagnose TB due to failure to follow up on abnormal chest x-rays.” (MacNeil Report at 227).

133. Patients with possible tuberculosis are subject to other deficiencies in care, including delayed reading of tuberculosis skin tests and lack of provider involvement in care.[9]

134. For example, one patient was noted to have a cough when he arrived at the jail. He was given an antibiotic to which he did not respond. No PPD test (a test indicating either past exposure to tuberculosis or the presence of active tuberculosis) was performed until nine days after booking. The test was positive. He was admitted to the infirmary. A chest x-ray demonstrated pneumonia in two lobes of the lung, the lingular and the right upper lobe. This x-ray was consistent with tuberculosis, as well as other pneumonias (lung infections) including coccidiomycosis. (Cohen Report at 32).

135. In another case, a patient arrived at the jail and told staff that he had been treated for tuberculosis for five months in Mexico, and still had one more month of treatment. He reported that he had recently had two negative sputum tests in Mexico but that his chest x-ray was abnormal. He had not had any medication for the previous five days. He was not seen by a provider. No emergency chest x-ray was obtained, no provider examined him. Verbal orders were given for INH and B6 (medications for treatment of tuberculosis) but he did not receive these medications until two days later. He did not have his initial health assessment until 12 days after booking; it was performed by a nurse, not a provider. A chest x-ray was ordered and 3 sputum collections for smear and culture were ordered. The chest x-ray was taken 4/2/13 and the film showed “Bilateral apical infiltrates with associated cavitary lesion seen in the right apex. Without previous films for comparison, an active TB process cannot be

[9] (Cohen Report at 59 (Patient 50), 38-39 (Patient 25); King’s Tenth Report at 13 ¶ 4).

excluded." Eleven days passed before Patient 25 was placed in respiratory isolation. He should have been placed in isolation on admission until his tuberculosis status was clarified. (Cohen Report at 38-39).

136. Another patient did not have a PPD test until two weeks after arrival. The result was very positive. Follow-up of positive PPD requires a chest x-ray to determine if the person has active tuberculosis. No follow-up chest x-ray was obtained until four months later. The image showed a right lower lobe pneumonia, consistent with active tuberculosis. (Cohen Report at 59).

137. Such failures place patients and staff at risk. (*Id.*)

138. Another patient had a PPD test performed 11 days after booking. It was positive but no chest x-ray was ordered until three days later. The x-ray was not performed until two days after the order and the results not signed until five days after the x-ray was performed. The results showed a right upper lobe infiltrate. The x-ray report was signed off on 5/27/13. Additional tests were performed and the patient was placed in respiratory isolation. The additional test came back positive and he was started on medication. A subsequent culture showed tuberculosis bacteria. This patient had active tuberculosis but there were delays in his diagnosis that represent systemic problems. The delays resulted in patients and staff being unnecessarily exposed to tuberculosis for more than two weeks. (Cohen Report at 59-60).

Inadequate Access to Medication and Pharmacy Services

139. A pharmacy services system must be able to timely, safely, and accurately provide patients with uninterrupted access to medications until discontinued by provider order. Not only must appropriate medications be ordered, but they must be started timely and continued without interruption until discontinued by a provider order. This includes medications that should be ordered at intake and medications that should be ordered throughout the patient's incarceration. (Cohen Report at 6).

140. There are systemic medication-related failures in MCJ's medical program. (Cohen Report at 6).

141. There are delays in patients getting medications for chronic conditions, including HIV infection. (Mar. 4, 2014 TT at 99:23-100:4 (Cohen)).

142. Patients who arrive at the jail taking critical medications are subject to delays in receiving those medications. They may have those medications discontinued or not restarted upon arrival at the jail. These delays and interruptions can place patients at serious risk of harm.[10]

143. MCJ's failure to meet the medication-related needs of patients places them at a substantial risk of serious harm, by failing to timely order medications at intake, discontinuing medications at intake without reason, and failing to make available key medications. (Cohen Report at 7).

144. For example, one patient arrived at the jail on May 29, 2013 and was screened that day. She reported being treated for hepatitis c infection with a regimen of the medications interferon, ribavirin, and bocepravir. She never received these medications at any time during her jail stay, which ended on June 6, 2013. Discontinuing ribavirin prematurely lowers the success rate of this very difficult treatment regimen. Thus, the Jail's failure to provide her with her medications places her at risk of rendering the treatment useless. (Cohen Report at 22).

145. Another patient had been hospitalized for HIV/AIDS just prior to his screening on February 26, 2013. He had a critically low T-cell count of 47 (normal is 450+) and had been hospitalized for life-threatening pneumocystis pneumonia and

[10] Cohen Report at 63 (Patient 56: cardiac patient with delay in receiving cardiac medications), 26-27 (Patient 11: four-day delay in antihypertensive medications), 27 (Patient 12: 5-day delay in cholesterol medication, 7 day delay in Flomax), 37-38 (Patient 24: cardiac patient with delays in cardiac medications), 32-33 (Patient 20: delays in cardiac medications in patient with congestive heart failure secondary to cardiomyopathy), 19-20 (Patient 2: 11-day delay in meds for rheumatoid arthritis), 28, 38-39 (Patient 25: two day delay in TB medications), 39-40 (Patient 26: no inhaler ordered at intake for patient with chronic obstructive pulmonary disease).

candida infection. He also suffered from cytomegalovirus infection, which is also life-threatening and can lead to blindness in patients with AIDS. He did not receive his first dose of fluconazole to treat the candida until March 1, 2013. Nor did he receive five out of thirteen days' worth of valganciclovir to treat his cytomegalovirus. (Cohen Report 30-31).

146. A patient suffering from congestive heart failure was screened on June 4, 2012. He reported taking metoprolol at intake. However, it was not ordered until three days later. Interruptions in beta blockers such as metoprolol can be dangerous. On June 12, two additional cardiac medications, carvedilol and amiodarone, were ordered. The latter was prescribed to prevent a dangerously rapid heart rate. He did not receive these medications until three days later, 11 days after he arrived at MCJ. (Cohen Report at 32-33).

147. Another patient, 62 years of age, was screened on May 19, 2013. He reported suffering from chronic obstructive pulmonary disease (COPD), hypertension, and back pain. He was taking three medications, including an inhaler for his COPD. His peak flows were low at intake and remained low, suggesting bronchospasm. CHS failed to continue this patient's inhaler at intake. His condition and ability to breathe deteriorated over the next 10 days and, ultimately, he required hospitalization. (Cohen Report at 39-40).

148. Some of the medication-related deficiencies in the health care system at MCJ might be remedied if the intake system, discussed above, were functional. (Cohen Report at 7).

149. Patients arriving at the Jail on medications to treat HIV infection and related conditions are subject to delays in receiving those medications. Interruptions in

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HIV medications are associated with the development of resistance, which can render the medications useless.[11]

150. Patient 56 was a 61-year-old man who came to the Jail on July 10, 2013. He gave a history of atrial flutter (a very rapid heart rate), which had been treated four months earlier with electric shock cardioversion. He told the staff that he was on multiple medications, including metoprolol, which slows the heart rate, an anticoagulant, which is a medication to prevent clots from forming, and a cholesterol-lowering drug. (Mar. 4, 2014 TT at 100:10-20 (Cohen)).

151. Despite this history, Patient 56 was not seen by medical staff after intake screening to evaluate his condition. There were no tests of coagulation status, no EKG was done to take heart rate and heart rate to determine whether there was a problem. (Mar. 4, 2014 TT at 100:21-25 (Cohen). On July 12, two days after he was admitted and his history taken, he submitted an HNR[12] asking for his high blood pressure and heart medications, and five days later, on July 15, not having received them, he again submitted an HNR asking about his medications. (Mar. 4, 2014 TT at 101:1-3, 19-23 (Cohen)). He stated, "I'[m] going into the fifth day without blood pressure and heart prescriptions, I was booked on the 10th. The info was collected,… nurse can't find chart." He explained that he needed his metoprolol, omeprazole, lovastatin, aspirin, and blood thinner. (Mar. 4, 2014 TT at 102:2-15 (Cohen)).

152. On July 15, he was evaluated by a physician at which point his heart was beating very rapidly. He had a supraventricular tachycardia, and was sent to the emergency room where he was treated with an emergency surgical cardiac procedure,

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[11] Cohen Report at 22-23 (Patient 6: three day delay in antiretroviral medication), 40-41 (Patient 27: four day delay in HIV medication), 30-31 (Patient 17: three day delay in fluconazole).

[12] A HNR is a written request for medical care, completed and submitted by a patient. (Mar. 4, 2014 TT at 62:23 – 63:2 (Cohen)).

called ablation, which is designed to scar the heart to cure the arrhythmia. (Mar. 4, 2014 TT at 101:4-9 (Cohen)).

153. Patient 17 had HIV and a very severe HIV infection. He had T cells of less than 50: anything below 200 T cells mean that a person is at risk for the opportunistic infections which define AIDS. Patient 17 was very, very severe immune compromised and was a risk for a disease called cytomegalovirus ("CMV") infection, which can affect different organs but in particular in HIV affects the eyes and causes blindness. (Mar. 4, 2014 TT at 103:9-25 (Cohen)). Patient 17 had just had pneumocystis pneumonia and thrush in the esophagus; he also had CMV infection and was on treatment for that when he came to the facility. (Mar. 4, 2014 TT at 103:25-104:3 (Cohen)).

154. Patient 17 did not receive treatment for his thrush until three days after his arrival at MCJ, and he did not receive his medication for the CMV infection for many days: He missed five doses over thirteen days. The consequence of not treating CMV is blindness. (Mar. 4, 2014 TT at 104:2-10 (Cohen)).

155. Patient 27 also had HIV infection, and waited four days to receive his HIV medications. (Mar. 4, 2014 TT at 104:13-16 (Cohen)).

14-day Initial Health Assessments

156. The purpose of the initial health assessment which, according to NCCHC, must occur within 14 days of booking, is to document a complete history and physical, and to establish or review the database of laboratory studies available for the patient. It provides an opportunity to speak with the patient, to obtain information about past history, allergies, family history if relevant, and a complete review of systems. It is accompanied by a complete physical examination, of the unclothed patient. (Cohen Report at 12).

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157. For many patients, conducting this initial assessment within 14 days of booking is adequate. (Mar. 4, 2014 TT at 40:1-3 (Cohen)).

158. However, some patients who, based on the screening interview at booking, are identified as having or being likely to have serious medical problems should be seen within 24, 48, or 72 hours. (Mar. 4, 2014 TT at 40:3-11 (Cohen)). For example, a patient who reported during screening that she had a history of liver disease and drank about 40 ounces of alcohol per day, did not receive an initial assessment by an RN until 11 days after admission, and her blood was not drawn for testing until 15 days after admission. (Mar. 4, 2014 TT at 33: 17-25, 35:8-11 (Cohen)). Based on her screening interview, she should have been seen by a provider within 24 hours of admission. (Mar. 4, 2014 TT at 40:3-11 (Cohen)).

159. The failure to prioritize patients with serious medical problems and delaying their initial health assessments is a systemic problem. (Mar. 4, 2014 TT at 40:15-20 (Cohen)).

160. Additionally, CHS' policy is to exclude patients who were seen at a hospital within 14 days of arriving at the Jail from receiving 14-day initial health assessments. (Cohen Report at 12).

161. This exclusion is problematic. Exams provided at hospitals are often quite different - and serve a very different purpose - from 14-day health assessments. The hospital record generally records an acute, emergent problem, and does not provide the database that the 14 day history and physical is designed to obtain. In particular, patients with emergency hospitalizations which occurred in the first two weeks of their incarceration at MCJ are the patients whose care will most benefit from the time spent in performing a comprehensive history and physical. (Cohen Report at 12).

162. For example, a patient with a history of two heart attacks and a stroke arrived at the jail but was not evaluated by a provider at screening. Two days later, he

had trouble breathing and was sent to the hospital, where he was found to have had another heart attack. Upon return to the jail, a note was written into his medical chart stating "PE done @ MMC 5/11/13." Thus, because the patient had had an emergency, no new 14-day initial health assessment was performed even though CHS had failed to have a provider timely assess him *before* the emergency hospitalization. (Cohen Report at 37-38).

163. CHS does not provide 14-day initial health assessments to patients "readmitted to jail when the last health assessment was performed within the last 12 months and the initial receiving screening shows no change in health status." (Cohen Report at 12, quoting Pl Ex. 4 (CHS Policy J-E-04 "Initial Health Assessment")).

164. Because the CHS screening process fails to adequately assess the health status of patients with serious medical needs, it is dangerous to make an exclusion based on a determination that a patient's "initial receiving screening shows no change in health status." (Cohen Report at 12).

165. It should also be noted that, because tuberculosis screening is tied to the occurrence of the 14-day health assessment, patients who do not get such assessments may fall through the cracks and never get necessary tuberculosis screening. (Cohen Report at 12).

166. It is problematic that RNs perform the majority of 14-day health assessments. RNs are not trained to perform a comprehensive history and physical examination. The health assessment is a comprehensive evaluation of the patient's present history, past medical history, and the physical examination. It also includes ordering and evaluating the results of laboratory and other diagnostic tests, and the consideration and incorporation of supplementary medical records including hospital charts and available consultations. All of this material must be combined into a comprehensive assessment of the patient's problems, a plan for the treatment of those problems, and plans for future monitoring of the response to treatment. RNs are not

trained to perform this complex clinical function, and it is outside the scope of their practice. (Cohen Report at 12-13).

167. In one instance, a patient with severe congestive heart failure arrived at the jail taking multiple cardiac medications and with elevated blood pressure. The patient's 14-day initial health assessment was performed by a RN. The RN documented a normal exam except for cavities. The RN did not mention or document that the patient had congestive heart failure. She wrote that the patient was a "50-year- old male with no medical concerns at present time." A physician counter-signed the RN's exam six days later, one hour after the patient was found dead. (Cohen Report at 13, 52). In another example, a complex patient with liver disease had her 14-day initial health assessment performed by a RN. Although a physician counter-signed the RN's exam the same day, there is no evidence that the physician examined the patient. (Cohen Report at 13, 56-57).

168. That RNs perform the 14-day initial health assessments at MCJ is a systemic problem. (Mar. 4, 2014 TT at 40:20-24 (Cohen)).

Insufficient Provider Involvement in Patient Care Creates Risks of Harm

169. Provider involvement in patient care refers to the degree to which patients have appropriate access to physicians, physician assistants, and nurse practitioners to meet serious medical needs. (Cohen Report at 13).

170. CHS fails to ensure that providers are sufficiently involved in the care of patients with serious—and even life-threatening—medical needs.[13] "[B]y design, the nursing staff is being asked to do a lot more than they are able to do . . . they are

[13] Cohen Report at 13, 24-25 ("In [Patient 8]'s case, the lack of access to a qualified provider cause[d] him almost a week of severe untreated knee pain, and almost a week of ineffectively treated infection"), 44-45 (Patient 32: patient with abscess and cellulitis not assessed promptly by provider); 45-46 (Patient 33: provider did not see patient with cirrhosis and recent hospitalization who was vomiting blood).

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encouraged through various protocols to manage complex medical problems beyond their training." (Mar. 4, 2014 TT at 56:8-25 (Cohen)).

171. Failure to ensure adequate provider involvement in care is a systemic problem at MCJ. (Mar. 4, 2014 TT at 125:15-25 (Cohen)).

172. This failure places patient' health and lives at risk. (Mar. 4, 2014 TT at 125:21-25 (Cohen)).

173. CHS sets the threshold for seeing a provider at a high level that places patients at risk. (Cohen Report at 13). Although Defendants contend that the nursing assessment protocols address this concern, the protocols actually push nurses to act beyond the scope of their practice in circumstances where the patients need to see providers. (Mar. 4, 2014 TT at 67:2-25, 68:1-12 (Cohen)).

174. In one example, a patient with dangerously uncontrolled hypertension submitted two separate HNRs requesting care for high blood pressure and management of his antihypertensive medications. On neither occasion was he seen by providers. A few days later, he went into cardiac arrest, but survived. (Cohen Report at 31-32).

175. In another example, a patient with lung cancer that had spread to his brain and adrenal glands asked to speak with a provider about his cancer treatment; he was not seen until six days later. (Cohen Report at 36-37).

176. In one case, a psychiatrist took steps to ensure that a patient would *not* have adequate access to medical care. The front of the patient's health care chart read, in black marker, **"This man fakes mandowns. Do not send to MMC for unwitnessed mandowns or symptom exaggeration. If patient has a mandown return him to MHU P3. Per Dr. Picardo 6/4/2013"** (emphasis in original). (Cohen Report at 63-64).

177. Regardless of this patient's medical or mental health history, it is categorically wrong and dangerous to issue a blanket order denying treatment to a patient for a potentially life-threatening emergency. (Cohen Report at 64).

178. Nurses play a critical role in any health care system but are not substitutes for providers. Nurses lack the training to assess, manage, and treat serious medical conditions. Accordingly, overreliance on nursing care places patients at great risk. (Cohen Report at 13).

179. CHS uses nurses to manage skin infections and abscesses even when those infections are severe enough to ultimately require transfer to an emergency room. (Cohen Report at 24-25, 44-45, 47-48).

180. Nurses lack the training to diagnose, treat, and manage cellulitis and skin and soft tissue infections.[14]

181. CHS has nurses use a "Skin and Soft Tissue Infection" nursing protocol sheet. The sheet is one page and contains various check boxes that nurses are supposed to check based on their observations. (Def Ex. 585 (Skin and Soft Tissue Infection Protocol) at Bates No. 034628). Such protocol sheets are not a substitute for clinical judgment and place patients at risk. (Cohen Report at 25, 45).

182. CHS fails to ensure that nurses act within their scope of knowledge and practice. (Cohen Report at 35.)

183. CHS inappropriately relies on Licensed Practical Nurses (LPNs) to independently provide care to patients with serious medical needs.[15]

184. For example, a patient with severe cardiovascular disease complained that he could not breathe. He was seen by a LPN who noted that the patient was pale, had a

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[14] (Cohen Report at 25 (Patient 8: "Appropriate treatment of an infected knee requires that a trained provider listen to the patient's history, examine the knee, and make a judgment about the need for antibiotics, imaging studies, and surgical consultation. This is not the province for RNs."), 45 (Patient 32: "Nurses are not trained to diagnose and treat skin infections. These infections must be examined and treated by providers."), 48 (Patient 35: "Nursing staff is not trained in the diagnosis and treatment of complex skin infections involving the hand.")).

[15] (Cohen Report at 50 (Patient 38: LPN assessed cardiac patient for shortness of breath and did not contact provider), 37-38 (Patient 24: LPN assessed patient with chest pain and did not urgently call a provider)).

rapid pulse, and very low blood pressure. The LPN said that the patient was not short of breath and could walk, although slowly. There is no indication that the LPN measured the patient's oxygen saturation. The LPN advised the patient to drink fluids. No provider was contacted. The patient was sent back to his housing unit. The following day, the patient was found to have had a heart attack. (Cohen Report at 37-38 (Patient 24)).

185. A LPN cannot evaluate shortness of breath in a patient with serious heart disease. (Cohen Report at 38).

186. The LPN's actions may have contributed to the patient's heart attack. (Cohen Report at 38).

187. When nurses do attempt to involve providers in the care of patients, providers frequently give orders by telephone without ever seeing the patient in person or examining the patient. CHS fails to ensure that providers examine patients when nurses seek assistance.[16]

188. A telephonic consultation with a provider is not equivalent to an in-person exam by a provider. (Mar. 4, 2014 TT at 61:10-14 (Cohen)). Dr. Cohen described substituting telephone access for in-person access in this way: "[T]he term phoning it in, I think, characterized a lot of the . . . access to providers." (Mar. 4, 2014 TT at 30:14-21 (Cohen)).

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[16] Cohen Report at 13-14, 54 (Patient 38: nurse contacts provider about patient with chest pain, rapid heart rate and hypertension on December 21, 2012 at 0700 but provider does not see patient), 44-45 (Patient 32), 34 (Patient 21: when called by nurse, provider does not examine patient with intermittent numbness and tingling in left extremities), 47-48 (Patient 35: after speaking with nurse, provider does not see patient complaining of abdominal pain and vomiting blood who had recently been sent to the emergency room), 43-44 (Patient 31: provider does not see patient after being contacted about a patient in severe withdrawals in a safe cell), 25-26 (Patient 10: provider contacted by nurse but did not examine patient who complained of lightheadedness and painful urination), 24-25 (Patient 8: provider orders antibiotic by phone for large infected area but does not examine patient).

189. In one instance, a patient with recent chest pain told a nurse that she had a history of abnormal heart rhythm. A note from detention staff stated that the patient was feeling like she was having a heart attack. The nurse spoke with a provider. The provider did not speak with or see the patient. Instead, the patient was treated for withdrawals, given water to drink, and sent back to her housing unit. Two hours later, the patient collapsed and died without having seen a provider. (Cohen Report at 52-53).

190. In another instance, a nurse assessed a seriously mentally ill patient who had been assaulted by other detainees. Although a provider countersigned the nurse's note documenting the assessment, the provider did not evaluate the patient. Two days later, the patient's injuries were found to include a fractured orbit and injury to his lung that required placement of a chest tube to keep his lung from collapsing. These injuries were life threatening. (Cohen Report at 28-30 (Patient 16)).

Lack of Access to Laboratory and Radiology Services

191. Access to laboratory and radiology services means that provider orders for lab tests and radiological studies (x-rays, etc.) are conducted in a timely manner and that results are timely reviewed and followed up upon by providers. (Cohen Report at 16).

192. With regard to labs and radiology, there are two operative time frames: (1) the time between when a lab/study is ordered and when it is performed; and (2) the time between when the results become available for review and the time when the provider actually reviews those results. Delays in either end of the process place patients at unnecessary risk of serious harm. (Cohen Report at 16).

193. Communication of critical laboratory values and abnormal radiological studies, timeliness, tracking, and review of laboratory and diagnostic tests, and quality control of on-site laboratory testing are central components of access to care. (King's Ninth Report at 13-14, 23).

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194. In Dr. King's most recent report, he concluded that "[t]here are weaknesses in the capacity of CHS to manage, coordinate, and control the quality of its internal and external laboratory and radiology services." (King's Tenth Report at 20 ¶6).

195. Chart reviews by Dr. King and Dr. Cohen support Dr. King's conclusion and demonstrate that CHS fails to ensure that patients have timely access to laboratory and radiology services and timely and appropriate review of and follow-up on results.[17]

196. In one example, a patient told medical staff that he suffered from idiopathic thrombocytopenic purpura, a disorder that can cause excessive bleeding or bruising due to low platelet levels. A doctor ordered lab tests. Although the results were available for the doctor to review the following day, the results were not reviewed until three days later when the patient was transferred to the emergency room. (Cohen Report at 61).

197. In another example, a patient with multiple serious medical problems had lab results showed low sodium, anemia, and abnormal liver function. Dr. Cohen descr4ibed these results as "ominous" and as demonstrating the need for immediate follow up. However, medical staff failed to review and sign these very abnormal results. (Cohen Report at 57-58; Mar. 4, 2014 TT at 52:1-3 (Cohen)).

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[17] King's Tenth Report at 16 ¶14 (delay in obtaining chest x-ray); Cohen Report at 55-56 (Patient 46: in patient with history of valley fever, chest x-ray ordered on May 30, 2012 was not performed until five days later and then not reviewed until eight days later), 56-58 (Patient 47: no provider review of very abnormal labs showing anemia and liver disease), 59 (Patient 49: no follow-up on positive PPD result for more than four months), 59 (Patient 50: tuberculosis skin test not read until more than six weeks after result was available), 59-60 (Patient 51: five-day delay in reviewing chest x-ray that showed lung infiltrate).

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Assessment of Patients by Medical Staff Following the Use of Force

198. Serious injuries, and even death, can result from the use of force against a detainee. (Mar. 4, 2014 TT at 122:2-9 (Cohen)).

199. It is critically important that all prisoners be evaluated by medical staff following the use of force. (King's Tenth Report at 18 ¶1; Cohen Report at 18). Medical staff must perform a careful history and physical examination of the detainee in a confidential setting. (Cohen Report at 50).

200. The current MCSO use-of-force policy does not require such an assessment following the use of force. Instead, the decision to seek medical attention is left to the discretion of detention officers.[18]

201. Not having health staff present prior to the use of force results in health staff being unaware of prior circumstances that may have caused injuries of medical complications. (King's Ninth Report at 20-21).

202. The determination that a detainee has sustained injuries from the use of force is one that should be made by qualified medical staff, not detention officers who have no medical training. King 10th report at 18-19, 12. "[P] hysical examination of someone subject to use of force by a provider is a basic rule of personal healthcare." (Mar. 4, 2014 TT at 122:10-11 (Cohen)).

203. It is not a sound practice to substitute security staff examining the patient for a provider examining the patient after a use of force. (Mar. 4, 2014 TT at 124:24-125:4 (Cohen)).

204. Detention staff lack the medical training to determine if a detainee has been injured. (King's Tenth Report at 18-19). (Mar. 5, 2014 TT at 11:22-12:17 (Vail)).

205. Basic first aid training is insufficient to assess patients following the use of force. (Mar. 5, 2014 TT at 14:20–15:1 (Vail)).

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[18] Pl Ex. 64 (MCSO Policy CP-1 "Use of Force") at Bates No. 002054; King's Ninth Report at 20, 13.

206. The emotions of an officer involved in the use-of-force incident may influence his or her decision to seek medical care for the detainee. (Pl Ex. 62 (Declaration of Eldon Vail) (Doc. 2177-25) at 8 ¶24; Mar. 4, 2014 TT 11:3-6 (Vail)).

207. Requiring officers to assess patients beyond the documentation of obvious and serious injuries would place detainees at risk of harm. (Vail Dec. at 9 ¶26). The level of force involved in some authorized uses of force can result in severe injuries, including internal injuries that are not obvious from "across a room." (Mar. 4, 2014 TT at 122: 6-9 (Cohen)). Following the use of force, there is a risk of undetected injuries. (Cohen Report at 18; Vail Dec. at 8 ¶24; Mar. 5, 2014 TT at 10:16-23 (Vail)).

208. The current MCSO policy of not requiring medical assessments after the use of force is "extremely dangerous and likely to harm." (Vail Dec. at 7 ¶18; Mar. 5, 2014 TT at 9:17-18 (Vail)).

209. It is standard practice in other jurisdictions to require a medical consultation following every use of force incident. (Mar. 6, 2014 TT at 12:23-24 (Vail)). Model policies authored by the National Institute of Corrections and the National Sheriffs' Institute for Jail Operations contain such requirements. (Vail Dec. at 8-9 ¶¶25-26).

210. There is no legitimate penological justification for MCSO's policy. (Mar. 5, 2014 TT at 9:14-17 (Vail)).

211. There is no reason that MCSO cannot simply articulate a policy and provide proper guidance to detention staff that medical assessments are required following the true use of force. MCSO could draft a policy that excludes from the requirement certain officer interventions such as the search, escort, or un-resisted application of authorized restraints. (Vail Dec. at 10 ¶¶28-29).

212. The failure to provide such guidance creates an ongoing and systemic risk of harm to detainees. (Vail Dec. at 11 ¶30).

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213. Medical and mental health care provided to a detainee following the use of force is germane to the requirements of the Second Amended Judgment. (King's Ninth Report at 20).

Patients Lack Timely Access to Consultations with Specialists

214. Access to specialty consultations means that patients are able to timely see specialists when ordered by a provider. (Cohen Report at 17).

215. CHS fails to ensure that patients have access to specialty consultations.[19]

216. For example, one patient fell in the shower and broke his jaw. He was sent to the emergency room and returned with an urgent referral for follow-up with a surgeon within three days to repair his jaw. Seven days passed and the patient had not yet seen the surgeon. During this time, he developed serious bacterial infections of his fractured jaw and required hospitalization. The patient ultimately had surgery more than a week later: weeks after the fracture. (Cohen Report at 21 (Patient 4)).

217. This delay resulted in substantial increased pain and development of a serious infection of the face. (Cohen Report at 21).

218. Dr. Alvarez stated that CHS has no control over appointments with specialists. This is a serious problem since it results in specialty care not being available to patients within a timeframe that is responsive to their medical needs. (Mar. 4, 2014 TT at 120:21-121:5 (Cohen)).

219. That specialty care is provided by a separate clinic, outside of MCSO's direct control, does not remove this obligation. If the specialists currently used cannot timely schedule patients, CHS should find specialists who can. Specialty care needs to be available to the patients within a time frame that is responsive to the medical needs.

[19] Cohen Report at 25-26 (Patient 10: two-month delay in urology consultation and cystoscopy for diagnosis and treatment of bladder cancer), 21-22 (Patient 4: delay in follow-up consultation for patient with fractured jaw), 23-24 (Patient 7: MRI and cardiology consults).

(Mar. 4, 2014 TT at 121:1-2 (Cohen)). If a particular clinic is unable to provide timely care, then the care should be sought somewhere else. (Mar. 4, 2014 TT at 121:3-5 (Cohen)).

Access to Infirmary Care and Medical Observation

220. The Third Amended Judgment requires that

> *[a]ll pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. When necessary, pretrial detainees confined in jail facilities which lack such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services.*

(Third Amended Judgment (Doc. 2094) at ¶7) (emphasis added).

221. The threshold for transferring complex patients from intake to the infirmary should be directed in favor of timely transfer. (King's Third Report (Doc. 1879-2) at King 3rd Report at 16 ¶48).

222. In 2011, CHS agreed to implement Dr. King's recommendation that an observation area be created at intake to house patients whose medical conditions and/or physical disabilities required a higher level of care and monitoring. CHS and MCSO agreed to a six-month time frame for creating this facility.[20]

223. Dr. King later modified this recommendation based on representations by MCSO and difficulty in converting space at intake. (King's Sixth Report at 36-37). In modifying his recommendation, Dr. King stated that CHS must "ensure that all newly received patients whose clinical condition indicates need for an infirmary level of care will be transferred to the LBJ Infirmary no later than 24 hours after booking" and that CHS establish "a formal, continuous system of medical record review/monitoring to confirm that this 24 hour timeline is being met." Dr. King required CHS to conduct

[20] Lambert King's Fifth Report, Dec. 29, 2010 (Doc. 1932) at 12 ¶15.

monthly and quarterly reviews and to track, trend, and report infirmary transfers. (King's Sixth Report at 37).

224. In their First Request for Production of Documents, Plaintiffs requested that Defendants produce "[a]ll Documents relating to the monitoring or auditing of Health Care provided to detainees including, but not limited to, continuous quality improvement, quality assurance, clinical performance reviews, peer reviews, in-service trainings, internal or external audits, technical assistance, accreditation, reports, contract monitoring, health care record reviews, or metrics from January 1, 2013 through the Response Date." The Response Date was defined as August 9, 2013.[21]

225. Although there is a process study related to infirmary policies and procedures (Bates Nos. 000807-08), none of the documents produced in response to this request reflects the reporting and monitoring requirements required by Dr. King. (Eber Dec., ¶16).

226. Patients who have complex medical problems but who do not require infirmary-level care should be housed in a medically-supervised setting where they can be adequately observed. (Cohen Report at 33).

227. CHS fails to ensure that patients in need of infirmary care or observation-level care have access to such care.[22]

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[21] Eber Dec. ¶15; Eber Dec. Ex. 9, Plaintiffs' First Set of Requests for Production.

[22] King's Tenth Report at 15 ¶11 (patient with accelerated hypertension). Cohen Report at 32-33 (Patient 20: patient with congestive heart failure who needed to be in a medical supervised setting), 48-49 (Patient 36: patient with alcohol withdrawal who needed treatment in an appropriate hospital or infirmary setting), 62 (Patient 55: elderly patient with cognitive impairment who required infirmary placement), 55-56 (Patient 46: 61-year-old woman with diabetes, hypertension and pulmonary disease who required admission to an appropriate clinical observation facility pending evaluation), 61-62 (Patient 54: patient with multiple chronic medical conditions who should have been placed in an appropriate medical setting at intake). (Mar. 4, 2014 TT at 88:16-18 (Cohen)) ("this is a patient who needed to be placed either in an infirmary or in the hospital when he came in because he previously had delirium tremens.")

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228. For example, in one case, an 80-year-old man with multiple cardiac problems arrived at the Jail. His behavior was noted to be bizarre. And his responses to questions inappropriate. (King's Tenth Report at 11 ¶4; Cohen Report at 62 (Patient 55)).

229. Over the next three months, the patient remained in general population where he was confused and disoriented. He got into fights with other detainees and upset nursing staff. Cohen Report at 62.

230. The patient required a catheter but was unable to care for himself. On June 19, 2012, he pulled out his catheter and was sent to the emergency room. (King 10th Report at 11 ¶4).

231. Upon return from the ER, he was placed in the infirmary for the first time in his three months of incarceration. The following day, he became more confused and was sent out to the hospital for suspected sepsis. He died the following week. (King 10th Report at 11 ¶4).

232. Given his frailty, challenging behavior, and medical history, and in accordance with paragraph 7 of the Second Amended Judgment (SAJ), he should have been placed in the infirmary upon intake. (King's Tenth Report at 11 ¶4).

233. CHS failed to identify the patient's special needs. Cohen Report at 62. In accordance with paragraph 6 of the SAJ, the receiving screening should have been sufficient to recognize and provide services to the physically handicapped. (King's Tenth Report at 11 ¶4).

234. This patient suffered greatly in the three months prior to his infirmary admission. (Cohen Report at 62).

235. Patients in the infirmary receive mental health services through as solid window. (Cohen Report at 15). Patients in the infirmary have no access to recreation, exercise, or time outdoors. Some patients have not seen the sky in months. Patients in single cells in the infirmary are in conditions that amount to solitary confinement.

However, detainees in the regular solitary confinement units are permitted one hour per day of out-of-cell time. Patients in the infirmary are not. (Cohen Report at 15).

CHS' Copayment Policy Places Patients at Risk

236. MCJ's co-pay policy places patients at a risk of harm. (Mar. 4, 2014 TT at 114:6-116:10 (Cohen)).

237. As a result of the co-pay policy, people will choose not to receive necessary medical care. (Mar. 4, 2014 TT at 116:12-20 (Cohen)).

238. The CHS copayment policy which has been in place since May 28, 2013. (Pl Ex. 23 (CHS Co-Pay Policy Charge Sheet)).

239. According to this policy, CHS charges patients $5.00 as a copay for nursing assessments and nursing sick call. (*Id.*)

240. CHS charges patients $10.00 as a copay to see a provider, regardless of whether the visit is for follow-up on an existing issue. (*Id.*)

241. CHS charges patients $5.00 for each medication and refill. (*Id.*)

242. CHS charges patients $10.00 for each admission to the Mental Health Unit (MHU), the Infirmary, or a hospital. CHS charges patients $10.00 for each visit with a specialist. *Id.* Ten dollars is the maximum amount that prisoners may be charged for co-payments per Arizona law. (*Id.*)

243. The co-pay policy at MCJ is unusual because, among other things, it charges patients when a provider orders a patients placed in the infirmary or mental health unit due to deterioration of their health. (Mar. 4, 2014 TT at 115:10-22 (Cohen)).

244. In every jurisdiction with which Dr. Cohen is familiar, involuntary use of care (e.g., hospitalizations, transfers to the infirmary, placement in a mental health unit) is exempt from co-payment. In every jurisdiction with which Dr. Cohen is familiar, there are copayment exemptions patients with chronic conditions who need hospital care, medications, infirmary care, and specialist visits. (Cohen Report at 17).

245. The purpose of a co-pay policy is to discourage the utilization of health care. (Mar. 4, 2014 TT at 115:10-22 (Cohen)).

246. MCJ's unique copayment policy places patients at risk of significant an irreversible harm. (Cohen Report at 17). This is especially true for people with chronic diseases. (Mar. 4, 2014 TT at 116:4-8 (Cohen)). As Dr. Cohen testified: "I think people will choose not to have their blood pressure checked. People will not put in HNRs. People will miss medication refills if they have very limited funds in their commissary and, you know, feel that what little they have will be utilized for medical care and that they don't want that to happen." (Mar. 4, 2014 TT at 116:12-20 (Cohen)).

Deficiencies in Care for Patients with Chronic Medical Conditions

247. CHS fails to ensure that patients with chronic medical conditions receive adequate care.[23]

248. For example, CHS fails to ensure that patients with diabetes receive proper monitoring of blood sugar, including involvement by providers in care, and dosing and treatment with appropriate insulin regimens.[24]

249. An example of failure to provide proper care for diabetes: By policy, CHS does not allow patients to be treated with insulin pumps.[25] Treatment with an insulin pump is standard approach to management of diabetes and is beneficial to many patients. (Cohen Report at 55).

[23] Cohen Report at 27-28 (Patient 13: seizure disorder), 19-20 (Patient 2: patient with rheumatoid arthritis who did not receive care in accordance with national standards), 35-36 (Patient 22: hypertension), 39-40 (Patient 26: chronic obstructive pulmonary disease), 41-43 (Patient 30: Parkinson's disease).

[24] Cohen Report at 25 (Patient 9: no provider notification when blood sugars reach 521 and 530mg/dl), 27 (Patient 12), 51-52 (Patient 39: no provider contacted for blood sugar of 482mg/dl in patient who ultimately developed ketosis the next day), 54-55 (Patient 45: patient with history of diabetic ketoacidosis told to drink water and recheck in 5 hours when blood sugar reached 588mg/dl), 26-27 (Patient 11).

[25] Cohen Report at 55; CHS Clinical Guidelines for Diabetes (Doc. No. 2177-53).

250. Further, treatment with rapid-acting insulin is a standard approach to diabetic management and is beneficial to many patients. By policy, CHS does not allow treatment with rapid-acting insulin. (Cohen Report at 55).

251. Sliding scale insulin coverage refers to the practice of administering pre-determined doses of insulin based on blood sugar as measured by finger sticks. Sliding scale coverage can be a reasonable short-term approach when blood sugars are monitored frequently. (Cohen Report at 54). However, CHS uses sliding scale coverage inappropriately.[26]

252. Diabetic retinopathy can cause blindness. (King's Tenth Report at 15; Cohen Report at 60). Patients with diabetes require periodic dilated eye exams to check for diabetic retinopathy. Many diabetic patients at MCJ have not had stable care and have not necessarily had baseline or follow-up dilated eye exams in the past year. (King's Tenth 10th Report at 14-15).

253. Based on standards promulgated by the American Diabetes Association, Dr. King provided a "specific recommendation that patients who have diabetes be scheduled for initial eye examinations within one month of booking unless they have such an exam documented as having been done in the community or during a prior MCJ admission within the past year." (King's Tenth Report at 14-15).

254. The "ready access to care" provision of the SAJ encompasses timely evaluation of diabetic retinopathy. (King's Tenth Report at 14-15).

255. Current CHS practice is to not screen for diabetic retinopathy until six to twelve months into incarceration.[27]

D. FINDINGS OF FACT REGARDING MENTAL HEALTH CARE

256. Maricopa County Jail's mental health care system is inadequate to meet the serious mental health care needs of the prisoner population, and exposes them to an

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[26] Cohen Report at 54-55 (Patient 45), 51-52 (Patient 39).

[27] King's Tenth Report at 14-15 ¶10; Eber Dec. Ex. 11 (CHS Clinical Guidelines for Diabetes) (Doc. 2177-53) at Bates No. 034503.

unreasonable risk of harm. (Stewart TT *passim*; Burns TT *passim*; Pl Ex. 96 (Declaration of Pablo Stewart) (Doc. 2177-2, Ex. A), ¶ 29).

257. MCJ routinely fails to send patients to a higher level of care when needed; fails to ensure timely access to providers; has inadequate suicide prevention and defective medication management practices; provides inadequate access to hospitalization and an inpatient level of care; has under-utilized or inadequate mental health programs; exposes mentally ill prisoners to assaults from fellow prisoners, excessive force, and disciplinary sanctions related to their mental illness; and unnecessarily subjects seriously mentally ill prisoners to isolation conditions so harsh as to predictably exacerbate their illness. These deficiencies, working singly and in combination, cause unnecessary and avoidable suffering to detainees who have serious mental health needs in the Jail. (Stewart TT *passim*; Burns TT *passim*; Stewart Dec., ¶ 30).

258. Defendants have long known about the substantial harms that result from deficiencies in MCJ's mental health care programs, and have failed to correct them. (Stewart TT *passim*; Burns TT *passim*; Stewart Dec., ¶ 31).

259. Many of the problems identified at the 2014 hearing in this case existed during the 2008 termination proceedings, and have been reported by the Court's mental health expert, Kathryn Burns, M.D., M.P.H., during her four-year tenure. (Mar. 6, 2014 TT at 14:16-19 (Stewart); Burns TT *passim*).

260. Many detainees at MCJ with serious mental illness remain in psychotic, depressed, manic, and potentially assaultive conditions for lack of adequate mental health interventions and transfers to more intensive mental health treatment programs and outside psychiatric hospitals. (Stewart TT *passim*, Burns TT *passim*, Stewart Dec., ¶ 34).

261. Seriously mentally ill detainees are particularly vulnerable to psychiatric harm from the harsh conditions in the isolation cells in segregation and closed custody

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units at the Jail, especially in the Jail's Special Management Unit (SMU). (Findings, *infra* ¶¶ 417-50; Stewart Dec., ¶ 35).

262. The deficiencies in the Jail's mental health care system are inter-related and reinforce one another. For example, Defendants' practice of discharging seriously mentally ill detainees from the MHU even though they are clinically unstable leads to these detainees deteriorating further, given the deficiencies in the Jail's program to treat seriously mentally ill prisoners in the outpatient facilities. (Stewart TT *passim*, Burns TT *passim*, Stewart Dec., ¶36).

Deficiencies in the Jail's Intake Process

263. Sentenced inmates who are admitted to a state prison system generally arrive from local jails, where they presumably have received some health care treatment, and have had the opportunity to detoxify from drugs or alcohol. In contrast, newly arrested men and women are admitted to the Jail from the community, and thus they tend to be a much more acutely ill population. They may arrive under the influence of drugs and/or alcohol, suffering acute symptoms of mental illness, suicidal, or otherwise at risk of self-harm due to untreated mental illness. The intake process at the Jail is critical to identifying and treating prisoners quickly, particularly those who are acutely ill. (Mar. 5, 2014 TT at 80:12-17 (Burns); Mar. 6, 2014 TT at 86:5-12, 87:15-88:19 (Stewart); Feb. 25, 2014 TT at 75:16-25, 95:16-96:24 (Hodges)).

264. As part of the intake process, newly-booked prisoners answer a comprehensive screening questionnaire to determine if they have mental health care needs. The screening is the initial point in the intake process: for prisoners with a positive mental health screening, they must be timely assessed by mental health staff to determine their mental health needs and for treatment to begin. The most seriously mentally ill prisoners must be timely seen by a provider (psychiatrist, psychiatric nurse

practitioner (PNP), or physician's assistant (PA)) in order to begin to receive adequate care. (Mar. 6, 2014 TT at 15:11-22 (Stewart); Stewart Dec., ¶46).

265. Defendants, however, fail to ensure that the Jail's intake process results in seriously mentally ill detainees being timely assessed by a provider to continue or initiate necessary mental health treatment. After a positive intake screen, Defendants fail to ensure that detainees who exhibit to mental health staff active symptoms of mental illness (warranting an immediate provider encounter) are timely seen by a provider. (Mar. 5, 2014 TT at 9:9-19 (Burns); Mar. 6, 2014 TT at 14:20-24, 15:11-22 (Stewart); Stewart Dec., ¶46).

266. Defendants' failure to ensure a timely provider appointment results in seriously mentally ill prisoners being denied adequate treatment, including the continuation of psychotropic medications they were prescribed before their arrest. (Mar. 5, 2014 TT at 7:17-8:25; 9:9-10:7 (Burns); Pl Ex. 97 (Ex. D, Stewart Dec. (Doc. 2177-6)) at 10-19 (patients SA, HS, SW, HN, RD, MM, KV, IL, AD, TD, LL, SC MM, GG, SG, UB, LG, GG, MR, and AT)).

267. It is critical that patients arriving at the Jail on confirmed psychotropic medications be continued on those medications, or on comparable medications to treat their mental illness. (Feb. 25, 2014 TT at 71:10-25 (Hodges); Stewart Dec., ¶¶ 51, 57).

268. There are many reasons why newly-admitted prisoners should be timely continued on their medications: First, the disruption of prescribed medications at intake places prisoners at an unreasonable risk of developing breakthrough symptoms, including hallucinations, paranoia, and delusions. (Mar. 5, 2014 TT at 9:20-10:7 (Burns); Mar. 6, 2014 TT at 17:13-19 (Stewart)). Second, the longer a patient is off prescribed medications, the longer it will take for that patient to become stabilized once the medications are restarted. (Mar. 6, 2014 TT at 18:4-9 (Stewart)). Third, the longer a patient is left untreated and symptomatic, the worse his or her long-term prognosis and response to treatment will grow. (Mar. 6, 2014 TT at 18:10-13 (Stewart)).

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269. In 2011, the Court's mental health expert Kathryn Burns, M.D., M.P.H., recommended that the Jail revise its policies and procedures to require that prisoners be seen by a psychiatrist after a positive screen according to three triage categories (urgent, emergent, and routine). (Mar. 5, 2014 TT at 7:10-16 (Burns); Pl Ex. 66 (Addendum to Burns' Fifth Report) ("Remedial Plan") (Doc. 1948-1) at 2).

270. If fully implemented, Dr. Burns' recommendations would likely result in timely assessments by a provider. (Mar. 6, 2014 TT at 21:4-6 (Stewart); Stewart Dec., ¶ 48).

271. Correctional Health Services (CHS), the Jail's medical provider, has not followed Dr. Burns' recommendation. CHS Policy J-E-05 "Mental Health Screening and Evaluation" undermines Dr. Burns' recommendation by providing that the prisoner can be seen by *either* mental health staff (a mental health assistant (MHA) or mental health professional (MHP)) for an assessment, *or* by a psychiatrist for an evaluation within the triage time frames. (Stewart Dec., ¶ 49; Pl Ex. 118 (CHS Policy J-E-05 "Mental Health Screening and Evaluation") at Bates 3407 000349).

272. This is inadequate: there are prisoners, including the most acutely ill, who must be timely seen by a provider in order to receive appropriate treatment, and MHAs and MHPs are not physicians and are not licensed or authorized to prescribe medications, and do not have the requisite training and skills to adequately treat the most seriously mentally ill prisoners. (Mar. 5, 2014 TT at 7:17-8:10, 9:4-8 (Burns); Mar. 6, 2014 TT at 15:11-22 (Stewart)).

273. Dr. Burns' remedial plan also requires that prisoners exhibiting active symptoms of mental illness be seen by a psychiatrist as soon as possible and in all cases within 24 hours. (Remedial Plan at 2). The CHS policy, however, omits that requirement. (CHS Policy J-E-05 "Mental health Screening and Evaluation").

274. Lack of a policy and practice requiring that symptomatic prisoners at intake are seen within 24 hours by a provider places them at an unreasonable risk of

harm. (Mar. 5, 2014 TT at 9:4-19 (Burns); Mar. 6, 2014 TT at 15:18-22 (Stewart); Stewart Dec., ¶ 50).

275. Defendants' own quality improvement (QI) studies show significant problems with the intake process. About a quarter of all prisoners who say at the time they are booked that they are on psychotropic medications are not seen by any mental health staff, a non-compliance rate Dr. Burns agreed was significant. (Mar. 5, 2014 TT at 12:14-13:5 (Burns); Pl Ex. 113 (Maricopa County CHS Mental Health Evaluation and Psychotropic Medication Audits, Transfer Screening Process Studies (Doc. 2138-10) ("Collected QI Studies")). A June 2012 QI study showed that 38% of prisoners reporting medications were not seen. (Mar. 6, 2014 TT at 20:8-22 (Stewart); Collected QI Studies).

276. CHS has a system in place to receive the outside medical records and medication lists for those newly admitted prisoners who are currently receiving community-based treatment via Magellan, the County's community mental health provider. (Mar. 5, 2014 TT at 11:6-13 (Burns); Feb. 25, 2014 TT at 67:19-68:23 (Hodges)).

277. At any one time, about 5% (425/8200) of the Jail's population are Magellan enrolled. (Feb. 25, 2014 TT at 91:22-25 (Hodges)).

278. However that system cannot be used to collect treatment records for newly-admitted prisoners who are receiving treatment from non-County mental health providers. (Mar. 5, 2014 TT at 11:13-15 (Burns); Feb. 25, 2014 TT at 90:10-15 (Hodges)).

279. In particular, that system cannot be used to collect the outside treatment records for prisoners who are receiving mental health services via the Veteran's Administration (VA) before their arrest. Defendants acknowledge that this includes some of the most acutely ill people who are booked into the Jail. (Feb. 25, 2014 TT at 90:19-24 (Hodges)).

280. For all non-County records, including VA records, CHS needs to take several steps to secure outside records: the first step is to get the prisoner to complete a release so that CHS can request the outside records. (Mar. 5, 2014 TT at 11:13-15 (Burns); Feb. 25, 2014 TT at 90:19-91:15 (Hodges)).

281. CHS does not secure releases of medical information for half of the detainees who reported a previous treatment history from non-County providers. (Mar. 5, 2014 TT at 11:16-21 (Burns)).

282. Absent a release, the Jail cannot and does not collect these patients' previous treatment records from non-County providers, which can be vital to understanding a patient's treatment history. (Mar. 5, 2014 TT at 10:11-24 (Burns); Stewart Dec., ¶¶ 52, 55, 56).

283. Though it is possible that prisoners may refuse to sign a release, it is unlikely that 50% of prisoners who told staff they were receiving mental health treatment then would refuse to sign a release so the Jail could get their records and effectively continue that treatment. (*Cf.* Mar. 5, 2014 TT at 54:13-16 (Burns) (concluding that it would be unlikely for 20% of prisoners who reported receiving current medications at intake would then refuse to sign a release)).

284. The fact that CHS receives outside treatment records from Magellan does not ensure that the treatment and medications prescribed by Magellan are continued once the patient is in jail. In order for medications to be continued, a Jail provider must review the records, and enter a medical order. For treatment to be continued, the most acutely ill patients must be timely seen by a provider. This does not consistently happen at the Jail. (*See, e.g.*, Findings, *supra*, ¶¶264-75).

285. Examples of problems with the intake mental health system include the following:

286. Patient SA has a documented history of mental health treatment during previous jail stays for psychosis and bipolar disorder. Ms. SA was booked on

September 28, 2012. Her intake screen was negative for mental health despite her history. On October 1, 2012, the Jail received faxed records from Choices Network, a county-based mental health network, including a Magellan At-Risk Crisis Plan listing a diagnosis of schizophrenia, paranoid type, and a Magellan medication log listing Risperdal as her current medication. This packet was not countersigned by a provider until October 10, almost two weeks after Ms. SA's admission. She was eventually seen by a psychiatrist on October 18. On exam, she was delusional, and rambled about going deaf. The psychiatrist ordered Risperdal, which she received the next day. In all, she was denied her confirmed medications for three weeks after her arrest. (Mar. 6, 2014 TT at 16:15-17:12 (Stewart); Ex. D, Stewart Dec. at 10-11).

287. Patient HS has a long mental health history, including a history of psychiatric hospitalizations, and a community diagnosis of schizophrenia, paranoid type. He was booked on Dec. 22, 2012. At the time of booking, he was prescribed anti-psychotic medications per Magellan, Maricopa County's community mental health provider. He also had an active involuntary treatment order, called a COT Order (exp. Aug. 13, 2013). (Mar. 6, 2014 TT at 21:15-22 (Stewart); Ex. D, Stewart Dec. at 11).

288. Mr. HS's Dec. 22, 2012 intake mental health screen was positive noting he was Magellan-enrolled and that he did not respond to his intake questions. A mental health assessment and a psychiatric evaluation were both scheduled for Dec. 24 with urgency code 1, which is the highest urgency code used at the Jail. According to intake notes, "pt did spit on an officer" and "pt is irate mildly combative verbally abusive pt refusing to cooperate. Will be put in med iso and have mental health follow up." He was moved to closed custody housing. There is no documented clearance by a provider for closed custody in his medical record. (Mar. 6, 2014 TT at 21:15-22:12 (Stewart); Ex. D, Stewart Dec. at 11).

289. Mr. HS was not seen by a provider by the Dec. 24, the date set by his intake screening, despite his history and being symptomatic at intake. Five days after

his admission, Mr. HS was moved from closed custody to the MHU after a nurse observed him eating chunks he had pulled from his cell wall. He had not been seen by a provider during his time in closed custody. (Mar. 6, 2014 TT at 22:13-19 (Stewart); Ex. D, Stewart Dec. at 11).

290. Patient IL was booked on June 11, 2013. He was receiving treatment from Magellan, the county mental health network, at the time of his arrest, and had confirmed Magellan medication of Seroquel as of the time of his arrest. Mr. IL's intake screen was positive for mental health, noting Seroquel as his current medication and that he was Magellan enrolled, and had a Court-Ordered Treatment (COT) Order that expired May 8, 2013. Intake staff ordered a psychiatric evaluation for June 12, 2013, with urgency code 1. Mr. IL was not seen by a provider until two weeks later (June 25, 2013) and was not given medications (Celexa) until June 29, 2013, 18 days after his admission. (Ex. D, Stewart Dec. at 14).

Deficiencies in the Mental Health HNR and Referral Process

291. Prisoners can request mental health care via a Health Needs Request (HNR). They can also be referred to mental health staff by custodial staff and medical staff if they display symptoms of mental illness. (Mar. 5, 2014 TT at 13:8-17 (Burns)).

292. Defendants fail to ensure that there is a reliable system for prisoners to make their mental health needs known for treatment by qualified staff via an HNR, or for prisoners who have been referred by detention and medical staff for mental health care to be timely seen by qualified staff. As a result, seriously mentally ill prisoners do not receive timely and appropriate care, and they are placed at an unreasonable risk of harm. (Mar. 5, 2014 TT at 13:18-14:4, 16:12-20; 17:19-22 (Burns); Mar. 6, 2014 TT at 23:8-13 (Stewart); Stewart Dec., ¶ 59; Ex. D, Stewart Dec. at 1-10 (patients AM, MM, JG, PL, GG, NC, CA, JE, AH, MA, YF, DT, CC, SA, and SW)).

293. Dr. Burns testified as follows as to how prisoners suffer when they are not timely seen by a provider as part of the HNR and referral process:

> They have – they suffer in sort of two respects; one is they are suffering from whatever the acute effects are of the reason that they have requested to see a provider, or be seen, and then the second thing that happens is they continue to decompensate. They could wind up getting disciplinary infractions for behaviors as a result of their mental illness[,] symptoms which could have been caught earlier and treated. They may wind up in a segregated setting as a consequence of their disciplinary infractions where access to health care is more difficult. And they also, once treatment is delayed, they have a less robust response to treatment if it's withheld that when it [is] started sooner. So if it's started early, the response is better and quicker; and [if] benefits [of treatment are] withheld, they will respond but it takes longer for a response and the degree of improvement isn't quite as good.

(Mar. 5, 2014 TT at 17:25-18:15 (Burns)).

294. Deficiencies in the Jail's HNR and referral process are longstanding and well-known. Each of Dr. Burns' last four reports describes delayed responses to inmate and staff referrals. (*See, e.g.,* Stewart Dec., ¶60 (noting Dr. Burns' findings regarding a prisoner who committed suicide after not being timely seen by a provider following an HNR and a referral from detention staff after the prisoner's mother called the Jail and reported her son was suicidal).

295. Based on these ongoing problems, Dr. Burns found in 2011 "a need for a more clinically oriented review of the triage decision and recommended follow-up, particularly as it relates to more timely referrals for psychiatric follow-up on issues related to medications . . . and increasing the frequency and/or type of intervention in response to a clinical need." (Stewart Dec., ¶60, citing Burns' Seventh Report (Doc. 2001) at 5).

296. In her remedial plan, Dr. Burns recommended that the Jail revise its policy and practice to require mental health staff (mental health associates (MHAs) and mental health professionals (MHPs)) to timely assess all prisoners who file a mental health HNR, and to refer to a provider those prisoners in need of additional treatment

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according to four triage categories (urgent, emergent, routine, no referral), each of which has a set timeline for the provider appointment. (*See* Remedial Plan at 3; Mar. 5, 2014 TT at 14:10-20 (Burns)).

297. Defendants have not complied with Dr. Burns' recommendations. CHS policy does not track Dr. Burns' remedial plan. The policy does not require that mental health staff assign triage codes for mental health follow-up after seeing prisoners in response to an HNR. Nor does the policy otherwise set criteria for when a provider referral is required. (Mar. 5, 2014 TT at 16:6-11 (Burns); Pl Ex. 118 (CHS Policy J-E-07 "Nonemergency Health Care Requests and Services")).

298. Dr. Burns found ongoing problems with referral responses in her 2013 report. (Stewart Dec., ¶62, citing Burns' Tenth Report (Doc. 2099) at 3 ("issues related to referral responses persist and were identified by me, the ACLU, and CHS.")). Defendants nevertheless have failed to conduct adequate internal reviews to identify and correct problems with the HNR and referral process. (Mar. 5, 2014 TT at 18:20-19:14 (Burns) (noting poor and incomplete CHS QI study results with no apparent follow-up)).

299. MHAs and MHPs do see prisoners in response to HNRs. However, they fail to refer on to providers those prisoners who, by reason of their acuity or the nature of their complaint, must be seen by a provider in order to receive adequate care. Dr. Stewart testified as follows:

> [T]his is one of the difficulties that I noted in this that currently, they have the lowest level staff. I believe it's referred to as an MHA, or mental health assistant, or associate, see these people right away. So here you have a system where you have people that potentially need a provider evaluation or psychiatric evaluation, but yet the gatekeeper is some[one] of . . .much lower level qualifications. So that gatekeeping, in the charts that I reviewed, certainly impeded the ability of psychiatric staff from being able to see these people that had submitted HNRs.

May 6, 2014 TT at 23:17-24:1 (Stewart).

300. While MHAs and MHPs can handle a great number of mental health HNRs and referrals, they do not have the training or licensure to handle those that raise the most serious issues of care. They cannot prescribe medications, make changes to existing medication orders, or discontinue medications. (Feb. 25, 2014 TT at 195:18-25 (Espinoza)). They cannot order that a patient be moved to the MHU for more intensive treatment and monitoring. (Feb. 25, 2014 TT at 197:25-198:6 (Espinoza)).

301. Prisoners raising the most serious mental health issues via a referral or HNR must therefore be timely referred to a psychiatrist to receive adequate care. To leave their care in the hands of MHAs and MHPs creates an unreasonable risk of harm. (Mar. 5, 2014 TT at 14:24-15:15; 17:19-18:15 (Burns); Mar. 6, 2014 at 23:17-24:1 (Stewart); Stewart Dec., ¶61).

302. There are numerous instances at the Jail that call for the involvement of a psychiatrist but none are involved. These include instances where prisoners are in mental health crisis and needed immediate attention by a provider. A number of these prisoners end up decompensating to the point where they have to be transferred to the MHU for care. (Mar. 5, 2014 TT at 15:9-16:20 (Burns); Stewart Dec., ¶69).

303. In many cases where detainees are acutely ill, suffering hallucinations and delusions, and unable to follow simple commands, they are not timely seen by a psychiatrist, even when detention officers file multiple referrals essentially pleading with mental health staff to remove actively psychotic prisoners from the unit. Because these men and women were not timely seen by a provider, they suffered without adequate care, and were at increased risk of harm from their undertreated illness and from victimization by fellow prisoners. (Mar. 5, 2014 TT at 15:9-16:20 (Burns); Stewart Dec., ¶ 70).

304. The Jail has also not instituted a reliable system for prisoners who exhibit symptoms of mental illness to medical staff to be referred and seen by mental health staff. (Mar. 5, 2014 TT at 17:1-18 (Burns); Stewart Dec., ¶71).

305. Examples of inadequate and dangerous HNR and referral practices include the following:

306. Prisoner YF was booked on February 6, 2013. She was moved to Estrella. On Feb. 11, MHP Unsworth wrote that Ms. YF was seen at the request of a detention officer after she cursed at medical staff, had tried to hit and spit at staff, and had not showered since her arrest. The MHP noted that the patient was treated in the MHU during her last jail stay. Ms. YF was talking to herself during the assessment. MHP Unsworth consulted with "Josh PNP" who agreed there was no reason for MHU placement. Despite her presentation, Ms. YF was not seen by a provider. (Mar. 6, 2014 TT at 24:8-19 (Stewart); Ex. D, Stewart Dec. at 7).

307. On February 18, Ms. YF had her History and Physical (H&P). During her H & P, a significant mass was found on her abdomen (20 cm). She refused assessment of the mass, and received no other medical treatment. She was not referred to mental health by medical staff, and there was no documented effort made for medical and mental health staff to develop a plan to address Ms. YF's refusal to have a potentially serious abdominal mass fully assessed. All that medical staff did was note on her H & P form that she was "being followed by mental health." Given the potentially serious nature of her mass, and her refusal to be assessed, medical staff should have done much more to work with mental health staff. (Mar. 6, 2014 TT at 24:20-25:13 (Stewart); Ex. D, Stewart Dec. at 7).

308. On February 22, Ms. YF was again referred for psychiatric services by detention staff, who wrote, "inmate seems confused, awake most of the day and night will not respond to officers cell is very dirty." Behavior noted on the referral form included unusual isolation, no sleep, severe mood swings, confused, unusually slow to respond, cannot follow simple requests, and auditory hallucinations. On the same day, MHP Unsworth saw Ms. YF, and wrote, "initially cooperative, however, demeanor rapidly became hostile and aggressive. She began cursing and name calling, refusing to

answer any questions. She did report a recent psychiatric hospitalization." Ms. YF was not referred to a provider. (Mar. 6, 2014 TT at 25:16-25 (Stewart); Ex. D, Stewart Dec. at 7).

309. On March 17, detention staff filed another psychiatric referral for Ms. YF, writing, "inmate has no orientation of any people, places, time or personal hygiene. Communication is impossible as she does not acknowledge any interaction has happened. She is usually found to be pacing or staring at random objects for extended periods of time." (*Id.*at 8.) That day MHP Page saw Ms. YF. The MHP wrote, "seen for DO referral. Pt seen at cell front. Pt was pleasant upon approach, when asked the last time pt showered, pt reported, '3 years ago,' when pt was asked to take a shower, pt responded by [cursing]." On exam, Ms. YF was "agitated, distractible difficult to redirect, odoriferous, yelling." MHP Page nonetheless found her "marginally stable for GP. Plan to consult with provider the next business day." Ms. YF was discharged on March 21, 2013. She did not see a provider. In all, for close to two months Ms. YF remained symptomatic, dangerous, and non-compliant with treatment, and her behavior generated multiple detention referrals, all without being seen by a provider This failure left Ms. YF to unnecessarily suffer, and left her at risk of harming herself, other prisoners, and staff. (Mar. 6, 2014 TT at 25:16-26:22 (Stewart); Ex. D, Stewart Dec. at 7-8).

310. On February 2, 2013 a detention officer referred prisoner MA to psychiatric staff based on delusional statements he had made. The referral form was stamped for a mental health assessment, urgency code 2, by February 5, but Mr. MA was not seen by mental health staff. On February 9, a detention officer wrote in a psychiatric referral form, "talks of hallucinations and his phlegm being sperm and embryo eggs, bizarre. Advises he was seeing Magellan recently." There is no triage code on this form, and Mr. MA was not seen by mental health staff. That same day, RN Diaz saw Mr. MA due to complaints of shortness of breath. She wrote, "says his

brain feels strange. [Says] phlegm looked like semen and female embryo eggs. His talk became more and more bizarre during our conversation. Pt. became abusive with language so assessment stopped. Mental health referral made." Mr. MA was not seen for ten days. On February 19, MHP Berman saw Mr. MA, who was incoherent, animated, dirty and disheveled. His cell was littered with trash and he appeared to be responding to internal stimuli. Mr. MA was moved to the MHU that day. These delays in timely assessments following referrals left Mr. MA to unnecessarily suffer, and placed him at risk. (Mar. 6, 2014 TT at 27:2-21 (Stewart); Ex. D, Stewart Dec. at 6-7).

Deficiencies in MHU Care and Access to Hospitalization

311. The MHU is the designated treatment facility for the most seriously mentally ill prisoners, and those the Jail determines cannot be adequately treated and safely housed elsewhere. (Mar. 5, 2014 TT at 19:19-25 (Burns); Stewart Dec., ¶ 74).

312. Defendants fail to ensure that seriously mentally ill prisoners receive adequate care in the MHU. There are problems with the adequacy, frequency, and intensity of the treatment interventions MHU prisoners receive. The most acute and restrictive units (P-5, P-3, P-1-B) operate as lockdown units. Many of the prisoners housed there, and others housed elsewhere in the MHU, require an inpatient level of care that is not provided at the MHU. However, Defendants fail to hospitalize those prisoners who cannot be adequately treated at the Jail. (Mar. 5, 2014 TT at 28:8-20, 29:14-25, 32:23-33:16 (Burns); Mar. 6, 2014 TT at 28:2-29:14 (Stewart); Stewart Dec., ¶ 75, 85; Ex. D, Stewart Dec. at 20-39 (patients DT, HS, BT, RW, LQ, NM, BT, AN, VL, MR, EV, AH, JE, TW, JL, SH, AJ, ML, RW, LJ, DM, ER, IV, DC, AF, GG, and EB)).

313. The admission criteria for the MHU are too high in practice and the discharge criteria too low. As a result, seriously mentally ill prisoners languish in the outpatient facilities, while clinically unstable patients are discharged back to these

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facilities. (Mar. 5, 2014 TT at 20:7-19, 21:11-22:17, 24:7-23 (Burns); Mar. 6, 2014 TT at 29:23-30:8 (Stewart); Stewart Dec., ¶ 80; Ex. D, Stewart Dec. at 20-26, 28, 30-32, 34-39 (patients DT, HS, BT, EV, JE, TW, SH, AJ, LJ, IV, DC, AF, GG, and EB).

314. Dr. Burns testified about the resulting harm to seriously mentally ill prisoners:

> The same cycle gets set up where people continue to experience acute symptoms of their illness. They get more ill. They end up having to be housed in higher security settings, such as the segregation unit or Special Management Unit where they get worse. And then when they finally do get to the Mental Health Unit they can't mingle with other inmates because they have too high of a custody level to be able to do that. So they suffer with continued symptoms. They suffer in terms of getting their custody level raised and then placed into settings where access is even more difficult not only to the Mental Health Unit but also staff access to them within those confinement areas.

(Mar. 5, 2014 TT at 21:11-22 (Burns)

315. Problems with MHU care are well-known, longstanding, and documented by Dr. Burns. (Stewart Dec., ¶¶78-79, citing Burns' Seventh Report at 8 (finding "inadequate, incomplete admission assessments; premature release; unilateral discharge decisions made by MHU without discussion, [poor] coordination or continuity of care with outpatient providers; [and] concerns about the frequency, intensity and quality of treatment interventions in the MHU.")). In her Ninth Report, Dr. Burns documented over a dozen cases of prisoners who were receiving inadequate MHU care. (Stewart Dec., ¶79, citing Burns' Ninth Report (Doc. 2088)).

316. Dr. Burns recommended that the Jail develop and implement appropriate MHU admission and discharge criteria to ensure that clinically unstable and seriously ill prisoners are timely transferred to and remain in the MHU. (Remedial Plan at 4-5; Mar. 5, 2014 TT at 23:23-24:15 (Burns)).

317. Defendants have failed to comply fully with Dr. Burns' recommendation. (Mar. 5, 2014 TT at 24:2-6 (Burns)).

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318. Limiting MHU placement to prisoners who are actively a danger to themselves or others leaves extremely symptomatic and unstable prisoners to languish in general population and isolated confinement housing, though the closer observation they would receive in the MHU would reduce their risk of harm. (Mar. 6, 2014 TT at 36:21-37:4 (Stewart)).

319. Since issuing her remedial plan, Dr. Burns has continued to document problems with delayed admission to and premature discharges from the MHU. (Stewart Dec., ¶82, citing Burns' Seventh Report at 6, 10 (Burns' Seventh Report, finding that prisoners continued to be prematurely discharged from the MHU, and to suffer at outpatient facilities, where the "clinical threshold to refer a patient to a higher level of care [that] is too high," including case of a prisoner who remained housed at Durango despite growing increasingly psychotic over a months-long period and refusing medications and assaulting staff.)); Stewart Dec., ¶83, citing Burns' Ninth report at 8, 22, and 25 (Burns' Ninth Report, again finding that prisoners were prematurely discharged from the MHU, and that the admission criteria for the unit were too stringent, citing the cases of a prisoner who had multiple MHU admissions and attempted suicide at an outpatient facility after a premature MHU discharge (patient MK), and another prisoner who suffered multiple manic episodes and was non-compliant in the Special Management Unit (SMU) but remained housed there (patient EM)).

320. On November 21, 2012, CHS reported to Dr. Burns that problems persist with the timeliness of MHU transfers, based on a record review that Dr. Burns asked CHS to carry out. In that report, CHS concluded that one patient "clearly should have been referred to the MHU more quickly," another "would have fared better with a referral to MHU as she was not stabilizing," while another "was not timely referred to a provider by mental health staff as she deteriorated." (Pl Ex. 120 (CHS Responses to ACLU Report on Visits in April and October 2012) at 1 (patient 1), 8 (patient 10), and

11 (patient 18). In several cases, CHS found that the failure to transfer patients to the MHU in a timely manner resulted from poor communication between CHS staff members. *See, e.g., id.* at 1 (patient 1's delayed MHU transfer "stem[med] from communication issues between intake staff and outpatient staff, between MHPs and psychiatrist, and between medical staff and psychiatrist.")

321. Dr. Burns attributed the premature discharge of clinically unstable mentally ill prisoners from the MHU in part to MHU staff's desire to retain open beds in the acute units to accept prisoners undergoing alcohol and drug withdrawal. (Pl Ex. 67 (Burns' Eleventh Report (Doc. 2215-1)) at 2).

322. Though Defendants did open a unit at the Durango jail in April 2013 to house withdrawing prisoners, that unit does not accept prisoners with a maximum or closed custody status. As a result, these higher custody prisoners continue to be housed in the MHU while undergoing withdrawals, taking up bed space that should be reserved for clinically unstable mentally ill prisoners who now are prematurely discharged to outpatient facilities. (Mar. 5, 2014 TT at 27:1-8 (Burns); Burns' Eleventh Report at 2).

323. Many prisoners spend their entire stay in the MHU in the acute units, where they are kept locked down in their cells 24 hours a day. They are not provided access to outdoor recreation, nor to any psychosocial rehabilitation services. These services are structured programs that, along with unstructured out of cell time, are a critical part of adequate care for seriously ill prisoners in the MHU. Without them, these prisoners are at risk of growing more ill, and of not responding fully to the treatment they do receive. This deterioration can take many damaging forms, including increased symptoms, and non-adherence to treatment. Prisoners in the acute units are rarely moved to the MHU's step-down and chronic care units, which offer greater out of cell time and psychosocial rehabilitation programs. (Mar. 5, 2014 TT at 28:1-29:13, 31:15-20, 32:4-17 (Burns); Mar. 6, 2014 TT at 37:22-39:15, 40:5-25 (Stewart); Stewart Dec., ¶¶ 86, 88, 89, 91).

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324. Defendants claim that one reason they discharge prisoners directly from the acute units to general population is to provide them mental health care in a less restrictive environment. This is pure pretext. If this truly were Defendants' concern, then they would routinely move clinically stable patients to the MHU's step-down units, which are far less restrictive than the acute units. This does not happen at the Jail—the step-down units are woefully underutilized. (Findings, *infra*, ¶¶ 329-31).

325. Mental health care should be provided in the least restrictive environment consistent with the clinical needs of the patient. Defendants' practice of transferring clinically unstable patients from the acute units to general population is inconsistent with this principle: the outpatient facilities are not equipped to, and do not, provide adequate mental health treatment to clinically unstable patients who are prematurely discharged from the MHU. (Mar. 6, 2014 TT at 90:9-91:9, 109:1-4 (Stewart); Findings, *supra*, ¶¶313-20 and *infra* ¶¶367-84).

326. In order to ensure that seriously mentally ill MHU prisoners receive adequate psychosocial treatment, Dr. Burns recommended in her remedial plan that Defendants provide a minimum number of hours of these services by unit type (acute, step-down, chronic). (Mar. 5, 2014 TT at 31:23-32:10 (Burns); Remedial Plan at 6). Defendants have failed to provide the recommended level of psychosocial services. (Mar. 5, 2014 TT at 32:18-22 (Burns).

327. Though P-3 and P-5 are intake units, prisoners can spend weeks or months housed in these units with little or no psychosocial rehabilitation programming. No psychosocial programming is offered to prisoners in P-3 and P-5-B. (Mar. 6, 2014 TT at 28:14-21, 37:22-38:4 (Stewart); Stewart Dec., ¶¶ 86, 88).

328. In P-3 and P-5-B, the prisoners are locked down 24 hours a day. (Pl Ex. 122 (MHU Day Room Access and Recreation Schedule)). Many of these prisoners are acutely ill and require an inpatient level of care, which is not provided in the MHU. Many of their cells are littered with trash, used food cartons, and rotting fruit. The

conditions in which these prisoners live, coupled with the inadequate treatment they receive, exacerbate their mental illness and undermine the treatment they do receive. (Mar. 5, 2014 TT at 29:20-30:22 (Burns); Mar. 6, 2014 TT at 28:25-29:14 (Stewart); Stewart Dec., ¶ 87).

329. It is common for prisoners to be admitted to the acute units, spend their entire MHU stays in those units, and be discharged from them, all without ever being stepped down to the other MHU units. The step-down units are extremely underutilized. (Mar. 5, 2014 TT at 28:1-29:13, 31:15-20 (Burns); Mar. 6, 2014 TT at 40:18-41:9 (Stewart); Stewart Dec., ¶¶ 89, 91).

330. The Jail's failure to utilize the step down units results in clinically unstable patients being prematurely discharged from the MHU, and often in their being transferred back to the MHU after they grow acutely ill and behaviorally impaired. (Mar. 5, 2014 TT at 21:25-22:11, 28:8-29:13 (Burns); Mar. 6, 2014 TT at 41:21-25 (Stewart); Stewart Dec., ¶ 90). The outpatient facilities are not equipped to adequately treat these unstable prisoners, placing them, fellow prisoners, and staff at unnecessary risk. (Mar. 6, 2014 TT at 41:10-20 (Stewart)).

331. In order to reinforce the importance of utilizing the step-down and chronic care units, Dr. Burns asked Defendants to conduct a study of prisoners who had endured multiple re-admissions to the MHU, particularly of the decision to discharge prisoners from the MHU to outpatient facilities. Defendants ignored her request. (Mar. 5, 2014 TT at 30:23-31:22 (Burns)).

332. Prisoners are often seen cell side by mental health staff and providers rather than in a confidential setting. This cell-side contact undermines the therapeutic alliance between patient and staff that is critical to adequate care. Though these contacts can provide some information to staff about the condition of a patient, they are not treatment, and are not an adequate substitute for treatment. (Mar. 5, 2014 TT at 22:18-23:22 (Burns); Mar. 6, 2014 TT at 34:1-15 (Stewart); Stewart Dec., ¶ 93).

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333. In other correctional systems around the country, providers and staff meet patients—even the highest security patients—in a confidential setting outside of the prisoners' cells where they have visual and oral confidentiality, while also ensuring the safety of staff. (Mar. 6, 2014 TT at 35:2-36:1 (Stewart)).

334. Moreover, as Dr. Stewart testified

> But I might add, Your Honor, if someone is so dangerous at that point where the provider is at risk for self-harm, I'm certainly not suggesting the provider put themselves at risk. But if a person is that unstable psychiatrically, then that person shouldn't be in that unit. They should be in a place where they can get more adequate care.

(Mar. 6, 2014 TT at 36:2-8 (Stewart)).

335. The Jail does not provide an inpatient level of care to prisoners housed in the MHU and elsewhere who need such care. Therefore, the Jail must ensure access to an outside facility that can provide this level of care. The Jail fails to ensure timely access to hospitalization and to an inpatient level of care. This includes prisoners who spend months locked in isolation cells for up to 24 hours daily. Their living conditions, coupled with the lack of adequate care, results in their unnecessarily suffering. They also remain at risk of harm to themselves and to others while housed at the Jail. Defendants also do not consistently and timely petition for COT Orders (involuntary treatment orders) for prisoners in need of acute stabilization, and do not timely renew and utilize existing COT Orders. (Mar. 5, 2014 TT at 33:11-16, 40:18-21, 44:16-23, 47:13-22 (Burns); Mar. 6, 2014 TT at 29:5-19, 42:18-21 (Stewart); Stewart Dec., ¶¶ 94, 102; Ex. D, Stewart Dec. at 4, 5, 8, 20-24, 27-28, 34-35, 37-38, 45 (patients NC, CA, YF, DT, HS, VL, LQ, NM, MR, EV, AH, LJ, DM, ER, IV, AF, and ML).

336. The problems with access to hospitalization are well-known and longstanding. In her remedial plan, Dr. Burns recommended that "Defendants . . . ensure that prisoners are timely transferred to a psychiatric facility when they cannot be adequately treated at the Jail." (Remedial Plan at 6).

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337. Full implementation of Dr. Burns' recommendations is essential to providing timely hospitalization to those prisoners in need of that care. (Stewart Dec., ¶ 96). Defendants have failed to implement Dr. Burns' recommendation and timely hospitalize those prisoners in need of inpatient care. (Mar. 5, 2014 TT at 34:2-5 (Burns)).

338. Sheriffs and county officials around the country have developed a number of ways to ensure the timely hospitalization of prisoners in need of inpatient care. Some operate jail units located at local hospitals, others execute contracts with hospitals to accept prisoners. Rikers Island, NY has a jail unit in Bellevue Hospital for prisoners in need of hospital-level care. Prisoners there remain under the custody of the Jail but are housed at Bellevue where they can receive hospital-level care. (Mar. 5, 2014 TT at 34:8-18, 37:11-17 (Burns)).

339. In San Francisco, county officials likewise created a jail unit at the county hospital for seriously mentally ill prisoners, one that was staffed by sheriff's deputies to ensure security. (Mar. 6, 2014 TT at 53:2-13 (Stewart)).

340. The Franklin County, OH Jail sends its prisoners in need of hospital care to a forensic unit at the state psychiatric hospital. (Mar. 5, 2014 TT at 34:8-18 (Burns)). These prisoners likewise remain in the custody of the sheriff though they are hospitalized. (Mar. 5, 2014 TT at 65:10-19 (Burns)).

341. The Arizona state forensic facility is equipped to handle high-custody and high-security mentally ill patients. (Mar. 5, 2014 TT at 37:18-24 (Burns)). Maricopa County also operates the Desert Vista psychiatric facility that provides in-patient treatment. (Mar. 5, 2014 TT at 38:13-18 (Burns)). Defendants, however, do not timely transfer prisoners in need of inpatient care to either facility for treatment. (Mar. 5, 2014 TT at 34:2-5, 36:4-13, 37:11-24 (Burns)).

342. Defendants have an agreement to pay Arizona State Hospital to accept prisoners in need of inpatient care. They have never transferred a prisoner from the Jail to the hospital under this agreement. (Mar. 5, 2014 TT at 46:9-47:4 (Burns)).

343. Prisoners who have been found incompetent to proceed in their criminal cases are placed in the Restoration to Competency (RTC) program. RTC prisoners are among the most acutely ill in the entire jail population, and many of them require an inpatient level of care. (Mar. 5, 2014 TT at 35:22-36:3 (Burns)).

344. Other jail systems around the country transfer prisoners deemed incompetent to proceed in their criminal cases to forensic hospitals to be restored to competency. While there, they receive hospital-level care. Maricopa County officials have chosen to keep the County's RTC program at the Jail. As a result, Maricopa RTC patients do not have access to the hospital-level care provided to prisoners undergoing competency restoration in other systems. (Mar. 5, 2014 TT at 38:1-6 (Burns); Mar. 6, 2014 TT at 47:14-19 (Stewart); Stewart Dec., ¶ 97).

345. Defendants' decision to keep RTC patients at the jail has resulted in their being denied timely inpatient and emergency mental health care. This delay in necessary treatment results in seriously mentally ill prisoners unnecessarily suffering, and compromises their response to inpatient treatment once they do receive it. (Mar. 5, 2014 TT at 35:18-37:1, 40:18-21 (Burns)).

346. It also results in very ill prisoners remaining housed in the MHU's acute units, where they take up limited bed space that could otherwise be used for clinically unstable prisoners who remain in the outpatient facilities. (Mar. 5, 2014 TT at 45:2-14 (Burns)).

347. The problem of failing to timely hospitalize RTC patients are well-known and longstanding. In her Tenth Report, Dr. Burns found that RTC patients continued to experience "delays in access to an inpatient level of care." (Stewart Dec., ¶98 (citing Burns' Tenth Report at 5)). Dr. Burns wrote that these delays cause "needless suffering

to the inmates themselves, poor utilization of MHU beds as 'holding cells' when other inmates could benefit from a longer course of treatment in the MHU and diversion of staff resources to manage/monitor psychotic inmates at the expense of providing treatment to other inmates." (*Id.*)

348. Similarly, in her Ninth Report, Dr. Burns found that RTC patients' access to hospitalization and involuntary treatment was delayed, resulting in "needless suffering and in fact studies have demonstrated that delays in providing treatment result in slower and less complete or robust responses to treatment when it is eventually provided." (Stewart Dec., ¶ 99 (citing Burns' Ninth Report at 13)).

349. The Defendants have claimed that their hands are tied under state law, and they cannot hospitalize RTC patients until their criminal charges are resolved.[28] Even if this were true, it begs the question why the County has chosen to place the RTC program in the jail, rather than at a hospital, while at the same time failing to contract with a hospital to accept chronically ill prisoners in need of an inpatient level of care. As a result of the County's choices, seriously ill prisoners are denied timely and appropriate care. (Mar. 5, 2014 TT at 37:11-24, 38:1-6; 39:14-40:1, 43:24-45:20 (Burns); Mar. 6, 2014 TT at 53:2-13 (Stewart); Stewart Dec., ¶ 100).

350. Moreover, there are a number of options short of moving the RTC program out of the Jail that would ensure timely hospitalization, including following the lead of counties around the country that have opened jail units in county hospitals to provide inpatient care, or utilizing the existing contract with Arizona State Hospital to accept seriously mentally ill prisoners in the RTC program. (Findings, *supra*, ¶¶338-40).

351. The Jail has transferred some prisoners to Desert Vista for a court-ordered evaluation to determine if they should be subject to involuntary treatment pursuant to a

[28] *See* Pl Ex. 123 (Joint Status Report to the Court Regarding Dr King and Dr. Burns' Tenth Report) (Doc. 2128) at 25.

Court Ordered Treatment (COT) Order. (Mar. 5, 2014 TT at 40:2-14 (Burns); Stewart Dec., ¶¶101-102).

352. The COT process is designed to determine if a patient should receive involuntary treatment; it is not designed to provide inpatient care. Though prisoners are sent to the Desert Vista psychiatric facility to be assessed for a COT Order, their hospital stays are very short, and end once the COT Order is secured. They are then transferred back to the Jail. The short-term hospital stays prisoners receive as part of the COT process are not an adequate replacement for psychiatric hospitalization, and even if involuntary treatment is ordered, its benefits are often dissipated through the inadequate care prisoners receive once they are moved back to the Jail. (Mar. 5, 2014 TT at 36:4-37:1, 40:2-14; 43:10-13 (Burns); Mar. 6, 2014 TT at 42:24-43:13, 44:2-8; 47:9-11 (Stewart)).

353. Defendants seek COT Orders for prisoners who are refusing treatment and presenting as dangerous to themselves or others. Their transfers to Desert Vista are unnecessarily delayed. (Mar. 5, 2014 TT at 35:18-36:3, 40:5-14 (Burns); Mar. 6, 2014 TT at 42:22-43:10 (Stewart); Stewart Dec., ¶101).

354. Defendants do not seek COT Orders for prisoners in the RTC program. This is a cohort that include many of the most acutely ill at the Jail, and are therefore the most likely to require an inpatient level of care (Mar. 5, 2014 TT at 35:18-36:3 (Burns); Mar. 6, 2014 TT at 42:22-43:6 (Stewart)).

355. Because Defendants will not initiate the COT process for RTC patients until their criminal charges are resolved, they are denied timely involuntary treatment. Dr. Burns testified, “The problem with that is then they finally get to a hospital after months, potentially, and months of no treatment so they are sicker. They get transferred as persistently and acutely disabled as opposed to at the time when they needed emergency care, which was months prior.” (Mar. 5, 2014 TT at 35:24-36:3 (Burns)).

356. Examples of inadequate care in the MHU and poor access to hospitalization include the following:

357. Prisoner DT was admitted to the MHU on July 5, 2013 for being paranoid, selectively mute, and for repeatedly injuring his penis, which eventually required treatment in the local hospital's emergency room. Mr. DT had languished essentially untreated in segregation for months before being moved to the MHU, despite displaying symptoms of acute illness, refusing to engage with staff, and being referred by detention staff for "playing with his own feces . . . regularly walk[ing] around in his cell stripped down of his clothing with feces and urine covering his floor." (Mar. 6, 2014 TT at 30:14-31:17 (Stewart); Ex. D, Stewart Dec. at 8-9). Given his presentation, Mr. DT should have been moved to the MHU months earlier, and the fact that he was not moved until he self-mutilated to the point where he had to be treated at the ER is indicative of a too-high threshold for MHU admission. (Mar. 6, 2014 TT at 32:7-14 (Stewart)).

358. Patient DT has remained paranoid, non-compliant, and psychotic in the MHU. He was placed in restraints in the MHU on four separate occasions from July 10-16, 2013 for a total of over 57 hours for repeatedly injuring his penis. Dr. Picardo on July 17 ordered that patient DT be handcuffed to a dayroom table for 6 hours, and that staff "[p]lace mattress in front of him to prevent him from banging his head on the table." On August 4, Dr. Picardo wrote, "seen cell side. He has been nude due to his repeated acts of aggression. Yesterday he was seen injuring his penis again. Unpredictable violence towards others, inappropriate affect, sits silent for long periods of time. Need to try medication, concern he has underlying mood dx or psychosis in addition to personality dx." Dr. Picardo prescribed "for acute agitation give Haldol 10 mg IM and Benadryl 50 mg IM BID PRN x 10 days." Patient DT has refused all medications. Plaintiffs' mental health expert Dr. Pablo Stewart interviewed patient DT during his recent visit to the MHU. Mr. DT had been hospitalized briefly, but had then

returned to the Jail. He was nude, very guarded, suspicious, and largely uncommunicative. He clearly is suffering from acute mental illness. He has not received adequate care at the Jail, and requires inpatient care or hospitalization. (Mar. 6, 2014 TT at 32:19-33:18 (Stewart); Ex. D, Stewart Dec. at 20-21).

359. Patient LQ was booked on June 8, 2013, and admitted to the MHU that day. Ms. LQ had been petitioned for a COT Order before her booking, and this petition was reinstated, and accepted, after her arrest. She was transferred to Desert Vista from June 15-23, 2013, and the COT Order was granted. She then was transferred back to the Jail, and placed in the MHU (Mar. 6, 2014 TT at 43:14-23 (Stewart); Ex. D, Stewart Dec. at 23).

360. On June 28, 2013, Ms. LQ told Dr. Fangohr that she wanted to be around people. Rather than stepping her down through the MHU, Dr. Fangohr discharged her to Estrella on July 3, 2013, one day after prescribing her an injectable anti-psychotic medication (Risperdal Consta 25 mg IM) under her COT Order. (Mar. 6, 2014 TT at 43:25-44:10 (Stewart); Ex. D, Stewart Dec. at 23-4).

361. Ms. LQ should have been stepped down in the MHU before her discharge. The medication she was prescribed is long-acting, and does not reach a steady state therapeutic level for several weeks. Rather than waiting for Ms. LQ to be stabilized on her new medication, and providing her with supporting oral medications until she was stabilized, she was transferred out of the MHU before she was stable on her anti-psychotic medication. (Mar. 6, 2014 TT at 44:13-45:22 (Stewart)).

362. Ms. LQ was readmitted to the MHU nine days later, on July 12, 2013, after she threatened to stab with a pencil and spit at other prisoners, and was seen eating out of the garbage. Since returning to the MHU, Ms. LQ has remained non-compliant, and has not consistently showered, or maintained personal hygiene. She has sporadically refused her medication, which has not been addressed via her COT Order. On July 16, 2013, she threw urine at an officer, threw her medication on the floor, was

disheveled, and her cell was dirty. On August 8, 2013, the detention officers would not put Ms. LQ in the conference room for a provider appointment because she was a "biohazard." Her August 12, 2013 Special Needs Treatment Plan (SNTP) reads, "Ms. [LQ] made no progress in reducing her irritability and remained uncooperative and hostile. She neglects her hygiene, trashed her cell and refused to be interviewed in a privacy room. Flat and withdrawn. Currently in RTC program." (Mar 6, 2014 TT at 46:20-47:8, 110:4-8 (Stewart); Ex. D, Stewart Dec. at 23-24).

363. Ms. LQ's case demonstrates the systemic limits of the COT process: though she had a COT Order, she has received inadequate care since her return to the Jail, and the COT Order does not ensure the inpatient level of care she requires. The short-term therapeutic gains Ms. LQ made while hospitalized for her COT assessment have been squandered through the inadequate care and living conditions she has endured since returning to the Jail (Mar. 6, 2014 TT at 42:24-43:13, 44:2-8; 47:9-11 (Stewart)).

364. Patient DM was booked on February 18, 2013. At the time of her arrest, she was pregnant. Ms. DM has a long and well-documented mental health history. This includes a Feb, 12, 2013 COT Order. Ms. DM was moved to the MHU on Feb. 19, 2013 after she was assaultive in Estrella dorms. She remained non-compliant with treatment in the MHU, refused all oral medications, including her pre-natal vitamins, and was symptomatic until her discharge on May 18, 2013. During her MHU stay, she remained housed on P-5, much of it on restricted status, confined to her cell at least 23 hours a day. (Mar. 6, 2014 TT at 47:23-48:5 (Stewart); Ex. D, Stewart Dec. at 35).

365. Soon after her arrest, she was admitted to the RTC program. She was not hospitalized despite her acuity. According to Ms. DM's March 23, 2013 SNTP, she "continues to display delusional and paranoid ideation with loose associations. . . . Ms. [DM]'s mood and behavior are completely unpredictable. Her capacity and or willingness to engage in any level of treatment are severely compromised. Ms. [DM]'s

1 judgment and insight are greatly impaired. [Her] volatile behavior, delusional
2 presentation . . . schizophrenia and history of alcohol and methamphetamine abuse
3 render her participation in treatment unfeasible. Her baseline on medication remains
4 delusional and paranoid. She is currently unable to participate and assist in making
5 progress toward the above outlined treatment goals. Setting and achieving meaningful
6 goals is not possible at this time." (Mar. 6, 2014 TT at 48:7-14 (Stewart); Ex. D,
7 Stewart Dec. at 35).
8 366. Ms. DM continued to be non-compliant with both her mental health
9 treatment and her treatment for her pregnancy, endangering herself and her unborn
10 child. (Mar. 6, 2014 TT at 52:10-23 (Stewart)). She was deemed incompetent and
11 unrestorable and transferred to Desert Vista on May 18, 2013. She continued to be
12 actively psychotic and unpredictable until her discharge. Because the jail's RTC
13 program is based at the Jail, and Defendants fail to hospitalize RTC patients like Ms.
14 DM, she unnecessarily suffered due to inadequate care coupled with her harsh living
15 conditions in the MHU's acute unit. (Mar. 6, 2014 TT at 48:15-21, 52:10-23 (Stewart);
16 Ex. D, Stewart Dec. at 35).
17
18 **Deficiencies in Outpatient Care**
19 367. Defendants fail to ensure that mentally ill prisoners housed in the Jail's
20 outpatient facilities (LBJ outpatient, 4th Avenue, Estrella, Durango, and Towers) receive
21 adequate mental health treatment, and are timely transferred to the MHU or an inpatient
22 psychiatric facility when they need that level of care. As a result, these prisoners
23 unnecessarily suffer, and are put at unreasonable risk of victimization by their fellow
24 prisoners. (Mar. 5, 2014 TT at 50:3-52:3 (Burns); Mar. 6, 2014 TT at 55:1-4 (Stewart);
25 Stewart Dec., ¶¶ 104-114; Ex. D, Stewart Dec. at 50-64 (patients IV, KH, AF, YF, GT,
26 RD, DT, MM, VL, MR, NC, AA, EB, LG, IL, OM, and QS)).
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368. A mental health program limited to medications is inadequate for many mentally ill prisoners. This includes those clinically unstable patients who have been prematurely discharged from the MHU. Mentally ill prisoners housed in the outpatient facilities must have access to a full range of mental health services necessary to provide adequate care. This includes individual and group therapy, active treatment planning, and pharmacological treatment. But the treatment for many seriously mentally ill outpatients is limited to medication management and monitoring by mental health staff that is not frequent enough given the patient's acuity. With little or no access to critical psychosocial rehabilitation services and timely access to a provider, many seriously mentally ill prisoners end up decompensating. (Mar. 5, 2014 TT at 47:24-52:2 (Burns); Mar. 6, 2014 TT at 55:5-9 (Stewart); Stewart Dec., ¶ 104).

369. Defendants fail to ensure that seriously mentally ill prisoners are seen at appropriate intervals by a provider. Instead, they are seen exclusively by MHAs and MHPs, who fail to refer them on to providers for inappropriately long periods, despite their acuity. This includes prisoners who have been prematurely discharged from the MHU while unstable, those who are psychotic, those who are refusing medications and treatment, and those who need to be moved to the MHU or an inpatient psychiatric facility for adequate care. (Mar. 5, 2014 TT at 49:15-51:21 (Burns); Mar. 6, 2014 TT at 55:14-25 (Stewart); Stewart Dec., ¶¶ 106, 107).

370. Defendants' failure to provide adequate care to seriously mentally ill prisoners, or timely move them to the MHU, places them at risk of being victimized by fellow prisoners, assaulting fellow prisoners and staff, and incurring disciplinary charges that can lead to their being locked down. (Mar. 6, 2014 TT at 57:12-16, 58:4-9 (Stewart); Stewart Dec., ¶109).

371. By way of example, prisoner TB was assaulted by fellow prisoners after he displayed symptoms of acute illness but was not removed from his housing unit. Mr. TB was booked on Mar. 15, 2013. At intake, he reported auditory hallucinations.

He was cleared for general population. His Mar. 19, 2013 SNTP reports that he had a history of aggressive behavior, and was having ongoing hallucinations. Mr. TB's cellmate told mental health staff that day that Mr. TB was mentally ill and thought he was a wizard. (Mar. 6, 2014 TT at 58:14-20 (Stewart), Stewart Dec., ¶108).

372. On Mar. 25, 2013 at 0100 hrs, a nurse saw Mr. TB at a detention officer's request because he was banging his head on the wall. He was agitated, unusually slow to respond to questions, and confused. Evidently, no one from mental health care staff was notified, and the on-call psychiatric provider was not contacted for orders. At 0810 hrs, Mr. TB was treated for facial trauma, "he kept inmates up all night – he was beat up. . . Raccoon eyes." He was noted as confused, had difficulty speaking, and lacerations to his face." At 0800 hrs, an MHP wrote that he was contacted by nursing staff and detention and reported Mr. TB had been beaten up. The Sgt. stated Mr. TB had urinated on the floor of his cell, and had been banging his cell door for the past several nights, keeping the other inmates up, and that is why he was beaten up. After safe cell placement, he was moved to the MHU. (Mar. 6, 2014 TT at 58:21-59:10 (Stewart), Stewart Dec., ¶109).

373. The problems with outpatient care are well-known and longstanding. Dr. Burns sought to remedy many of them through her remedial plan. (*See* Remedial Plan at 7-8). Dr. Burns' plan requires timely provider access as well as access to a full range of mental health services, using the three levels of care (Seriously Mentally Ill (SMI), mental health chronic care, and jail mental health) utilized by CHS to categorize patients on its mental health caseload. (*Id.*) Defendants have failed to comply with Dr. Burns' recommendations. (Mar. 5, 2014 TT at 48:22-49:4, 49:12-25, 51:22-52:3 (Burns)).

374. CHS Policy J-G-04 "Basic Mental Health Services: Outpatient Levels of Care" does not comply with Dr. Burns' recommendations, and sets assessment intervals that place prisoners at an unreasonable risk of harm. It does not set admission and

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discharge criteria for the three levels of care (SMI, mental health chronic care or jail mental health), as Dr. Burns recommended. It does not set frequency of interventions by discipline; it merely sets intervals without regard to who actually sees the patient. (*See, e.g.,* Pl Ex. 118 (CHS Policy J-G-04-6(g)(i) "Basic Mental Health Services") (SMI patients seen once every 45 days, no specification of staff level, no requirement for provider appointments)). It does not require that clinically unstable SMI patients be seen by a provider. (*See id.* (ii) (requiring that these patients be "seen 2 to 4 times per month until stable and/or medication compliant.")). SMI patients refusing treatment need not be timely referred to a provider. (*See id.* ¶ (6)(i)). If that same patient has a history of suicide attempts, he need only be seen by mental health staff (not a provider) once monthly. (*Id.*) The policy does not require a provider assessment even if an SMI patient refusing services with a history of suicide attempts becomes symptomatic, or is decompensating. (*See id.*) The policy does not set the frequency of treatment team meetings or treatment plan updates, as Dr. Burns recommended. It only calls for an initial treatment team meeting to develop a SNTP. (Stewart Dec., ¶¶ 112-14).

375. The Jail's failure to adhere to Dr. Burns' recommendations contributes to placing mentally ill prisoners at risk of harm in outpatient facilities. (Stewart Dec., ¶111).

376. Since issuing her recommendations, Dr. Burns has continued to find serious and ongoing problems with the provision of outpatient care. In her Seventh Report, Dr. Burns found the "problems with outpatient care previously identified continue to exist." (Burns' Seventh Report at 10). Dr. Burns continued:

> These issues are quite serious and include infrequent contact/treatment intervals, even when patients are not doing well; over-reliance on psychotropic medications as essentially the sole treatment intervention in many instances; contact in response to an HNR rather than pro-active, planned, clinically driven, and focused treatment interventions; poor continuity of care upon discharge from MHU; and concerns that the clinical threshold to refer a patient to a higher level of care is too high.

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(*Id.* at 10).

377. In November 2012**,** CHS also reviewed multiple records for prisoners in outpatient facilities who were not seen in a timely manner, including one who "was not seen in [the] Outpatient area for 2 months" after a positive mental health screening. (CHS Responses to ACLU Report on Visits in April and October 2012 at 6 (patient 8)). In total, CHS' report to Dr. Burns describes some form of non-compliance in outpatient care in more than half of the relevant cases reviewed. (*See id passim* (patients 1, 2, 3, 4, 7, 8, 10, 12, 14, 18, 19, 20, 29, and 31)).

378. Examples of outpatients who received inadequate care include the following:

379. Prisoner IV was booked on December 19, 2012 and cleared for Estrella, where she remained until being transferred to the MHU on May 9, 2013. She was not seen by a provider for four months at Estrella despite being acutely ill. Many opportunities to move her to the MHU were missed. She was actively symptomatic but not adequately treated. (Mar. 6, 2014 TT at 56:4-58:3 (Stewart), Ex. D, Stewart Dec. at 50-51).

380. On her December 31 H & P, Ms. IV told RN Diaz, "I am a government of all the USA and Mexico I am so rich." Ms. IV refused an assessment by mental health professional (MHP) Unsworth. There was no follow-up. (Mar. 5, 2014 TT at 56:4-12 (Stewart); Ex. D, Stewart Dec. at 50).

381. Detention staff filed four referrals for psychiatric services (3/21, 4/5, 4/7, 4/15) all reporting severe symptoms (4/5: "dorm mates say this inmate gets very angry and speaks to the devil." 4/15: "unknown individuals from Mexico trying to kidnap her"). She was not seen by a provider until April 11, when NP Burgett saw her. On exam she was grandiose, hyper religious, distracted. NP Burgett nevertheless found her stable in GP. "Bizarre behavior and HNRs but no functional impairment or safety risk

severe enough to warrant petition for COT. Does not want medication now." (Mar. 6, 2014 TT at 56:21-57:7 (Stewart); Ex. D, Stewart Dec. at 50).

382. This is indicative of the too-high threshold Defendants use for MHU admission. Limiting MHU admission to prisoners who are eligible for involuntary treatment under a COT Order results in their languishing in outpatient facilities without adequate care, and also places seriously mentally ill prisoners at risk of being victimized by fellow prisoners, assaulting fellow prisoners and staff, and incurring disciplinary charges that can lead to their being locked down. (Mar. 6, 2014 TT at 57:2-18 (Stewart); Ex. D, Stewart Dec. at 50). Ms. IV should have been moved to the MHU for more intensive treatment. (*Id.*)

383. On April 23 detention staff filed another referral after Ms. IV told an officer a man was pulling her legs and she spoke to the Mexican consulate. She was not seen by a provider. By May 3, 2013, Ms. IV was on lockdown. She was moved to the MHU on May 9 after telling NP Burgett that she "died for 28 days. I was already going to the cemetery 15 years ago." (Mar. 6, 2014 TT at 57:20-58:3; Ex. D, Stewart Dec. at 50).

384. Prisoner KH was booked on February 13, 2013. He remained housed in an outpatient facility for six months, despite being acutely ill. His outpatient mental health notes show that he was not seen by a psychiatrist between March 7, 2013 (Dr. Allison) and August 8, 2013 when he was transferred to the MHU for "psychosis, possible PAD," according to Dr. Jaffe's MHU admission order. Mr. KH needed more attention before then by a psychiatrist. His records indicate that he has been responding to internal stimuli (March 7), treatment non-compliance without adequate follow-up (April 4, July 18), feces in the corner of his cell (noted by a detention officer on July 24). His medications (Haldol D and Cogentin) were discontinued by PA Fleming on June 24 without a face to face assessment due to Mr. KH's ongoing refusals. Mr. KH was overtly psychotic for months, yet was not seen by a provider. As a result, he

unnecessarily suffered, and his MHU transfer was far too delayed. (Mar. 6, 2014 TT at 59:16-60:13 (Stewart); Ex. D, Stewart Dec. at 51-52).

Deficiencies in Medication Administration Practices

385. There are longstanding and well-known deficiencies in medication administration at the Jails. Dr. Burns made specific recommendations designed to ensure timely and appropriate medication administration practices, and documented clinical decision-making. (Remedial Plan at 8-9). The Jail's failure to fully implement them contributes to dangerous medication practices at the Jail. (Stewart Dec., ¶ 116; Ex. D, Stewart Dec. at 46-50 (patients TW, MM, SA, MM AJ, QS, LL, SLG, CA, and HN); CHS Responses to ACLU Report on Visits in April and October 2012 (Nov. 2012 CHS Report documenting instances when medications were not timely continued after intake, the patient was not timely assessed after initiating medications, or where medication non-compliance was not timely addressed) (patients 1, 10, 16, 18, 20, 26, 29)).

386. In order to ensure the timely verification and continuation of medications at intake, Dr. Burns recommended that the medications management policy "mirror the screening/intake policy in terms of the triage categories for psychiatric assessment as emergent, urgent, or routine referrals." (Remedial Plan at 9). But CHS Policy J-G-01-02 "Psychotropic Medication Management" does not set timelines for either verification of reported medications, or for prescribing verified medications after intake. (Mar. 5, 2014 TT at 52:6-15 (Burns); Pl Ex. 118 (CHS Policy J-G-01-02 "Psychotropic Medication Management"); Stewart Dec., ¶ 117).

387. Defendants still do not have a reliable system that ensures that prisoners are continued on their verified medications after intake. (Mar. 5, 2014 TT 53:11-54:22 (Burns); Stewart Dec., ¶ 57). CHS' own quality improvement (QI) studies show that the Jail fails to even begin the medication verification process for close to 20% of

prisoners who report they are taking medications at the time they are booked. (Mar. 5, 2014 TT 53:14-55:3 (Burns); Pl Ex. 55 (CHS Mental Health Evaluation and Psychotropic Medication Audit – July 2013 Bookings/Audit Completed August 2013).

388. This level of non-compliance cannot be attributed to prisoners' refusing to sign a release to allow the Jail to verify the medications they themselves have reported to CHS staff. (Mar. 5, 2014 TT at 54:13-16 (Burns)).

389. Dr. Burns recommended that psychiatrists "must document a clinical rationale supporting their medication choices and any changes made, including changes from medications previously prescribed in the community." (Remedial Plan at 9). Defendants have failed to follow this recommendation, creating an unreasonable risk of serious harm to prisoners. (May 5, 2014 TT at 55:13-56:25 (Burns); Stewart Dec., ¶119; CHS Mental Health Evaluation and Psychotropic Medication Audit Aug. 2013 at 2 (showing that providers failed to document a clinical justification for not prescribing medications to 75% of prisoners who reported medications at intake)). Absent a documented clinical justification, there is no reason why a prisoner who has been prescribed psychotropic medications by a provider in the community should be denied those same medications when they are jailed. (Stewart Dec., ¶¶ 119, 129).

390. Dr. Burns also recommended that the Jail adopt a policy to ensure that medications are not be renewed, changed, or discontinued without a face-to-face encounter except in documented unusual circumstances. Defendants have disregarded Dr. Burns' recommendation. (Remedial Plan at 9; Mar 5, 2014 TT at 58:3-59:3 (Burns); Stewart Dec., ¶¶120-121).

391. In practice, Defendants have failed to ensure that a provider timely sees a patient when changing or discontinuing their medications. Defendants' practice creates an unreasonable risk of harm. Absent a face-to-face assessment, a provider cannot know the true condition of the patient, whether a change in medication is warranted, or whether other medication and treatment should be considered. (Mar 5, 2014 TT at

1 58:14-21 (Burns); Stewart Dec., ¶¶ 120-125; Ex. D, Stewart Dec. at 47-50 (patients
2 MM, QS, LL, and HN).
3 392. Defendants fail to ensure that patients refusing their medications are
4 timely seen by a provider. A refusal of medications can indicate that a patient is
5 clinically deteriorating, or is suffering side or adverse effects from the medications.
6 Defendants' failure to ensure that these patients are timely seen by a provider increases
7 the risks of their unnecessarily suffering due to increased symptoms, self-harm,
8 victimization from other prisoners, or altercations with staff due to behavior that is a
9 product of their mental illness. (Mar. 5, 2014 TT at 59:12-61:1 (Burns); Mar. 6, 2014
10 TT at 61:8-21 (Stewart); Stewart Dec., ¶¶ 126-127; Ex. D, Stewart Dec. at 47-50, 58-59
11 (patients SA, MM, QS, HN, and NC).
12 393. Examples of inadequate medication practices include the following:
13 394. Prisoner SA consistently refused her anti-psychotic medication
14 (Risperdal) from October-December 2012 while housed in Estrella. MHP Retter Rojas
15 saw Ms. SA on November 18, 2012 and noted she had been refusing her medications,
16 and that she was symptomatic, but did not refer her to the provider. On November 27,
17 2012 Dr. Drapeau saw Mr. SA, described her as "verbose rapid speech irritable
18 anxious." She did not address her medication non-compliance. On December 14, 2012
19 Ms. SA got into a violent altercation with detention officers. Dr. Drapeau saw her cell
20 side and wrote, "she had been refusing Risperdal 1-2 months and I was unaware." (Mar.
21 6, 2014 TT at 62:1-13 (Stewart); Stewart Dec., ¶127).
22 395. Prisoner LL received poor monitoring of medications and inadequate
23 medication administration at Estrella from April to August 2012. Ms. LL's medications
24 were changed repeatedly throughout March, April, and May, but Ms. LL was not timely
25 seen by providers for follow-up during this time. For instance, on April 28, Ms. LL had
26 a sub-therapeutic lithium level, which was noted in a lab signed by a nurse two weeks
27 later, on May 9. However, Ms. LL was not seen for follow-up for almost a month (May
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25). Subsequent changes to medication were also not timely monitored. Ms. LL's extra-pyramidal symptoms (EPS) were not timely addressed; a nurse noted Ms. LL's possible EPS on April 10, but it was not until June 5 that a doctor noted Ms. LL "clearly has bilateral EPS." Subsequent changes to medication were not properly monitored; Ms. LL submitted an HNR on June 10 complaining of problems with her new regime, but she was not seen by a provider again until July 18. Additionally, Ms. LL's medication non-compliance was not appropriately handled; she was noted as a no-show/not-in-cell for a number of Haldol dosages throughout April 2012. (Ex. D, Stewart Dec. at 48-49).

Deficiencies in Involuntary Treatment

396. Involuntary treatment should only be used as a last resort when other measures have been tried and have failed. When treatment is forced on a patient improperly it harms the therapeutic relationship between patient and provider, which places the patient at an unreasonable risk of harm. (Stewart Dec., ¶¶131-132).

397. Dr. Burns proposed changes in policy and practice regarding involuntary treatment procedures to ensure "that these treatment measures are used as a last resort when other measures have tried and failed or are impractical under the circumstances." (Remedial Plan at 5). This recommendation, as well as Dr. Burns' other recommendations regarding involuntary treatment, are consistent with sound mental health practice. Defendants' failure to implement them has contributed to putting prisoners subject to involuntary treatment at risk of harm. (Stewart Dec., ¶ 132).

398. CHS' Restraint Policy J-I-01 does not establish written criteria for when to initiate, maintain, or discontinue restraint use, as Dr. Burns recommended. The policy does require that the provider establish release criteria in the restraint order. But few if any provider orders actually establish written release criteria. (Stewart Dec., ¶ 134).

399. CHS' forced medication policy does not require that forced medications be used only after less restrictive methods have failed. Rather, it allows forced medications to be ordered "when less restrictive or intrusive alternatives are not available or indicated, or would not be effective." (Stewart Dec., ¶ 135).

400. Prisoners may be placed in therapeutic restraints or seclusion because they are injuring themselves, and/or pose an ongoing threat to others, and cannot be redirected. They may also be treatment and/or medication non-compliant. Defendants sometimes use restraints or seclusion for exceedingly long periods of time, and restrain the same prisoner multiple times. These episodes can be indications that a patient requires a higher level of care or hospitalization. (Mar. 5, 2014 TT at 61:17-62:21 (Burns); Stewart Dec., ¶ 136).

401. Restraints and seclusion should not be used as a substitute for adequate treatment. Defendants have failed to ensure that prisoners restrained or secluded multiple times, or for long periods, transferred to a higher level of care, or hospitalized. (Mar. 5, 2014 TT at 62:22-24 (Burns); Stewart Dec., ¶¶136-139). Dr. Burns recommended that prisoner subjected to involuntary treatment for long periods, or on multiple occasions, be assessed by a treatment team to consider whether they should be moved to a higher level of care, but Defendants have not implemented her recommendation (Mar. 5, 2014 TT at 61:7-62:24 (Burns)).

402. For example, Prisoner DT was placed in restraints in the MHU on four separate occasions from July 10-16, 2013, for a total of over 57 hours, for repeatedly injuring his penis. CHS staff failed to timely consider Mr. DT for hospitalization despite these repeated restraint episodes. Patient DT has remained paranoid, non-compliant, and psychotic in the MHU. He has not received adequate care at the Jail, and requires inpatient care or hospitalization (Mar. 6, 2014 TT at 31:12-32:2, 32:15-33:18 (Stewart); Stewart Dec., ¶ 137).

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403. After patient DT was restrained four times over a five day period in early July, Dr. Picardo on July 17 ordered that patient DT be handcuffed to a dayroom table for 6 hours, and that staff "[p]lace mattress in front of him to prevent him from banging his head on the table." Dr. Picardo did not document any less restrictive treatment that had failed with patient DT. This is a prime example of the improper use of restraints. There are many safeguards that must be followed for therapeutic restraints, and they were not followed here. (Mar. 6, 2014 TT at 31:18-23, 53:21-54:19; Stewart Dec., ¶138). CHS has failed to internally review its restraint practices via the QI process. (Mar. 6, 2014 TT at 54:20-25 (Stewart)).

404. Defendants have failed to ensure that providers document some clinical rationale supporting forced medications, and document other interventions that had been tried and failed before involuntary medications were ordered. Requiring a clinical rationale is important: it discourages unnecessary resort to forced medication. (Stewart Dec., ¶¶ 140-141).

Deficiencies in Suicide Prevention

405. The conditions under which prisoners are kept on suicide watch in the MHU are so punitive that some suicidal prisoners will deny their suicidality in order to be released from these conditions. Systemic deficiencies in mental health care at the Jail also contribute to the risk that suicidal prisoners will commit suicide. (Stewart Dec., ¶153).

406. There have been at least five suicides at the Jail since December 10, 2010. In each, problems with the care these prisoners received contributed to the risk of their committing suicide. (*Id.*, ¶¶ 155-188).

407. Patient JC committed suicide on Feb. 26, 2011. Dr. Burns found the following problems with Mr. JC's care: no treatment to prevent or ameliorate alcohol withdrawal, no system to flag the patient's history of suicide attempts and risk factors

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that should warrant an immediate referral, and no referral from medical staff for a known history of depression and suicide attempt. (Burns' Seventh Report at App. B at 2-3 (patient #2)). There is an ongoing problem with medical staff failing to refer to mental health patients in mental health crisis, and those with positive mental health findings in their H & P's. (Findings, *supra,* ¶¶ 292, 304, 307; Stewart Dec., ¶¶ 155, 161, 162).

408. Prisoner SC hanged himself on February 27, 2011. Dr. Burns identified the following deficiencies in the care of Mr. SC: the threshold for referral to psychiatry was too high, the patient was not assessed in response to a second medical referral, there was a lack of a comprehensive suicide risk assessment, and the follow-up interval of two weeks that mental health staff ordered for Mr. SC was too long given that he was in acute distress when seen. (Burns' Seventh Report at App. B at 4 (patient #3)). There are ongoing problems with a too-high threshold for being referred to a provider, untimely assessments following referrals, and follow-up intervals for outpatients in acute distress remaining too long. (Findings, *supra,* ¶¶ 367-84; Stewart Dec., ¶ 171).

409. Prisoner CF committed suicide on December 10, 2010. Dr. Burns reviewed Mr. CF's suicide, and identified the following problems regarding his care: a failure to follow-up on an HNR complaining of depression; an inadequate evaluation by the MHP on November 28, 2010 after Mr. CF threatened to hang himself; no referral to a provider for the suicide threat; no suicide risk assessment; an inappropriately long follow-up interval planned for the patient; and no timely follow-up by the provider following a telephone order for anti-anxiety medications. (Burns' Seventh Report at App. B at 1 (patient #1)).

410. Many of the problems Dr. Burns identified as contributing to Mr. CF's suicide continue to plague the Jail: nursing staff do not consistently refer to mental health prisoners in acute psychiatric distress, MHAs and MHPs do not timely and appropriately refer on to providers prisoners who require treatment by a psychiatrist,

mentally ill prisoners in the outpatient facilities are not seen at appropriate intervals, and there is not consistent psychiatric follow-up to telephone orders for medication. (Findings, *supra*, ¶¶ 292, 304, 307, 367-84; Stewart Dec., ¶ 180).

411. CHS conducted reviews of the care provided to all three prisoners identified above, and even developed action plans to correct the deficiencies in their care that may have contributed to their committing suicide. Compliance with the action plans has not been consistently measured via quality improvement studies, and these reviews did not result in concrete improvements to practice that corrected all of the shortcomings in these prisoners' care. (Stewart Dec., ¶¶ 161-165, 171, 177).

412. Prisoner AH committed suicide on July 21, 2013. He reported a history of suicide attempts at both booking and to mental health staff. Three weeks before his death, he asked a provider to be put back on Abilify, on which he had had good results. He was not put back on his reported medications. Rather, he was started on a different medication, but there was no clinical justification given as to why he was not restarted on a medication that worked for him. He made several complaints that his new medication was ineffective and of ongoing anxiety, but he did not receive Abilify before he hanged himself. (Stewart Dec., ¶¶ 181-186). The problem of providers failing to document a clinical justification for declining to continue prisoners on their medications is longstanding. (*See, e.g.,* Burns' Seventh Report at 13 (Burns noting in her Seventh Report as "an area that continues to need improvement" that providers failed to document a clinical justification for not prescribing medications to 80% (21/26) of prisoners who reported medications at intake).

413. Patient LH P954608 committed suicide by hanging on March 23, 2013. He committed suicide one day after being taken off of suicide watch and transferred to MHU P-1 No mental health staff assessed Mr. LH for the entire time he was on MHU P-1. He went from close monitoring on suicide watch to no monitoring in the 22 hours before his death. Also, Mr. LH was able to hang himself in the unit used to step down

prisoners immediately after being taken off suicide watch. That unit should not have hanging points which would allow a prisoner coming off suicide watch to hang himself. (Stewart Dec., ¶¶ 187-188).

414. The danger of prisoners attempting suicide immediately after being taken off suicide watch is exacerbated by the punitive conditions that prisoners endure on suicide watch in the MHU. Prisoners regularly are stripped of all clothing, and given only a safety smock. They are locked down in their cells 24 hours a day. Their daily human contact can be limited to cell side interactions with mental health staff. These punitive, isolating conditions do not help a patient become less suicidal. And they raise the risk that in future these same prisoners will hide their true suicidal feelings because they do not want to be exposed to such conditions. (Stewart Dec., ¶ 189).

415. The 4th Avenue Jail is the main intake facility for MCJ. It is critical that intake facilities like 4th Avenue have in place adequate systems to monitor prisoners at risk of self-harm. An adequate suicide prevention system must include observation cells that allow an officer or staff to see any and all prisoners in those cells. Direct visual observation is the standard of care for suicidal prisoners: video observation can be an adjunct, but never a substitute, for direct observation. (Stewart Dec., ¶ 192).

416. At 4th Avenue, prisoners identified at risk of self-harm are placed in safe cells until they are either cleared by mental health staff, or can be transported to a hospital or the MHU for additional monitoring. The window in these cells is too high for an officer or staff of average height to be able to observe all areas of the safe cell. 9Stewart Dec., ¶ 193).

Deficiencies with Mental Health Care for Prisoners in Isolated Confinement

417. There is an enduring population of seriously mentally ill prisoners at the Jail who are housed in isolated confinement. (Mar. 5, 2014 TT at 68:21-25 (Burns); Mar. 6, 2014 TT at 67:17-18 (Stewart)).

418. Locked down in single cells for 22-24 hours a day, they enjoy little human contact, have little or no access to programming, and extremely limited or no access to recreation. Prisoners subject to isolated confinement are those housed in the acute units of the MHU (P-3 and P-5-B), those single-celled in Estrella's closed custody and segregation units, where there is also no programming in three towers; and those in the Special Management Unit (SMU). (Mar. 5, 2014 TT at 29:20-30:22, 68:21-25, 72:23-73:15 (Burns); Stewart Dec. ¶ 194).

419. The SMU conditions are particularly stark. Prisoners there are secured behind two security doors. They are locked down at least 22 hours daily. The only times they are daily released from their cells is for one hour of exercise alone in a walled area next to their cells, and an hour to use a small anteroom equipped with a phone. The configuration of the unit makes it exceptionally difficult for them to communicate with fellow prisoners. A number of seriously mentally ill men are housed there, in filthy and hazardous conditions—their cells strewn with trash and rotting food. (Mar. 5, 2014 TT at 25:24-26:7, 67:8-25, 72:25-73:9 (Burns); Mar. 6, 2014 TT at 66:19-68:5 (Stewart); Stewart Dec., ¶ 195).

420. In one important respect, the isolated confinement conditions in the MHU's acute units are actually more restrictive than those in the SMU. While SMU prisoners are let out of their cells to exercise and to use the small anteroom adjoining their cells, prisoners housed in the MHU's acute units are locked down 24 hours a day. They do not leave their cells for recreation, and have no regular access to a dayroom or common area. (Mar. 6, 2014 TT at 41:14-20 (Stewart)). Defendants have designated these units to house the most acutely mentally ill prisoners in the Jail. (Findings, *supra,* ¶¶ 311, 328).

421. The Jail does not exclude seriously mentally ill prisoners from isolated confinement housing units. The decision to place prisoners in these units is made by Maricopa County Sheriff's Office (MCSO) staff as part of the classification process.

Mental health staff is not involved in that decision. (Feb. 25, 2014 TT at 156:9-13 (Beverly), 179:8-17 (Espinoza)).

422. Mentally ill prisoners are prone to have their mental illness deteriorate and decompensate under isolated conditions at the Jail. This deterioration often takes the form of acting out and otherwise behaving in ways that constitute rule infractions. Their illness lowers their tolerance for the pain and stress of isolated confinement (in an environment that they should never have been placed in, in the first place). In short, they grow more ill. (Mar. 5, 2014 TT at 68:3-23, 72:18-22 (Burns); Mar. 6, 2014 TT at 68:5-10 (Stewart); Stewart Dec., ¶ 196).

423. Dr. Burns testified as follows:

> [P]eople with serious mental illness have problems dealing with the conditions of confinement within places where they are locked down 23 of 24 hours a day. It often exacerbates or makes worse their illness so that they experience an increase in symptoms or it doesn't help them get better. The medications are often less effective because of the conditions of being there and we believe it's due to the social isolation as well as the lack of any sort of meaningful activity or stimulation so that there's some degree of like sensory deprivation as well as just not having contact with other people. Some people don't get worse but they don't get better, and other people who haven't previously had a serious mental illness diagnosed sometimes have problems . . . when they are confined in that way.

(Mar 5, 2014 TT at 68:6-20 (Burns)).

424. There is a well-settled body of scientific literature that establishes the risk of harm posed to seriously mentally ill persons who are placed in isolated confinement. The recognition of this risk has led professional mental health organizations to call for the prohibition of the placement of the seriously mentally ill in such units or, if it is absolutely necessary (and only as a last resort) to confine them there, but under strict limits and with significant amounts of out-of-cell time and enhanced access to care. For example, the American Psychiatric Association ("APA") has issued a Position Statement on Segregation of Prisoners with Mental Illness stating:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.[29]

(Stewart Dec., ¶ 197).

425. The Jail disregards a substantial risk of harm to seriously mentally ill prisoners by placing them in isolated confinement, and providing them with inadequate care while housed there. The harsh conditions in the Jail's lockdown units, particularly in the SMU and Estrella closed custody, require enhanced care and monitoring of the seriously mentally ill, but at the Jail, they receive less effective care in these units than in the general population. (Mar. 5, 2014 TT at 25:24-26:17, 68:3-23, 72:9-74:2 (Burns); Stewart Dec., ¶ 199; Ex. D, Stewart Dec. at 39-46 (patients BV, MM, HS, GG, AA, DC, and ML).

426. The problems with inadequate care in the lockdown units are well-known and longstanding. In her Ninth Report, Dr. Burns wrote, "In general, inmates in SMU housing are locked down and isolated during their jail stay. In some instances, this may be for periods of months or years. The long-term effects of segregation of all inmates, and particularly SMI inmates, are well known." (Stewart Dec., ¶173, citing Burns' Ninth Report at 17). Dr. Burns found that there were a number of prisoners who had bounced between the SMU and MHU multiple times, and recommended that these cases be discussed collectively. She concluded, "[T]here is a general consensus that permitting SMU inmates access to out-of-cell opportunities for structured therapeutic activities would be beneficial for all involved (more normal and therapeutic interactions for the inmates, fewer crises and adverse incidents, easier management from a custody perspective with less call for use of force, cell extractions, etc.). The SMU environment

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[29] AM. PSYCH. ASSOC., POSITION STATEMENTS: SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2012), *available at* http://www.psychiatry.org/advocacy--newsroom/position-statements.

1 is harsh for the inmates as well as the people [who] work there." (*Id.*, citing Burns'
2 Ninth Report at 18).
3 427. Dr. Burns also reviewed several cases of prisoners who had received
4 inadequate care while housed in Estrella segregation, and those whose closed custody
5 (CC) status interfered with adequate care. These included patient MM, a well- known
6 SMI patient who was discharged from the MHU in spite of her ongoing psychosis and
7 "sent to closed custody where access to care [is] highly problematic." (Burns' Ninth
8 Report at App. 31). Dr. Burns concluded, "[c]losed custody classification presents
9 problems with inmate movement/participation in treatment in P6 [The MHU's female
10 step-down unit] and there are no structured therapeutic activities in segregation at
11 Estrella." (*Id*). Dr. Burns also reviewed the record of patient CG, who was discharged
12 from the MHU to Estrella and not seen at appropriate intervals though she was
13 considered for MHU readmission. (*Id.*) Dr. Burns found, "[d]ocumentation indicates
14 inmate was seen at cell front due to 'safety concerns' but further investigation indicates
15 she is *seen at cell front due to detention staff enforcement of security protocol for*
16 *closed custody inmates*—not because mental health staff are concerned about their
17 safety." (*Id.* (emphasis in original)).
18 428. Dr. Burns found eight months later that "[i]ssues associated with isolation
19 in the 4th Avenue Special Management Unit (SMU) housing persist." (Burns' Tenth
20 Report at 8). Dr. Burns noted that, beyond visits by mental health staff on rounds and
21 by provider for medication management, SMU prisoners "receive little treatment other
22 than medication unless transferred to the MHU." (*Id.*)
23 429. Defendants fail to ensure that adequate mental health care is provided to
24 prisoners with mental illness in the Jail's segregation units, particularly in the SMU.
25 This population has a very high level of acuity. For many of these prisoners,
26 psychosocial rehabilitation services are an essential element of care, especially in the
27 harsh conditions of isolation. Yet there are no psychosocial services provided for SMU
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prisoners, none provided to the prisoners housed in the MHU's acute units, and no programming for almost all of the women housed in Estrella's lockdown units. (Mar. 5, 2014 TT at 26:8-17, 72:9-13, 73:8-15 (Burns); Stewart Dec., ¶¶ 204, 205).

430. Defendants fail to ensure that isolation unit prisoners are seen at appropriate intervals by mental health staff. They are denied timely access to a psychiatrist and they shuttle between the MHU and the lockdown units without any consideration by qualified staff as to the effect of lockdown housing conditions on their mental health. They remain housed in the SMU and Estrella segregation despite being actively psychotic and non-compliant with treatment. (Mar. 5, 2014 TT at 24:24-26:17, 72:11-22, 73:8-74:2 (Burns); Stewart Dec., ¶ 206).

431. Dr. Burns testified as follows with regard to the care of seriously mentally ill female prisoners housed in Estrella closed custody units:

> Q: Is it your opinion that the care—could you offer your opinion as to whether the care provided to the women in the Estrella closed custody units is adequate?
> A: It's inadequate, and there are many instances where people cycle back and forth to the Mental Health Unit because they can't be taken care of adequately within the segregation unit.
> Q: So they get discharged from the Mental Health Unit, they go to Estrella and they deteriorate as a result of inadequate care?
> A: Or they weren't fully reconstituted before they got sent back there under the same conditions that precipitated the [MHU] admission in the first place.

(Mar. 5, 2014 TT at 73:16-74:2 (Burns)).

432. For SMU prisoners, virtually all of their contacts with mental health staff occur at their cell doors: the staff member remains in an anteroom adjoining the prisoners' cell, while the prisoner remains behind a locked cell door. Some mentally ill SMU prisoners share the anteroom with another SMU prisoner in an adjacent cell. (Feb. 25, 2014 TT at 165:17-166:1 (Beverly)).

433. Defendants deny prisoners in the SMU access to a private treatment room for a mental health assessment, while allowing prisoners to receive medical services in

private treatment rooms. (Feb. 25, 2014 TT at 154:25-155:11 (Beverly); Mar. 6, 2014 TT at 74:20-75:2 (Stewart)).

434. From a health care perspective, there is no valid reason why prisoners should be allowed private medical care visits, while they are denied private mental health assessments. (Mar. 6, 2014 TT at 75:6-9 (Stewart)). Prisons and jails around the country ensure that all health care visits, including those for mental health services, occur in a secured, confidential setting. (Mar 6, 2014 TT at 35:2-36:1, 75:10-15 (Stewart)).

435. There is also no valid penological justification for this practice. A prisoner undergoing a mental health assessment presents no greater a security risk than when the same prisoner is receiving medical services. While there may be some prisoners who need additional security to ensure safety for prisoners and staff, that is appropriately handled on an individual basis. (Mar. 5 2014 TT at 40:23-41:13, 42:11-17 (Vail); Pl Ex. 62 (Declaration of Eldon Vail) ¶ 62).

436. Requiring prisoners to speak with mental health staff at their cell front compromises their mental health care. (Mar. 6, 2014 TT at 34:1-15 (Stewart); Stewart Dec., ¶¶ 93, 207). Dr. Burns testified as follows with regard to cell-side contacts in the MHU:

> [C]ell side contacts really are not therapy because they are in full hearing range of every other inmate on the unit as well as correctional staff and whoever else happens to be passing by. So it's an assessment of a type because you can get some sense about a person's behavior, their physical characteristics, whether they are taking care of themselves, et cetera, but it really doesn't begin the therapeutic process.

(Mar. 5, 2014 TT at 22:23-23:4 (Burns))

437. These cell side contacts also undermine the therapeutic alliance between patient and mental health staff, since "one of the foundations is that the relationship and the information that's shared is confidential between the provider and the person." (Mar. 5, 2014 TT at 23:16-19 (Burns)).

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438. Finally, the cell side contacts hamper prisoners' willingness to speak openly about their mental health problems, thus compromising care. As Plaintiffs' corrections expert Eldon Vail testified: "At least for the male population the [correctional] environment is pretty hypermasculine and you don't want to appear weak. You don't want to talk to someone about your personal mental health problems in a place where other inmates or officers can overhear that." (Mar. 5, 2014 TT at 41:23-42:2 (Vail)).

439. Defendants have failed to institute adequate safeguards to ensure that seriously mentally ill prisoners are excluded from isolated confinement housing when clinically contraindicated. (Stewart Dec., ¶ 208).

440. The only regular monitoring of mentally ill prisoners by mental health staff are segregation rounds that appear from the records to be brief, empty contacts that rarely, if ever, result in referral to providers, transfer out of isolated confinement housing, or enhanced care. (Mar. 5, 2014 TT at 74:19-76:7 (Burns), Pl Ex. 105 (Excerpt of Medical Record of Prisoner GG); Mar. 6, 2014 TT at 72:13-73:6, 129:11-130:25 (Stewart); Stewart Dec., ¶ 210).

441. Corrections expert Eldon Vail testified on behalf of Plaintiffs in this case. Mr. Vail worked for 35 years in the Washington State Department of Corrections (DOC), culminating in his serving as Secretary of the Department. (Mar. 5, 2014 TT at 4:19-5:7 (Vail)). During his career with the Department, Mr. Vail worked extensively on programs that served the state's mentally ill prisons population. As warden of the McNeil Island Corrections Center, Mr. Vail oversaw the creation of a secure mental health unit, staffed with specially trained custodial personnel, that produced verified reductions in symptoms, behavioral problems, and rules infractions among its residents. (*Id.* at 5:10-7:2 (Vail)). Mr. Vail also served as the commissioner of the Washington State Criminal Justice Commission, which was responsible for developing operational

standards for all law enforcement and corrections officers throughout the state. (*Id.* at 8:9-23 (Vail)). This included all use of force policies. (*Id.)*

442. Mr. Vail testified that during his tenure as the DOC's deputy secretary, the department created a secure mental health unit that served as an alternative placement for mentally ill prisoner who otherwise would have been housed in a regular segregation unit. One of the goals of this unit was to ensure that mentally ill prisoners "receive[d] individualized care and treatment and work to get them out of the cells on an individual basis as much as was absolutely possible." (Mar 5, 2014 TT at 7:24-8:1 (Vail)).

443. During his three-decade career in correctional mental health, Dr. Stewart has extensive experience designing, administering, and evaluating high security mental health programs, as well as assessing the provision of mental health care to prisoners in in locked housing units and facilities. He serves as the court-appointed expert responsible for assessing mental health care in a number of facilities in the California prison system, including at Pelican Bay State Prison, which houses the highest security classification prisoners in the state prison system. He was retained by the State of New Mexico to design a mental health unit for high security patients, and, most recently, was appointed to a multi-disciplinary team to inspect segregated housing units throughout the Federal Bureau of Prisons (BOP). (Mar. 6, 2014 TT at 64:3-66:18 (Stewart)).

444. Dr. Burns likewise has extensive experience administering and assessing mental health services to prisoners in high security settings, both as the court-appointed expert responsible for monitoring mental health care for high security prisoners in California and Massachusetts, and in her current capacity as chief psychiatrist for the Ohio DOC. (Mar. 5, 2014 TT at 69:13-70:8, 71:9-11 (Burns)).

445. Both Dr. Burns and Dr. Stewart testified about the steps corrections systems have taken to mitigate the effect of isolated confinement on prisoners' mental health. Corrections systems around the country have categorically excluded mentally

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ill prisoners from isolated confinement housing. New York and Colorado have recently banned the practice, and, like Washington State, have opened secured psychiatric units for prisoners who otherwise would be placed in high security housing. (Mar. 6, 2014 TT at 69:6-12 (Stewart)).

446. The California DOC likewise created Psychiatry Security Units (PSUs), specialized units for mentally ill prisoners who otherwise would be housed in the state's segregation units. (Mar. 6, 2014 TT at 64:14-23(Stewart)). The PSUs provide intensive psychiatric services, including a minimum of ten hours of structured out-of-cell services weekly, as well as unstructured out-of-cell recreation time. (Mar. 6, 2014 TT at 69:19-70:5 (Stewart)).

447. In Ohio and Massachusetts, prisoners in segregation housing also are offered a minimum of ten hours of structured out of cell therapeutic activity under conditions that ensure their safety and security as well as that of staff. (Mar. 5, 2014 TT at 69:13-70:8 (Burns)). They also receive unstructured out of cell time, during which they can communicate with fellow prisoners—in the California prison system, they receive at least ten hours of unstructured time weekly. (Mar. 5, 2014 TT at 71:12-24 (Burns); Mar. 6, 2014 TT at 69:24-70:1 (Stewart)).

448. The prisoners in these correctional systems have the highest custody ratings, comparable to the prisoners housed in the SMU. (Mar. 5, 2014 TT at 71:2-8 (Burns); Mar. 6, 2014 TT at 69:16-20 (Stewart)).

449. A program of structured and unstructured out-of-cell time has been shown to be effective in reducing the symptoms and suffering of prisoners in isolated confinement. As Dr. Burns testified:

> But hand in hand with treatment, studies have shown, and Massachusetts in particular has shown, that there has been fewer uses of force, fewer inmate injuries, fewer staff injuries, fewer instances where inmates attempt suicide. They haven't had to go out to hospitals because they have inflicted—they have cut on themselves or they have tried to hang themselves. So the statistics are

> pretty impressive that it's helped people manage better and deal with those conditions.

(Mar. 5, 2014 TT at 70:17-25 (Burns)).

450. Defendants have failed to adopt any of the safeguards other corrections systems have developed to address the effects of isolated confinement on mentally ill prisoners. They do not categorically exclude seriously mentally ill from isolated confinement housing. They have not developed specialized mental health segregation units designed to house mentally ill prisoners who hold closed custody status. They do not provide enhanced structured psychosocial rehabilitative programs and unstructured out of cell time. They do not adequately monitor isolated confinement prisoners to determine if they are clinically deteriorating due to their living conditions. Their failure to take these steps, or otherwise adequately address the effect of isolated confinement on prisoners' mental health, has created an unnecessary risk of harm to prisoners in the Jail. Placing seriously mentally ill prisoners in the Jail's isolated confinement units, particularly the SMU, poses an especially serious risk of harm. The combination of toxic conditions and inadequate care endangers these patients' health and safety. (Mar. 5, 2014 TT at 72:9-22, 73:8-74:2 (Burns); Stewart Dec., ¶ 211).

Deficiencies in Use of Force Practices on Mentally Ill Prisoners

451. In December 2011, prisoner Ernest "Marty" Atencio died after a violent altercation with at least 7 deputies in the intake area of the Fourth Avenue Jail. During the altercation Mr. Atencio was Tased. Before he was Tased, Mr. Atencio appeared to be passively resisting staff, with his hands at his sides. (Stewart Dec. ¶ 142).

452. Mr. Atencio's family reported he had a history of mental illness, at least one of his arresting officers believed he was suffering from mental illness at the time of his arrest, and he reported at intake that he had a history of suicidal thoughts. (*Id.*)

453. Following Mr. Atencio's death, Lambert King, M.D., the Court's medical expert, made a series of recommendations to address the problems he found in

reviewing Mr. Atencio's treatment and death. Dr. King found that the Maricopa County Sheriff's Office (MCSO) Use of Force policy "contains no provision for prior consultation with mental health professionals whose advice, experience and capabilities might be utilized in an effort to avoid use of force on a mentally disturbed detainee who is passively resisting control." (Stewart Dec., ¶143, citing Burns' Ninth Report at 21; Mar 5, 2014 TT at 30:8-13 (Vail)).

454. Dr. King's recommendation is in line with accepted correctional mental health practice. (Mar. 5, 2014 TT at 63:23-64:7 (Burns); Stewart Dec., ¶ 144; Mar. 6, 2014 TT at 62:16-22 (Stewart)).

455. Mental health staff has specialized training that makes them especially equipped to de-escalate a potential confrontation with detention staff so that force need not be used. (Stewart Dec., ¶¶ 144-145). As Dr. Burns testified:

> [I]n a situation in which the use of force is contemplated, it's not an emergency response but it's a planned use of force, many times if mental health staff can be consulted they can talk to the inmate and get them to deescalate, calm down, so that force doesn't end up having to be utilized at all, or they can also help the officers understand if the inmate is in such a state that they are not even hearing orders much less able to comply with them about better ways to, perhaps, tell the inmate what it is that is expected of him, or, perhaps, even postpone the thing if it can wait until a time when the person can even take medication that's voluntarily handed to them and calm down so that the use of force can be avoided.

(Mar. 5, 2014 TT at 63:10-22 (Burns))

456. It is also a sound correctional practice to require mental health staff to attempt an intervention prior to a planned use of force with mentally ill prisoners and to document those efforts to intervene in the reports that follow a use of force incident. (Mar. 5, 2014 TT at 18:13-24 (Vail); Eldon Vail Dec., ¶ 41).

457. The use of force on a seriously mentally ill prisoner is traumatic, and can damage the relationship between mental health staff and the patient, and reinforce the patient's delusions that he is being victimized by his jailers and treatment staff. (Stewart Dec., ¶ 144; Eldon Vail Dec., ¶¶ 34, 40, 46). It can also result in significant

physical trauma. (Findings, *infra*, ¶ 467 (discussing Taser use on pregnant prisoner); Pl Ex 62 ¶¶ 34, 40).

458. For these reasons, jail and prison systems around the country require, when feasible, the involvement of mental health staff in planned use of force incidents involving mental health caseload prisoners. (Mar. 5, 2014 TT at 30:19-25 (Vail); Eldon Vail Dec., ¶¶ 42-44; Stewart Dec., ¶ 144). They also require that health care staff's involvement be documented in the prisoner's medical record. (Mar. 5, 2014 TT at 64:8-14 (Burns)).

459. It is particularly important that mental health staff is involved in planned use of force incidents that are initiated by a mental health order. For example, if a provider orders a patient to be moved for additional treatment (such as therapeutic restraints) and the patient refuses orders to be handcuffed so he can be moved, force may be used. In these circumstances, the provider should be consulted because in some cases the provider might decide to change or delay treatment, or provide treatment without moving the patient. The provider then would also have the opportunity to assess the patient, and assist in de-escalating the incident so that force does not have to be used. At the Jail, providers never have the chance to make this clinical decision, since they are not notified when their patients are refusing to comply. As a result, these prisoners are exposed to an unnecessary risk of harm. (Mar. 6, 2014 TT at 63:8-22 (Stewart); Stewart Dec., ¶ 146).

460. The MCSO use of force policy is designated as one of 11 critical polices deemed by the Department to be the most important. (Feb. 25, 2014 TT at 109:5-16 (Seibert)). Each year, all officers must renew their training on the use of force policy to ensure they comply with it. (Feb. 25, 2014 TT at 109:8-10 (Seibert)).

461. MCSO also has a use of force committee that reviews all force incidents to ensure compliance with the policy. (Feb. 25, 2014 TT at 113:9-13, 121:10-18 (Seibert)). The committee determines if a use of force was appropriate, or if remedial

actions, including more training, are necessary, based on whether the policy was adhered to. (*Id.*).

462. The MCSO policy on use of force makes no reference to a mental health intervention in a planned use of force event. There is no policy requiring that mental health staff be notified when a mental health caseload prisoner is potentially subject to a planned use of force. (Pl Ex. 64 (Maricopa County Sheriff's Office Policy CP-1 "Use of Force"); Mar. 5, 2014 TT at 20:1-9 (Vail); Stewart Dec., ¶ 147).

463. The absence of such a requirement in a planned use of force event creates an unreasonable risk that seriously mentally ill prisoners will be subject to unnecessary harm. (Mar. 5, 2014 TT at 21:22-22:6 (Vail); Eldon Vail Dec., ¶ 33).

464. Defendants fail to ensure that mental health staff are consulted and involved in planned use of force incidents, even when there is ample time for them to be notified and to attempt to de-escalate the situation. Prisoners may be so impaired by reason of their mental illness that they cannot readily comply with an officer's orders. In these circumstances, having mental health staff involved is essential to assess the condition of the patient, and to intervene in an effort to de-escalate the situation. (Mar. 5, 2014 TT at 19:4-25 (Vail); Stewart Dec., ¶ 148).

465. There have been a number of incidents of planned uses of force against mentally ill prisoners in the MHU where there was ample time for mental health staff to respond to the scene and attempt to de-escalate the situation, but where there is no evidence that this intervention occurred. (Mar. 5, 2014 TT at 23:10-24:1 (Vail)). As a result, seriously mentally ill prisoners were subjected to force that may have been avoidable had mental health staff intervened. (Mar. 5, 2014 TT at 22:4-6 (Vail); Eldon Vail Dec., ¶¶ 35-40; Stewart Dec., ¶¶ 148-152).

466. Many planned uses of force begin in the MHU with health care staff contacting security staff and asking for their assistance to carry out a medical order. The mere fact that these incidents occur in the MHU, where mental health staff are present,

or that mental health staff contact security staff asking for help, does not ensure that mental health staff are involved in an effort to de-escalate before force is used. (Mar. 5, 2014 TT at 21:8-21 (Vail)). Mr. Vail testified as follows in this regard:

> A: It's not unusual for a mental health to ask security staff to, for example, move an inmate who is resisting a move. But at that point it's a handoff of the mental health staff to the security staff. What I am saying is common practice and what is most effective in avoiding use of force is once the security staff are in charge that if it's not an emergent issue, if it's not someone's imminent danger, then they need to develop a plan about what they are going to do to accomplish whatever it is they have been asked to do. And routinely and regularly, part of that plan should be a structured attempt by mental health staff to de-escalate the situation.
> Q: Would it be fair to say that when you talk about the involvement of mental health staff you are not talking about a handoff by mental health staff to corrections but rather more something in the nature of a collaboration?
> A: Yeah. I'm not talking about notice to the security staff that something needs to happen. I'm talking about once that notice occurs and as part of the procedure of the security staff they rope mental health staff back into the process to see if there's a way to de-escalate the situation.
> Q: It's at that point that mental health staff needs to be involved, actively involved?
> A: That's where it matters. That's where it can make a difference.
>
> (Mar. 5, 2014 TT at 64:2-25 (Vail)).

467. In one incident, a mentally ill detainee, Ms. DM, refused to leave her classroom cell. She was not posing a danger to herself or others, and was throwing crayons and paper out of her locked cage. She was behind a locked door, and there was ample time to involve mental health staff. Mental health staff was not consulted or involved in an effort to de-escalate the situation and gain her compliance. She was Tased. Had mental health staff been consulted, they could have notified detention staff that Ms. DM was pregnant. The MCSO policy on Tasers states, "o[]fficers who are aware a female subject is pregnant shall not use the TASER device unless deadly force would be justified due to the danger created by the secondary impact or the possibility of muscle contractions leading to premature birth." This is clearly a case where deadly force would not remotely have been appropriate. (Mar. 5, 2014 TT at 25:3-28:11

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(Vail); Eldon Vail Dec., ¶ 36). The use of a Taser on a pregnant woman creates an unreasonable risk to her health, and of inducing premature labor. (Mar. 6, 2014 TT at 62:23-63:3 (Stewart); Stewart Dec., ¶ 150).

Deficiencies in the Disciplinary Process for Mentally Ill Prisoners

468. Defendants do not ensure that mental health staff is consulted when a mentally ill prisoner is charged with a disciplinary infraction. As a result, mentally ill prisoners are at an unreasonable risk of being punished for behavior that is the product of mental illness, and of being placed in isolated confinement even when such conditions may exacerbate their illness. (Mar. 5, 2014 TT at 31:1-14 (Vail); Eldon Vail Dec., ¶¶ 52, 53, 57, 61).

469. In her remedial plan, Dr. Burns recommended that the Jail revise its policies to ensure that mental health staff has meaningful input into the disciplinary process for prisoners on the mental health caseload. (Remedial Plan at 11-12).

470. Defendants have not complied with Dr. Burns' recommendation. The MCSO disciplinary policies do not require that mental health staff be notified or involved in disciplinary proceeding against mentally ill prisoners. (Mar. 5, 2014 TT at 31:15-32:6 (Vail); Eldon Vail Dec., ¶ 50). CHS policy J-A-08 (Communication on Patients' Health Needs) requires the following: "Health care professionals advise Detention staff of patients' special needs that can affect housing, work, program assignments, disciplinary measures, and admissions to and transfers from institutions." (Pl Ex. 118 (CHS Policy J-A-08 "Communication on Patients' Health Needs")). This language does not require an "internal process that reviews . . . whether the mental health input is actually considered by security staff in their deliberations around disciplinary infractions," as Dr. Burns recommended. (Mar. 5, 2014 TT at 31:11-32:6 (Vail); Eldon Vail Dec., ¶ 49).

471. There is no place on the Disciplinary Action Report (DAR) form to indicate whether or not a consultation with mental health took place. Instead, in some reports there is a notation in the margin showing that a consultation did occur. (Eldon Vail Dec., ¶ 52).

472. Mental health staff is rarely consulted as part of a disciplinary hearing. Likewise, the disciplinary sanction proposed is rarely set aside or mitigated as a result of mental health input. (Mar. 5, 2014 TT at 109:21-110:1 (Burns); Eldon Vail Dec., ¶ 53).

473. If there were a consult between mental health staff and the disciplinary officer, that would be documented on the DAR, even if no action was taken as a result of the consult. (Feb. 25, 2014 TT at 124:9-23 (Seibert)).

474. Of the 440 DARs involving mentally ill prisoners from January-August, 2013, only 51 (12%) had any documentation suggesting that mental health staff had been consulted, and in only 14 cases (3%) was the disciplinary proceeding set aside due to the prisoners' mental illness. (Mar. 5, 2014 TT at 32:24-33:5 (Vail)).

475. Hearing officers who handle disciplinary hearings receive from CHS a list of all prisoners designated seriously mentally ill (SMI), the highest of three categories used on the Jail's mental health roster. (Feb. 25, 2014 TT at 123:11-13 (Seibert)).

476. Receipt of that list does not ensure that officers contact mental health staff for every mentally ill prisoner facing a disciplinary charge, evidenced by the fact that 389 of the 440 records last year had no documented consultation between the hearing officer and mental health staff. (Mar. 5, 2014 TT at 37:3-24 (Vail)).

477. Mr. Vail concluded based on his review there were over 100 cases where he as a correctional administrator would want additional information on the prisoners' mental health as part of the hearing process before reaching a disposition. (Mar. 5, 2014 TT at 33:6-14 (Vail)).

478. These include a prisoner who refused to leave disciplinary segregation after his disciplinary time had ended, and was given 15 more days in disciplinary segregation; a prisoner given 30 days in disciplinary segregation for masturbating in his cell and laughing when told by the officer to cover himself up; and a prisoner who covered his cell windows, defecated and urinated on a paper and shoved it under his cell door, and was forcibly extracted from his cell, and given 30 disciplinary segregation and 30 days full restriction. In each of these examples, the prisoner was found guilty without the benefit of a documented mental health consultation that may have shown the behavior was solely a result of their mental illness. (Mar. 5, 2014 TT at 33:18-35:1, 35:22-7 (Vail); Eldon Vail Dec., ¶ 57).

479. There is no coherent system to track what is occurring in hearings for all mentally ill prisoners in the Jail who are charged with infractions. The lack of a structured system articulated in policy and followed in practice creates an unnecessary risk of harm to mentally ill prisoners. (Eldon Vail Dec., ¶ 53).

480. A sanction regularly and routinely applied to mentally ill inmates found guilty by an MCSO hearing officer is isolated confinement in a disciplinary segregation unit. (Mar. 5, 2014 TT at 35:6-12 (Vail); Eldon Vail Dec., ¶ 54).

481. Placing seriously mentally ill prisoners in long-term isolated housing as a result of disciplinary sanctions can create an unreasonable risk of their decompensating. (Findings, *infra*, ¶¶ 417-50; Stewart Dec., ¶¶ 196, 197).

482. Mentally ill prisoners are sentenced to segregation for up to thirty days after being found guilty of relatively minor behavior by MCSO hearing officers. One mentally inmate was found guilty because an American flag sticker had been removed from the wall of his cell. His sanctions were thirty days disciplinary segregation, thirty days of full restriction and seven days of nutra loaf meals. Another inmate, found guilty of the same behavior, was sanctioned to seven days of disciplinary segregation, full restriction and nutra loaf. In neither of these cases was there any indication there

was a consultation with mental health staff before assigning these severe sanctions. (Eldon Vail Dec., ¶¶ 54-56).

Deficiencies in Specialized Staff Training Regarding Mentally Ill Prisoners

483. In January 2011, Dr. Burns recommended that Defendants "review [their] detention officer training curriculum to revise or supplement it for officers assigned to posts dealing with mentally ill inmates;" namely, those assigned to intake, the MHU, and the Jail's segregation/isolation units. (Burns' Fifth Report (Doc. 1934) at 25).

484. Dr. Burns was prompted to make the recommendations after a series of incidents where MHU prisoners who were already in restraints were assaulted by detention staff. (*Id.*) Dr. Burns recommended that Defendants model their additional training on Crisis Intervention Team (CIT) training, which in other jurisdictions had reduced the incidence of arrests, assaults, and injuries to both law enforcement officers and the mentally ill. Dr. Burns concluded, "[R]eviewing and supplementing the curriculum for detention staff assigned to posts dealing with inmates most at risk and at highest risk of serious mental health problems would likely yield similar beneficial results in the jail." (*Id.*)

485. Four months later, Dr. Burns reviewed general mental health materials related to the training provided to all detention officers, and found them appropriate, but continued to recommended a review of the curriculum "in order to revise or supplement it as necessary for officers assigned to posts dealing with inmates most at risk and at highest risk of serious mental health problems (booking/receiving area, MHU and all segregation unit posts). (Burns' Sixth Report (Doc. 1966) at 8).

486. In her Seventh Report, Dr. Burns noted that all MHU officers had received an additional 30 minutes of training "on the topics of trauma, stress, and compassion fatigue/self care." (Burns' Seventh Report at 16). Dr. Burns did not

identify additional training for segregation unit or intake staff, and has not reported on any additional training since issuing her Seventh Report.

487. The training offered to MCSO detention staff to prepare them to work with mentally ill prisoners is not effective. There is inadequate specialized training for those assigned to work in mental health units. This training is a critical element of successfully managing the mentally ill in a confinement setting. (Eldon Vail Dec., ¶ 21).

488. MCSO detention employees receive annual training for a two and a half hour class called Handling the Seriously Mentally Ill. This training appears to be a broad overview of subject matter related to working with the mentally ill that is targeted for a class of people who do not regularly or routinely work with that population. It is not of sufficient length or depth to prepare correctional officers to work with the mentally ill on a daily basis. (Mar. 5, 2014 TT at 39:17-22 (Vail); Eldon Vail Dec., ¶ 67).

489. The deposition transcripts of some detention officers involved in the events leading to the death of Ernest Atencio support this conclusion. In each deposition when asked about the training they received regarding mentally ill inmates, detention officers were unable to recall what they were taught. (Mar. 5, 2014 TT at 40:7-14 (Vail); Eldon Vail Dec., ¶ 68).

490. Given the officers' lack of retention of the information presented in the training materials, as reflected in the depositions, the training they received was not effectively reinforced in the workplace. (Eldon Vail Dec., ¶ 69).

491. Officers assigned to work in the MHU must be carefully selected as having the capacity to work with this population, and then they must be extensively trained on an ongoing basis in conjunction with mental health staff to emphasize that it takes both disciplines working together to successfully manage the mentally ill. The evident lack of specialized training contributes to an unreasonable risk of seriously

mentally ill prisoners being punished for behavior that is the product of mental illness, and planned use of force incidents occurring without the involvement of mental health staff. (Eldon Vail Dec., ¶ 70).

Deficiencies in the Jails' Quality Improvement Program:

492. An adequate quality improvement (QI) system is an essential element of a correctional mental health care system, because it leads to identifying and correcting systemic problems with mental health care. CHS does have a QI system that studies various aspects of health services at the Jail. There are deficiencies in the existing QI system, however. CHS has developed action plans after critical incidents such as suicides. But it has not produced QI studies showing whether those critical action items have been implemented. It has also failed to study essential elements of its health care system that the court-appointed experts have repeatedly criticized, such as admission and discharge criteria for the MHU, and access to hospitalization (Mar. 5, 2014 TT at 77:8-14 (Burns); Stewart Dec., ¶¶ 214-15).

493. Defendants have also failed to follow-up on substandard QI results. For example, Defendants' QI studies showed over a two year period through 2012 that only 50% of prisoners who reported at intake that they had been previously treated for mentally illness had signed releases in their medical records. (Mar. 5, 2014 TT at 11:16-21 (Burns)). Absent a release, the Jail cannot collect these patients' previous treatment records, which can be vital to understanding a patient's treatment history. (Mar. 5, 2014 TT at 10:11-24 (Burns); Stewart Dec., ¶¶ 52, 55, 56). Dr. Burns testified that if she were presented with similar results in her current position as the chief psychiatrist for the Ohio Department of Rehabilitation and Correction, she would order additional QI studies to get baseline data and identify the scope and causes of the problem. (Mar. 5, 2014 TT at 12:3-9 (Burns)). Dr. Burns has not seen any subsequent QI studies from CHS measuring releases. (Mar. 5, 2014 TT at 12:10-13 (Burns)).

494. Though a QI system may not be independently constitutionally required, an effective and comprehensive QI system at the Jail is a means of ensuring compliance with constitutionally-required remedies ordered by the Court. It requires CHS and MCSO staff to test their compliance with these remedies, and to develop corrective actions when they fail to comply.

Findings of Fact with Regard to Remedies

495. In 2009, the Court appointed Lambert King, M.D., and Kathryn Burns, M.D., MPH as its medical and mental health experts, respectively. (Doc. 1769). Dr. Burns served as Defendants' expert during the 2008 termination hearing in this case. The parties stipulated to Dr. Burns' and Dr. King's appointment by the Court. (*Id.*) Dr. King and Dr. Burns were charged with "evaluat[ing] the delivery of medical and mental health care at Maricopa County Jails, identify[ing] deficiencies, assist[ing] Correctional Health Services ("CHS") in developing a corrective action plan, if needed, to achieve compliance with the Second Amended Judgment." (Doc. 1763 at 4). Both Dr. Burns and Dr. King have extensive experience both as court-appointed health care experts, and as correctional health administrators in both prison and jail systems. (Findings, *supra*, ¶¶ 6, 7).

496. Since their appointment, Dr. Burns and Dr. King have filed 21 reports with the Court on Defendants' compliance with the Second and Third Amended Judgments. Each of their reports has included recommendations to Defendants to bring them into compliance with the Court's Judgment. (*See* Doc. 2177-14-24 (Burns reports), 2177-31-41 (King reports)).

497. Following its receipt of the experts' fourth reports, the Court in 2010 found that "sixteen months after the Second Amended Judgment was entered—significant areas of failure to comply with the Second Amended Judgment's medical and mental health requirements remain." (Doc. 1880 at 3). The Court went on to state:

> Because correction of constitutional violations has not proceeded expeditiously to date, the parties and counsel will be ordered to meet and confer to develop a proposed procedure for achieving and demonstrating Defendants' complete compliance with the Second Amended Judgment. . . . The Court's purpose is to set a procedure by which full compliance with the Second Amended Judgment is either confirmed or specific implementing remedies are ordered and complied with by the end of this calendar year.

(*Id.* at 4).

498. Following the Court's Order, the parties agreed that Dr. Burns and Dr. King would propose remedies in those areas where Defendants had failed to comply with the Second Amended Judgment and, "[i]f neither party objects to a consultant's/experts findings and remedial recommendations, the Court will adopt those findings and that remedy as an order of the Court." (Doc. 1895 at 16).

499. Pursuant to the parties' agreement, both Dr. King and Dr. Burns submitted remedial plans. (*See, e.g.*, Remedial Plan). Both parties offered their feedback on the proposed plans before they were finalized by the experts, who considered the parties' comments and revised their plans accordingly. (Mar. 5, 2014 TT 4:21-5:7 (Burns)). Since those plans were issued, Defendants have never raised any objection to implementing their specific terms. (Mar. 5, 2014 TT at 5:17-20 (Burns)).

500. Defendants have failed to implement Dr. King's and Dr. Burns' recommended remedies, or otherwise address longstanding problems the experts have identified in their reports. *See, e.g.*, Findings, *supra, passim*. They have failed to do so despite the fact that both Dr. Burns and Dr. King have documented time and again over the past five years the same life-threatening deficiencies plaguing the Jail's health care system in their combined 21 reports to the Court. None of the deficiencies identified in this decision are new—they are in many cases the same enduring problems that the Court first took evidence of at the 2008 termination hearing.

501. It has been over five-and-a-half years since the Court entered the Second Amended Judgment. It has been almost four years since the Court admonished

Defendants for their failure to comply. Since then, Defendants have not devised and implemented corrective actions to bring them into compliance, despite having the ready assistance of Dr. Burns and Dr. King.

502. During that time, prisoners have unnecessarily suffered due to systemic deficiencies in the Jail's health care system. Defendants have had ample time and opportunity to correct these problems, including by fully implementing the recommendations made by Dr. Burns and Dr. King over three years ago. They have failed to do so. There is no just reason why Plaintiffs should continue to be exposed to an excessive risk of harm, to suffer from untreated chronic and acute illness, to endure untreated psychosis, to be housed in conditions that predictably exacerbate their mental illness, to wither and deteriorate, and some to die, due to Defendants' ongoing disobedience of the Court's Judgment.

II. CONCLUSIONS OF LAW

A. THE LEGAL STANDARD FOR TERMINATION OF PROSPECTIVE RELIEF

503. The Prison Litigation Reform Act (PLRA) generally requires the termination of all prospective relief in cases concerning prison conditions after two years from the court's grant or approval of relief. 18 U.S.C. § 3626(b)(1)(A)(i). The PLRA provides, however, that the prospective relief "shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the Federal right, extends no further than necessary to correct the violation of the Federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation." 18 U.S.C. § 3626(b)(3).

504. The Court must assess the circumstances at the jails at the time termination is sought. *Pierce v. County of Orange,* 526 F.3d 1190, 1205 (9th Cir. 2008) (citing *Gilmore v. California*, 220 F.3d 987, 1010 (9th Cir. 2000)).

505. As the Court has stated previously, the relevant time period for assessing "current and ongoing violations," is presumed to be one year. *Graves v. Arpaio*, No. CV–77–0479–PHX–NVW, 2008 WL 4699770, at *3 (D. Ariz. Oct. 22, 2008).

506. District court judges have wide discretion in determining whether older evidence should be considered for the purposes of determining whether there is a "current and ongoing violation." The Court may consider evidence older than one year if it is sufficiently relevant. *See Graves v. Arpaio*, No. CV-77-0479-PHX-NVW, 2008 WL 4699770, 2008 WL 2008966, at *5 (D. Ariz. Apr. 25, 2008) (indicating that evidence from the 2003-2004 termination hearing could be offered in the August 12, 2008 hearing so long as the offering party proved its "relevance and admissibility"); *Brown v. Plata*, 131 S. Ct. 1910, 1924-25 n.2 (2011) (relying on evidence of 2006 suicide rate in California prisons to sustain order of three-judge district panel to reduce California prison population because the suicide data had been updated in 2010 by special master report showing that "data is not showing improvement in suicide prevention"); *United States v. Virgin Islands*, 884 F. Supp. 2d 399, 418 (D.V.I. 2012) ("The Court acknowledges that, while too dated to stand on its own, the factual findings incorporated in the 2006 Order provide an extensive and well-documented account of the conditions at [the prison] at that time and, if properly updated by current findings, could serve as an appropriate factual foundation.").

507. Evidence may be sufficiently relevant if it "systematically match[es] or track[s]" the older findings in a manner that creates a "coherent and comprehensive picture of the current conditions" at the facility. *United*

States v. Virgin Islands, 884 F. Supp. 2d at 419. Evidence older than one year may also be sufficiently relevant if it concerns a violation that has occurred repeatedly. *See, e.g.*, *Clark v. California*, 739 F. Supp. 2d 1168, 1189 (N.D. Cal. 2010) (adopting findings of expert witness report for purposes of finding continuing and ongoing violations in which most expert's evidence was from 1-1.5 years old, but some allegations of rape went back to 2006); *see also Graves*, 2008 WL 4699770, at *43-45 (relying extensively on 2003 dietician's report for nutritional inadequacy claims); *Skinner v. Lampert*, 457 F. Supp. 2d 1269, 1280 (D. Wyo. 2006) (relying on evidence of inmate-on-inmate assaults that occurred two years before the termination hearing to sustain finding of current and ongoing violations).

508. Consistent with § 3626(b)(3), "a district court cannot terminate or refuse to grant prospective relief necessary to correct a current and ongoing violation, so long as the relief is tailored to the constitutional minimum." *Gilmore, 220 F.3d* at 1008.

509. Even if the existing relief qualifies for termination under the need-narrowness-intrusiveness standard of § 3626(b)(2), if the Court finds current and ongoing violations, it must modify the relief to satisfy the PLRA. *Gilmore*, 220 F.3d at 1008. ("[if] the existing relief qualifies for termination under § 3626(b)(2), but there is a current and ongoing violation, the district court will have to modify the relief to meet the Act's standards"); *see also Ruiz v. United States,* 243 F.3d 941, 950-51 (5th Cir. 2001) (recognizing that prospective relief under the PLRA remains subject to modification); *Castillo v. Cameron County,* 238 F.3d 339, 357 (5th Cir. 2001) (remanding and instructing that if current and ongoing violations exist, plaintiffs are entitled to seek a modification of existing relief); *Laaman v. Warden,* 238 F.3d 14, 19 (1st Cir. 2001) (concluding that a "district court may modify the

decree so that it both addresses the current violation and conforms to the statutory requirements" of being "no further than necessary").

510. Thus, even if a court were to find that defendants have fully complied with the provisions of the consent decree, they would not be entitled to termination of all relief, if current and ongoing constitutional violations persist. *Gilmore,* 220 F.3d at 1008.

511. If the evidence establishes a current and ongoing violation of federal rights at the Jail, the court is obliged to provide a remedy, whether that violation affects few prisoners or many. "A district court is bound to maintain or modify any form of relief necessary to correct a current and ongoing violation of a federal right, so long as that relief is limited to enforcing the constitutional minimum." *Gilmore,* 220 F.3d at 1000; *see also id.* at 1007-08.

512. If the evidence establishes a current and ongoing violation at only one of the Jail's facilities, or with respect only to a subset of the plaintiff class, the court is still required to grant a remedy for that violation. *See Gomez v. Vernon,* 255 F.3d 1118, 1130-31 (9th Cir. 2001) (approving relief to individual class members as consistent with the PLRA's requirement that injunctive relief be "narrowly drawn"); *Benjamin v. Fraser,* 343 F.3d 35, 56 (2d Cir. 2003) (admonishing the district court for failing to make facility-by-facility findings, stating that "considering facilities in the aggregate was problematic: that some inmates are subjected to sub-constitutional conditions is not erased by the fact that others are not"). *See also Balla v. Idaho Bd. of Corr., No. CV81-1165-S-EJL,* 2005 WL 2403817 at *9 & n.1 (D. Idaho Sept. 26, 2005) (denying the termination motion and preserving certain remedies to only four units of the prison, where the existing decree covered nine units of the prison, but evidence showed constitutional violations at only four units).

513. The party moving for termination bears the burden of proving that the existing prospective relief qualifies for termination under § 3626(b)(2), and that there

is no current and ongoing constitutional violation in the areas covered by the decree. *Gilmore,* 220 F.3d at 1008 (holding that the district court erred when it "placed the burden on plaintiffs to establish a current and ongoing violation of a Federal right rather than requiring the CDC, which had moved to terminate the decree, to prove its compliance with inmates' right of access to the courts").

514. Given defendants' burden of proving their compliance with constitutional mandates, conditions shown to exist in the past are presumed to continue, absent evidence to the contrary. *Thompson v. City of Los Angeles,* 885 F.2d 1439, 1449 (9th Cir. 1989) (holding that jail conditions found to exist in 1978 would be presumed to continue in 1985 in the absence of evidence to the contrary; noting that "it is a bedrock common law principle that in certain situations, once a condition has been proven to exist, it is presumed in the absence of proof to the contrary that the condition has remained unchanged").

B. THE LEGAL STANDARD REGARDING REMEDY

515. In fashioning an appropriate remedy, the Court must exercise restraint, using the least possible power adequate to the remediation of constitutional violations. *See Missouri v. Jenkins*, 495 U.S. 33, 51 (1990).

516. However, the Court is not required to restrict its powers to those means that have proven inadequate, or that show no promise of being effective. Rather, "federal courts are not reduced to issuing injunctions against state officers and hoping for compliance. Once issued, an injunction must be enforced." *Hutto v. Finney*, 437 U.S. 678, 690 (1979).

517. In *Hutto*, the Supreme Court held that where prison officials had been given "repeated opportunities" to remedy unconstitutional conditions, the district court was justified in "entering a comprehensive order to insure against the risk of inadequate compliance." *Id.* at 687. The Court concluded, "[i]n fashioning a

remedy, the District Court had ample authority to go beyond earlier orders and to address each element contributing to the violation." *Id.*

518. Following *Hutto*, the Ninth Circuit has held that district courts "may order relief that the Constitution would not of its own force initially require if such relief is necessary to remedy a constitutional violation," and in fashioning such relief, courts may take into account "[a] defendant's history of noncompliance with prior court orders." *Toussaint v. McCarthy*, 801 F.2d 1080, 1087 (9th Cir. 1986), *abrogated in part on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995).

519. In *Plata v. Schwarzenegger*, No C01-1351, 2005 WL 2932253 (N.D. Cal. Oct. 3, 2005), the district court ordered a receivership to take control of medical services in the California Department of Corrections and Rehabilitation (CDCR) three years after entering a consent decree, based on the defendants' ongoing non-compliance with the remedy. The district court found that the defendants had disregarded the court-appointed experts "specific achievable measures and . . . innumerable informal suggestions as to how defendants can move forward," and had disregarded the district court's "request[] that defendants present it with a series of proposed orders so that the Court could help empower them to overcome some of their bureaucratic hurdles on their own." *Id.* at *26. The court concluded that contempt sanctions and further remedial orders would be inadequate to compel compliance, and took the "drastic measure" of taking medical services out of the hands of state officials and appointing a receiver to administer the state prison medical care system. *Id.* at *31.

520. More recently, in *Brown v. Plata*, the Supreme Court upheld a population limit ordered by a three-judge court in the face of ongoing noncompliance with earlier remedies regarding medical and mental health services in the California Department of Corrections. The Court concluded by stating that the district court would "retain[] the authority, and the responsibility to make further amendments to the existing order or any modified decree it may enter" because "'[t]he power of a court of equity to modify

a decree of injunctive relief is long-established, broad, and flexible.'" 131 S.Ct. at 1946-47 (quoting *State Ass'n for Retarded Children, Inc. v. Carey*, 706 F.2d 956, 967 (2d Cir. 1983)).

521. Two years after the Supreme Court's affirmance, the three-judge court in *Brown* found that California's plans for population reduction were going to fall short of the constitutional requirements and ordered specific actions, explaining that such a remedy was appropriate because defendants "continually equivocated" and "consistently sought to delay the implementation of [the population reduction] Order." *Coleman v. Brown*, 952 F. Supp. 2d 901, 926, 936 (E.D. Cal. 2013).

C. THE LEGAL STANDARD FOR FINDING A CURRENT AND ONGOING CONSTITUTIONAL VIOLATION IN CONDITIONS OF CONFINEMENT

522. Pretrial detainees are protected from punishment by the Due Process provisions of the Fifth and Fourteenth Amendments. *Bell v. Wolfish,* 441 U.S. 520, 535-36 & n.16 (1979); *Pierce,* 526 F.3d at 1205 (noting that the standard for pretrial detainees under the due process clause "differs significantly from the standard relevant for convicted prisoners").

523. This standard differs significantly from the standard for convicted prisoners, who may be subject to punishment that does not violate the Eighth Amendment's ban on cruel and unusual punishment. *Graves*, 2008 WL 46699770, at *4 (citing *Pierce*, 526 F.2d at 1205).

524. The "more protective Fourteenth Amendment standard . . . requires the government to do more than provide minimal necessities." *Graves*, 2008 WL 46699770, at *4 (quoting *Jones v. Blanas*, 393 F.3d 918, 931 (9th Cir. 2004). "[T]he Eighth Amendment provides too little protection for those whom the state cannot punish." *Id.* (quoting *Hydrick v. Hunter*, 500 F.3d 978, 994 (9th Cir. 2007)).

525. Nevertheless, courts evaluating the claims of pretrial detainees under the Fourteenth Amendment have used the Eighth Amendment's analytical framework of deliberate indifference to analyze these claims. *See Simmons v. Navajo County, Ariz.*, 609 F.3d 1011, 1017 (9th Cir. 2010) (quoting *Clouthier v. County of Contra Costa*, 591 F.3d 1232, 1244 (9th Cir. 2010)); *Redman v. County of San Diego,* 942 F.2d 1435, 1441 n.7 (9th Cir. 1991); *Burdette v. Butte County,* 121 Fed. App'x 701, 702 n.1 (9th Cir. 2005).

526. Because due process rights are at least as great as Eighth Amendment protections afforded convicted prisoners, the guarantees of the Eighth Amendment provide pretrial detainees a "minimum standard of care for determining their rights." *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983); *Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1120 (9th Cir. 2003) (quoting *City of Revere*, 463 U.S. at 244); *Campbell v. Cawthron*, 623 F.2d 503, 505 (8th Cir. 1980).

527. Prisoners prove an Eighth Amendment violation when they show that they were incarcerated under conditions posing a substantial risk of serious harm to their health or safety, and officials acted with deliberate indifference; that is, with conscious disregard for that risk. *Farmer v. Brennan,* 511 U.S. 825, 834, 839-840 (1994).

528. Evidence of objective risk of serious injury may establish defendants' knowledge of such risks. *See Farmer,* 511 U.S. at 846 n.9 ("If, for example, the evidence before a district court establishes that an inmate faces an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness, any more than prison officials who state during the litigation that they will not take reasonable measures to abate an intolerable risk of which they are aware could claim to be subjectively blameless for purposes of the Eighth Amendment, and in deciding whether an inmate has established a continuing constitutional violation a district court may take such developments into account.").

529. Unsafe conditions that "pose an unreasonable risk of serious damage to [a prisoner's] future health" may violate the Eighth Amendment even if the damage has not yet occurred and may not affect every prisoner exposed to the conditions. *Helling v. McKinney,* 509 U.S. 25, 33 (1993).

530. Prison officials may not "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year" merely because no harm has yet occurred, and a "remedy for unsafe conditions need not await a tragic event." *Helling,* 509 U.S. at 33; *accord Farmer,* 511 U.S. at 845.[30]

531. Conditions that have "a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth, or exercise" violate the Eighth Amendment in combination, even if the conditions separately would not be unconstitutional. *Wilson v. Seiter,* 501 U.S. 294, 304 (1991); *Wright v. Rushen*, 642 F.2d 1129, 1133 (9th Cir. 1981) (courts must consider the effect of each condition in its context, "especially when the ill effects of particular conditions are exacerbated by other related conditions").

532. Corrections officials' treatment of prisoners violates the Eighth Amendment, whether or not it causes physical injury, when it "'offend[s]

[30] Defendants cite *Hadix v. Caruso*, 465 F. Supp. 2d 776 (W.D. Mich. 2006), for the proposition that low death rates and the existence of a Quality Improvement Program indicate a successful health care delivery system. Doc. 2261 at 12. "Logically," Defendants argue, "low death rates such as that in Maricopa County jails, indicate a successful health care delivery system." Doc. 2261 at 13. *Hadix* does not support this position. In fact, it categorically rejected an analogous argument that, because most prisoners were not sick, the defendants were fulfilling their duties. *Hadix*, 465 F. Supp. 2d at 792 ("Defendants may wish that by simply pointing out an obvious red herring—that most people are not sick most of the time regardless of their medical treatment—they may wish away their involvement in this suit. It is not so. Wake up Dorothy. You are not in Kansas anymore."). Nothing in *Hadix* states that the defendants failed to create a Quality Improvement Program, but it found the defendants in contempt of an earlier decree and found ongoing constitutional violations. *Id.* at 802-03.

contemporary concepts of decency, human dignity, and precepts of civilization which we profess to possess.'" *Hope v. Pelzer*, 536 U.S. 730, 737 & n.6, 738 (2002) (quoting *Gates v. Collier,* 501 F.2d 1291, 1306 (5th Cir. 1974)) (holding that prison officials violated the Eighth Amendment by handcuffing a prisoner to a hitching post, thereby knowingly subjecting him to a substantial risk of physical harm, unnecessary pain, prolonged thirst, taunting, and deprivation of bathroom breaks that created a risk of discomfort and humiliation; and finding that such treatment "violated the 'basic concept underlying the Eighth Amendment, which is nothing less than the dignity of man'"); *Hutto,* 437 U.S. at 685 (recognizing that the Eighth Amendment's ban on cruel and unusual punishments extends beyond physical punishment, and proscribes penalties that "transgress today's 'broad and idealistic concepts of dignity, civilized standards, humanity, and decency'" (quoting *Estelle v. Gamble,* 429 U.S. 97, 102 (1976))).

533. "'The degree of civilization in a society can be judged by entering its prisons.'" *Hadix v. Caruso,* 461 F. Supp. 2d 574, 599 (W.D. Mich. 2006) (quoting *Respectfully Quoted: A Dictionary of Quotations,* no. 1527 (Suzy Platt, ed., Library of Congress 1989) (attributing quote to Feodor Mikhailovich Dostoyevsky)).

534. Underlying the Eighth Amendment is the fundamental premise that prisoners are not to be treated as less than human beings. *Spain v. Procunier,* 600 F.2d 189, 200 (9th Cir. 1979) (citing *Furman v. Georgia,* 408 U.S. 238, 271-73 (1972) (Brennan, J. concurring)) ("The [Eighth] [A]mendment is phrased in general terms rather than specific ones so that while the underlying principle remains constant in its essentials, the precise standards by which we measure compliance with it do not.")

535. To evaluate the constitutionality of pretrial detention that is not alleged to violate any express constitutional guarantee, a district court must determine if conditions of confinement amount to punishment, whether they are reasonably

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related to a legitimate purpose, and whether they are excessive in relation to that purpose. *Graves*, 2008 WL 46699770, at *6. *See Bell,* 441 U.S. at 535, 539-40; *Pierce, 526 F.3d at 1205.*

536. The "determination of whether a particular condition or restriction imposes punishment in the constitutional sense will generally turn on whether an alternate purpose is reasonably assignable." *Pierce,* 526 F.3d at 1205 (citing *Bell,* 441 U.S. at 539).

537. "If a restriction is not reasonably related to a legitimate governmental objective - if it is arbitrary or purposeless - the Court may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon pretrial detainees." *Bell,* 441 U.S. at 538-39; *Pierce,* 526 F.3d at 1205 (noting that the Court may "infer a given restriction's punitive status 'from the nature of the restriction'" (quoting *Valdez v. Rosenbaum,* 302 F.3d 1039, 1045 (9th Cir. 2002))).

538. Legitimate non-punitive governmental objectives include ensuring the detainee's appearance at trial, maintaining security and order, and operating the detention facility in a manageable fashion. *Bell,* 441 U.S. at 540 n.23.

539. Even when limitations on a pretrial detainee's freedom are rationally related to a legitimate non-punitive government purpose, they will amount to punishment if "they appear excessive in relation to that purpose." *Bell,* 441 U.S. at 561.

540. "[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being." *DeShaney v. Winnebago County Dep't of Social Servs.,* 489 U.S. 189, 199-200 (1989). When the State fails to provide an individual's basic human needs - food, clothing shelter, medical care and reasonable safety – "it transgresses the substantive limits on state action set by the Due Process Clause." *Id.* at 200.

541. Retribution and deterrence are not legitimate governmental objectives. *Demery v. Arpaio*, 378 F.3d 1020, 1030-31 (9th Cir. 2004). The cost or inconvenience of providing adequate conditions is not a defense to the imposition of punishment. *See Spain*, 600 F.2d at 199-200.

D. THE LEGAL STANDARD FOR CORRECTIONAL MEDICAL AND MENTAL HEALTH CARE CLAIMS

542. Pretrial detainees have a right to adequate care for serious medical and mental health needs. *See Hoptowit v. Ray*, 682 F.2d 1237, 1252-53 (9th Cir. 1982) (affirming the lower court's decision that prison medical services were so deficient that they constituted a violation of the Eighth Amendment, when the prison lacked, among other things, basic mental health services and routine medical examinations). The Ninth Circuit has held:

> The Eighth Amendment requires that prison officials provide a system of ready access to adequate medical care. Prison officials show deliberate indifference to serious medical needs if prisoners are unable to make their medical problems known to the medical staff. Access to the medical staff has no meaning if the medical staff is not competent to deal with the prisoners' problems. The medical staff must be competent to examine prisoners and diagnose illnesses. It must be able to treat medical problems or to refer prisoners to others who can. Such referrals may be to other physicians within the prison, or to physicians or facilities outside the prison if there is reasonably speedy access to these other physicians or facilities. In keeping with these requirements, the prison must provide an adequate system for responding to emergencies. If outside facilities are too remote or too inaccessible to handle emergencies promptly and adequately, then the prison must provide adequate facilities and staff to handle emergencies within the prison. These requirements apply to physical, dental and mental health.

Id. at 1253.

543. The Eighth Amendment prohibits deliberate indifference to prisoners' serious medical needs. *Estelle,* 429 U.S. at 103. "This is true whether the indifference

is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983." *Graves*, 2008 WL 4699770, at *8.

544. Accreditation by national organizations does not mean a facility is constitutional; courts have found facilities accredited by professional accrediting bodies to violate the Eighth Amendment. *Id.*, 2008 WL 4699770, at *25-32, *28, *33 (finding the Jail failed to provide constitutional health care despite holding NCCHC accreditation); *see Morales Feliciano v. Rosselló González,* 13 F. Supp. 2d 151, 158 (D.P.R. 1998) (noting that during the same period that the NCCHC accredited facilities in the Puerto Rico prison system, court monitors had found noncompliance on at least one essential standard at every facility accredited by the NCCHC); *Gates v. Cook,* 376 F.3d 323, 343 (5th Cir. 2004) (finding that "MDOC's assertion that it is already in compliance with ACA and NCCHC standards is incongruous with the trial court's findings, including the statement that 'the mental health care afforded the inmates on Death Row is grossly inadequate'"). NCCHC accreditation does not preclude a finding that jail conditions violated the Eighth and Fourteenth Amendment.

545. When problems in the system for delivering health care are shown, the number of prisoners affected is not determinative of the constitutional violation; instead, the emphasis is on the sufficiency of the systems themselves. *See, e.g., Williams v. Edwards,* 547 F.2d 1206, 1215-19 (5th Cir. 1977) (finding deliberate indifference with no reference to number of prisoners affected by inadequate records and out-of-date supplies); *Finney v. Arkansas Bd. of Corr.,* 505 F.2d 194, 203 (8th Cir. 1974) (finding constitutional infirmity in medical care system with no reference to the number of prisoners affected by unsatisfactory record keeping and other

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deficiencies); *cf. Woodward v. Corr. Med. Servs. of Illinois, Inc.,* 368 F.3d 917, 929 (7th Cir. 2004) ("That no one in the past committed suicide simply shows that CMS was fortunate, not that it wasn't deliberately indifferent.").

546. A prison official is deliberately indifferent if he or she "knows of and disregards an excessive risk to inmate health or safety." *Farmer,* 511 U.S. at 837. *See also Hutchinson v. United States,* 838 F.2d 390, 394 (9th Cir. 1988) (explaining that officials may be deliberately indifferent if they "deny, delay or intentionally interfere with medical treatment," or if the method by which they provide care is inadequate); *Hoptowit,* 682 F.2d at 1253 (observing that prison officials' deliberate indifference is also shown "if prisoners are unable to make their medical problems known to the medical staff"). "[T]he case law had made it clear that an official acts with deliberate indifference when he knows that an inmate is in serious need of medical care, but he fails or refuses to obtain medical treatment for the inmate." *Lancaster v. Monroe County*, 116 F.3d 1419, (11th Cir. 1997). *See also Hill v. Dekalb Reg'l Youth Det. Ctr.*, 40 F.3d 1176, 1186 (11th Cir. 1994) ("[K]nowledge of the need for medical care and intentional refusal to provide that care constitute deliberate indifference.").

547. Similarly, deliberate indifference is manifest when "prison authorities prevent an inmate from receiving recommended treatment for serious medical needs or deny access to a physician capable of evaluating the need for such treatment." *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987).

548. Circumstantial evidence may support a finding of deliberate indifference, and the very fact that a risk is obvious may allow a fact finder to conclude that prison officials knew of a substantial risk. *Farmer,* 511 U.S. at 842-43 (noting that when there is evidence of substantial risk that is "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it, then such

evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk").

549. When the entire system of health care is challenged in a class action suit, deliberate indifference "may be shown by proving repeated examples of negligent acts which disclose a pattern of conduct by the prison medical staff, or by proving there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures" that effectively deny inmates access to adequate medical care. *Ramos v. Lamm,* 639 F.2d 559, 575 (10th Cir. 1980) (citation omitted); *Cabrales v. County of Los Angeles,* 864 F.2d 1454, 1461 (9th Cir. 1988), *vacated and remanded,* 490 U.S. 1087 (1989), *reinstated,* 886 F.2d 235 (9th Cir. 1989) (concluding that mentally ill prisoners must go untreated because the limited number of psychiatric staff permitted only minutes per month with each patient); *Gibson v. County of Washoe,* 290 F.3d 1175, 1196 (9th Cir. 2002) ("When policymakers know that their medical staff members will encounter those with urgent mental health needs yet fail to provide for the identification of those needs, it is obvious that a constitutional violation could well result."); *Toussaint,* 801 F.2d 1080, 1111-13 (9th Cir. 1986); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Casey v. Lewis,* 834 F. Supp. 1477, 1543 (D. Ariz. 1993).

550. In the Ninth Circuit, the plaintiff may show a "serious medical need" by demonstrating that "failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" *Akhtar v. Mesa, 698 F.3d 1202, 1213 (9th Cir. 2012) (quoting Jett v. Penner,* 439 F3d. 1091, 1096 (9th Cir. 2006)). The plaintiff may satisfy the requirement of showing the defendant's response to the need was deliberately indifferent "by showing (a) a purposeful act or failure to respond to a prisoner's pain or possible medical need and (b) harm caused by the indifference. Indifference 'may appear when prison officials deny, delay or intentionally interfere with medical treatment, or it may be shown by the way in

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which prison physicians provide medical care.'" *Akhtar, 698 F.3d at 1213.*

551. Conditions that significantly affect a person's daily activities or cause chronic and substantial pain constitute serious medical needs, even if they are not life-threatening. *See, e.g.*, *id.* (rejecting officials' claims that prisoner had not alleged sufficiently serious medical needs when officials repeatedly ignored his disability, causing him chronic pain and humiliation); *McGuckin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992) ("[T]he presence of a medical condition that significantly affects an individual's daily activities[,] or the existence of chronic and substantial pain are examples of indications that a prisoner has a 'serious' need for medical treatment."), *overruled in part on other grounds by WMX Techs., Inc.* v. *Miller*, 104 F.3d 1133, 1136 (9th Cir. 1997); *Moreland v. Wharton*, 899 F.2d 1168, 1170 (11th Cir. 1990) (holding that the lack of medical treatment for a "significant and uncomfortable health problem" states a constitutional claim).

552. Deliberate indifference may be found even if the inadequacy in medical care does not result in the patient's physical deterioration, or the injury is not permanent. *See, e.g., Goodrich v. Clinton County Prison*, 214 Fed. App'x 105, 111 (3d Cir. 2007) (finding that bipolar inmate could show serious need for treatment based on mental suffering -- specifically feeling unstable, paranoid, and not in control of his thoughts -- as well as his formal psychiatric diagnosis); *Ellis v. Butler,* 890 F.2d 1001, 1003 (8th Cir. 1989) (concluding that the failure to provide pain medication could violate the Eighth Amendment); *H.C. v. Jarrard,* 786 F.2d 1080, 1086-87 (11th Cir. 1986) (finding that the delay in treating a detainee's injured shoulder violates the Constitution even though no permanent injury resulted).

553. Serious mental health needs are no less objectively serious than physical health needs. *Cabrales,* 864 F.2d at 1461 ("The very notion of deliberate 'indifference' connotes a regime where neglect of detainees' medical *and psychological needs* proves a constitutional violation." (emphasis added)); *Doty v.*

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County of Lassen, 37 F.3d 540, 546 (9th Cir. 1994) ("In accordance with the other courts of appeals that have examined this issue, we now hold that the requirements for mental health care are the same as those for physical health care needs." (citing *Torraco v. Maloney,* 923 F.2d 231, 234 (1st Cir. 1991); *Bowring v. Godwin,* 551 F.2d 44, 47 (4th Cir. 1977); *Smith v. Jenkins,* 919 F.2d 90, 93 (8th Cir. 1990); *Greason v. Kemp,* 891 F.2d 829, 834 (11th Cir. 1990)); *Partridge v. Two Unknown Police Officers,* 791 F.2d 1182, 1187 (5th Cir. 1986) ("A serious medical need may exist for psychological or psychiatric treatment, just as it may exist for physical ills.").

554. The failure to provide a sick call system that ensures prisoners receive required care amounts to deliberate indifference to a serious medical need. *Hoptowit*, 682 F.2d at 1252-53 ("prison officials show deliberate indifference to serious medical needs if prisoners are unable to make their medical problems known to the medical staff;" finding that paper triaging of sick call complaints without adequate examination was inadequate); *Bass by Lewis v. Wallenstein*, 769 F.2d 1173, 1184-86 (7th Cir. 1985) (finding that known deficiencies in sick call system supported a finding of deliberate indifference); *Morales Feliciano*, 13 F. Supp. 2d at 210 (explaining that the failure to provide a sick call system that ensures that prisoners receive needed care can result in constitutional violations).

555. Denial of needed medication constitutes deliberate indifference to a serious health care need. *Graves*, 2008 WL 4699770, at *32 ("Providing pretrial detainee's prescription medication without interruption is essential to constitutionally adequate medical care."). *See Sullivan v. County of Pierce,* No. 98-35399, 2000 WL 432368, at *1-2 (9th Cir. Apr. 21, 2000) (reversing and remanding for reconsideration of deliberate indifference where a detainee who needed AIDS medication did not receive that medication for at least two days); *McGuckin,* 974 F.2d at 1061 ("[T]he more serious the medical needs . . . , and the more unwarranted the defendant's actions in light of those needs, the more likely it is that a plaintiff has

established 'deliberate indifference' on the part of the defendant."); *Broughton v. Cutter Labs.,* 622 F.2d 458, 460 (9th Cir. 1980) (finding that a delay of only six days in treating hepatitis may constitute deliberate indifference); *Thomas v. Kippermann,* 846 F.2d 1009, 1010-11 (5th Cir. 1989) (noting that the plaintiff's claim was viable "if he told jail authorities that he needed his prescribed medication . . . and if they did not have him examined or otherwise adequately respond to his requests"); *McNally v. Prison Health Servs.,* 28 F. Supp. 2d 671, 674 (D. Maine 1998) (finding that the plaintiff sufficiently alleged deliberate indifference when he told prison health services of his HIV status and strict medication regimen, but was refused medication during his three days in custody).

556. Failure to put in place a sufficiently organized system for medication delivery constitutes deliberate indifference. *See, e.g., Williams,* 547 F.2d at 1216-17 (finding deliberate indifference where there were, among other things: a disorganized pharmacy, out-of-date supplies, no system for updating supplies, outdated drugs, inadequate records of medications dispensed, and prisoners not receiving their prescribed medications); *Newman v. Stet of Alabama*, 503 F.2d 1320, 1331 (5th Cir. 1974) ("Courts will not tolerate serious shortages in medication."); *Graves*, 2008 WL 4699770, at *32 ¶¶ 233-44 ("Correctional Health Services does not consistently ensure that all pretrial detainees actually receive all prescribed medications as ordered").

557. "[P]rescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluation, is an unacceptable method of treatment." *Balla,* 595 F. Supp. at 1577 ("Wholesale prescription of psychotropic drugs is an unacceptable means of dealing with psychiatric disorders . . . . The prescription of these drugs cannot supplant the necessity of psychiatric counseling.").

558. Medical staff must be competent—capable of examining prisoners and

diagnosing illnesses. *Graves*, 2008 WL 4699770, at *8 (quoting *Hoptowit,* 682 F.2d at 1253 ("Access to the medical staff has no meaning if the medical staff is not competent to deal with the prisoners' problems.")); *Cabrales*, 864 F.2d at 1461 (quoting *Hoptowit*, 682 F.2d at 1253).

559. The Jail's health care staff must be able to either treat medical and mental health issues identified or refer prisoners to providers, either within the facility or outside the prison if accessible in a timely manner. *Hoptowit,* 682 F.2d at 1253; *see Toussaint,* 801 F.2d at 1111-12 (when "unqualified personnel regularly engage in medical practice," it may reflect deliberate indifference to inmates' medical needs).

560. The number of medical staff must be adequate to provide adequate services. *Casey,* 834 F. Supp. at 1548 ("Because of inadequate numbers of staff, the existing staff cannot adequately treat inmates and their constitutional rights are violated."); *Graves*, 2008 WL 4699770, at *30 ¶ 200 (finding that lack of an effective medical records system prevents Correctional Health Services from determining whether it has enough qualified mental health staff to treat patients adequately).

561. The necessity of competent and qualified staff applies equally to medical and mental health staff; patients with either medical or mental health needs must be seen by staff qualified to treat them based on their conditions and acuity. *See Cabrales*, 864 F.2d at 1461 (9th Cir. 1988) (insufficient mental health staff to conduct meaningful assessments amounted to deliberate indifference); *Coleman v. Wilson*, 912 F. Supp. at 1298 & n. 10, 1306-07 (stating adequate prison mental health requires "employment of a sufficient number of trained mental health professionals;" holding requirement of "timely, responsible, and adequate care provided by qualified (and appropriately licensed staff," was "not materially different from the constitutional requirement of ready access to competent medical staff"); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1989) (use of unqualified lower level

staff with inadequate involvement and supervision by a psychiatrist supported constitutional claims).

562. Prisoners whose medical or mental health needs call for a physician's attention must receive it. *Hoptowit*, 682 F.2d at 1253 ("medical staff must . . . be able to treat medical problems or to refer prisoners to others who can"); *Mata v. Saiz*, 427 F.3d 745, 756-58 (10th Cir. 2005) (reversing summary judgment in favor of a LPN who failed to consult with a provider about a patient suffering from severe chest pain); *Petricjko v. Kurtz*, 117 F. Supp. 2d 467, 473 (E.D. Pa. 2000) (denial of access to a physician for two weeks stated a deliberate indifference claim); *Rodrigue v. Morehouse Det. Ctr.*, No. 09-985, 2012 WL 4483438, at *6 (W.D. La. Sept. 28, 2012) (entering judgment against LPN who failed to fulfill function as gatekeeper in the case of a patient with persistent severe abdominal pain).

563. Nursing and mental health staff therefore must refer patients to physicians and psychiatrists when medically indicated. *Hoptowit*, 682 F. 2d at 1253 ("Access to the medical staff has no meaning if the medical staff is not competent to deal with the prisoners' problems."); *Mandel v. Doe*, 888 F.2d 783, 789-90 (11th Cir. 1989) (damages awarded where physician's assistant failed to diagnose a broken hip, refused to order an x-ray, and failed to refer the patient to a physician); *Toussaint*, 810 F.2d at 111-12 (medical technical assistants and registered nurses cannot lawfully render services beyond their qualifications); *Madrid*, 889 F. Supp. at 1258 (N.D. Cal. 1995) (noting inadequate supervision of medical assistants in deciding whether a patient could see a physician); *Balla*, 595 F. Supp. at 1575-76 (medical personnel were performing functions that should have been performed by a doctor). *See also Garner v. Winn Corr. Ctr.*, No. 1:08-CV-01977, 2011 WL 2011502, at *5 (W.D. La. May 18, 2011) ("Simply sending an LPN to look at Garner and make a 'diagnosis' was not providing Garner with medical care.")

564. Reliance on "physician substitutes" results in having medical personnel

make decisions and perform services beyond what they are qualified and trained to perform. *Ramos v. Lamm*, 639 F.2d 559, 576 (10th Cir. 1981). Nor can "standing orders" substitute for adequate access to an on-site physician. *Id*.

565. The Jail's intake health care screening process must likewise ensure timely access to a physician or psychiatrist for those patients in need of a physician's care. *Gibson*, 290 F.23d at 1189 (holing policy of delaying intake screening for prisoners who were uncooperative or combative stated a deliberate indifference claim, since some of these prisoners would need immediate psychiatric care or medication); *Natale v. Camden County Corr. Facility*, 318 F.3d 575, 583 (3d Cir. 2003) (jail policy of seeing all prisoners within 72 hours of admission, but making no provision for prisoners with more immediate needs supported a deliberate indifference claim). The screening process must also ensure that prisoners receive all necessary diagnostic tests necessary to treat their chronic conditions and other diseases. *See Tillery v. Owens*, 719 F. Supp. 1256, 1308 (W.D. Pa. 1989) (deliberate indifference could be found "when x-rays are not ordered for new inmates with histories of heart or chest disease" and when laboratory testing for diabetic inmates is "not timely accomplished"), *aff'd*, 907 F.2d 418 (3d Cir. 1990).

566. The Constitution requires that prisons maintain a "systematic program" to screen and evaluate inmates in order to identify and treat those needing mental health treatment. *Coleman v. Wilson*, 912 F. Supp. at 1298 (citing *Balla*, 595 F. Supp. at 1577). *See also Pugh v. Locke*, 406 F. Supp. 318, 333 (M.D. Ala. 1976) (requiring that inmates in need of mental health services be identified). The need for a proactive mental health evaluation system is necessary in part because inmates who are severely mentally ill are not capable of initiating the communication and making their needs known to staff. *Madrid*, 889 F. Supp. at 1257; *Coleman v. Wilson*, 912 F. Supp. at 1305.

567. "[A] basic program for the identification, treatment and supervision of

inmates with suicidal tendencies is a necessary component of any mental health treatment program." *Balla*, 595 F. Supp. at 1577; *accord Coleman v. Wilson*, 912 F. Supp. at 1298 n.10 (citing *Balla*, 595 F. Supp. at 1577); *see also Collins v. Schoonfield*, 344 F. Supp. 257, 277 (D. Md. 1972) (noting that "adequate suicide prevention techniques" are constitutionally required); *Boncher ex rel. Boncher v. Brown County*, 272 F.3d 484, 486 (7th Cir. 2001) ("Jail managers who decided to take no precautions against the possibility of inmate suicide—to have no policy, for example no suicide-watch option—would be guilty of deliberate indifference in the relevant sense . . . ." (citations omitted)); *Simmons v. Philadelphia*, 947 F.2d 1042, 1064-65, 1072-75 (3d Cir. 1991) (finding deliberate indifference where there was no suicide-prevention training for officers, and the jail failed to adopt reasonable suicide-prevention measures appropriate for detainees exhibiting symptoms indicative of suicide risk).

568. Medical and custodial staff must timely refer symptomatic mentally ill prisoners to mental health staff for treatment. *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir. 1989) (physician's failure to refer a suicidal prisoner to a psychiatrist could constitute deliberate indifference). Once referred, seriously mentally ill prisoners must be timely assessed and treated by a psychiatrist. *Arnold ex rel. H.B. v. Lewis*, 803 F. Supp. 246, 253, 257 (D. Ariz. 1992) (finding deliberate indifference to a schizophrenic prisoner's serious mental health needs "when the incident reports were sent to psychiatric staff, DOC psychiatrists did not respond at all, even when the behavior reported indicated obvious psychiatric deterioration," and concluding that the prison "lacks an adequate system for behavior problems to be referred to psychiatric staff").

569. The Eighth Amendment requires that providers conduct *meaningful, hands-on* examinations. *See Cabrales*, 864 F.2d at 1461 (deliberate indifference was established where mental health staff could only spend "minutes per month" with

disturbed inmates); *Phillips v. Roane County*, 534 F.2d 531, 544 (6th Cir. 2008) (finding deliberate indifference where prisoner's provider appointment lasted a total of six minutes and where the provider "failed to even touch [the prisoner]"); *Williams v. Patel*, 104 F. Supp. 2d 984, 988 (C.D. Ill. 2000) (record supported finding of deliberate indifference where provider "diagnosed [prisoner's] eye injury from three to four feet away and merely prescribed ointment") (internal citations and quotation marks omitted).

570. The failure to provide access to specialized care required by a prisoner's medical condition amounts to deliberate indifference to a serious medical need. *Hoptowit*, 682 F.2d at 1253 ("medical staff must be competent to . . . treat medical problems or to refer prisoners to others who can. Such referrals may be to . . . physicians or facilities outside the prison"); *Farley v. Capot*, 384 Fed. App'x 685, 686-87 (9th Cir. 2010) (complaint alleging two-month delay in surgery for cancerous tumor alleged deliberate indifference to serious medical needs); *Howell v. Evans*, 922 F.2d 712, 722-23 (11th Cir. 1991) (failure to provide access to a respiratory therapist could constitute deliberate indifference), *vacated as settled*, 931 F.2d 711 (11th Cir. 1991); *Tillery*, 719 F. Supp. at 1307 (requiring services of cardiologist and dermatologist).

571. That a particular off-site medical provider cannot schedule appointments for prisoners in a timely manner does not absolve prison authorities of providing timely off-site care. "The responsibility for securing medical care for [a] prisoner's needs rests with the prison authorities, not with some outside medical facility." *Johnson v. Bowers*, 884 F.2d 1053, 1056-57 (8th Cir. 1989).

572. The Third Amended Judgment requires Defendants to transfer to a hospital all patients who cannot be adequately treated at the Jail. (Doc. 2094). A failure to timely transfer inmates to a hospital for medical or mental health treatment when jail staff cannot adequately diagnose or treat a serious condition amounts to

deliberate indifference. *Hoptowit*, 682 F.2d at 1253 ("Such referrals may be to other physicians within the prison, or to physicians or facilities outside the prison if there is reasonably speedy access to these other physicians or facilities"); *Kaminsky v. Rosenblum*, 929 F.2d 922, 927 (2d Cir. 1991) (failure to act on recommendation for immediate hospitalization); *Miltier v. Bourne*, 896 F.2d 848, 853 (4th Cir. 1990) (failure to transfer to a cardiology unit); *Washington v. Dugger*, 860 F.2d 1018, 1021 (11th Cir. 1988) (failure to return patient to VA hospital for treatment of Agent Orange exposure); *West v. Keve*, 571 F.2d 158, 162 (3d Cir. 1978) (reversing dismissal where prison refused to transfer inmate to hospital to get surgery that prison was not equipped to perform); *Pierce*, 487 F. Supp. at 642 (delay in transferring inmates who had been committed to mental hospitals formed part of constitutional violation; court ordered prison to establish policies for "transferring patients with delirium tremens promptly to appropriate facilities"); *Barnes v. Gov't of Virgin Islands*, 415 F. Supp. 1218, 1233, 1235 (D.V.I. 1976) (requiring intake procedures comprehensive enough to identify individuals who required hospitalization; finding "prisoners with special medical problems which cannot adequately be handled on a regular basis should be transferred to a facility which is equipped to treat these problems").

573. Transferring seriously mentally ill prisoners to psychiatric facilities for brief hospital stays, and then providing them with inadequate care on their return, amounts to deliberate indifference. In *Arnold ex rel. H.B. v. Lewis*, the court held Arizona Department of Corrections officials liable for failing to timely transfer to the Arizona State Hospital Ms. H.B., a schizophrenic inmate who could not be adequately treated at the prison. 803 F. Supp. at 257. Ms. H.B. had been repeatedly transferred to the state hospital for short stays, then moved back to the prison, where she often ended up in lockdown units, and clinically deteriorated. *Id.* at 249, 253. The court concluded, "because of her mental illness, [Ms. H.B.] needs the therapeutic

environment of a mental health treatment facility; however, such environment has not been provided by the DOC for nearly ten years." *Id.* at 256.

574. Patients under a court order to be restored to competency must also have timely access to hospital-level care. *Terry ex rel. Terry v. Hill*, 232 F. Supp. 2d 934, 944 (E.D. Ark. 2002). In *Terry*, the district court considered a challenge brought by seriously mentally ill pretrial detainees who had been ordered in their criminal cases to be transferred to the state psychiatric hospital—either for a competency evaluation or restoration—but who remained in jails around the state due to a lack of hospital bed space. *Id.* at 937-38. The district court took evidence from lay and expert witnesses that established that the local jails were not equipped to provide inpatient care, which many on the hospital waitlist required, that seriously mentally ill detainees therefore suffered with untreated illness in the state's jails, and they presented an increased risk of self-harm and of harming fellow prisoners and staff due to their acuity. *See id.* at 939-41. The district court found that the delay in transferring pretrial detainees for competency restoration or evaluation amount to punishment in violation of the standards set by the Supreme Court in *Bell v. Wolfish*. *See id.* at 943. The court concluded

> The lack of inpatient mental health treatment, combined with the long wait in confinement, transgresses the Constitution. The lengthy and indefinite periods of incarceration, without any legal adjudication of the crime charged, caused by the lack of bed space at [the state hospital] is not related to any legitimate goal, is purposeless and cannot be constitutionally inflicted upon the members of the class.

Id.

575. Though it applied the punishment standard from *Bell*, the district court further found that that the government officials' actions also showed deliberate indifference to the needs of the pretrial detainees, and that the failure to provide inpatient care to them "increases the risk that they will harm themselves or others or will suffer harm from other inmates." *Id.* at 944. The court noted that the

state had not allocated adequate funds to the state's mental health department to provide inpatient services in the local jails for detainees awaiting hospital beds, but that "limited resources cannot be considered an excuse for not maintaining the [department] according to at least minimum constitutional standards." *Id*. The court concluded, "[n]o matter who is at fault, the State of Arkansas must address the mental health needs of the class members in this case." *Id.*

576. Defendants suggest that they cannot more timely hospitalize prisoners due to restrictions under state law. Doc. 2261 at 15-16. Even if this were true, Defendants cannot rely on state law to excuse compliance with the Constitution, or with remedies premised on violations of federal law. *North Carolina Bd. Of Educ. v. Swann*, 402 U.S. 43, 45 (1971) ("state policy must give way when it operates to hinder vindications of federal constitutional guarantees"); *see Hook v. Arizona Department of Corrections*, 107 F.3d 1397, 1402-03 (9th Cir. 1997) (holding that a state law prohibiting the payment of a federal court-appointed Special Master was precluded by the Supremacy Clause where appointment of the Special Master was necessary to vindicate prisoners' constitutional rights); *Coleman v. Brown*, 952 F. Supp. at 931 (waiving sections of California Penal Code "to the extent necessary" to implement population reduction plan); *cf.* 18 U.S.C. § 3626(a)(1)(B) (permitting courts to order prospective relief requiring or permitting government officials to exceed authority under State or local law where federal law requires the relief, the relief is necessary to correct the violation, and no other relief will correct the violation).

577. Prison officials must ensure that a provider actively assesses and treats seriously mentally ill prisoners according to their clinical condition; monthly assessments by a psychiatrist without regard to the patient's acuity and living conditions amount to deliberate indifference. *See Arnold*, 803 F. Supp. at 250 (finding deliberate indifference when a seriously mentally ill prisoner on lockdown was not seen

immediately by a psychiatrist, and was only seen by a psychiatrist on a monthly basis, despite her acuity).

578. Federal and state courts have repeatedly held that holding prisoners with serious mental illness in prolonged isolated confinement violates the Eighth Amendment. *See, e.g.*, *Indiana Prot. & Advocacy Servs. Comm'n v. Comm'r*, No. 1:08-cv-01317-TWP-MJD, 2012 WL 6738517, at *23 (S.D. Ind. Dec. 31, 2012) (holding that the Indiana Department of Correction's practice of placing prisoners with serious mental illness in segregation constituted cruel and unusual treatment in violation of the Eighth Amendment); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1101-02 (W.D. Wis. 2001) (granting a preliminary injunction requiring the removal of prisoners with serious mental illness from "supermax" prison); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999) ("Conditions in TDCJ-ID's administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs' class made up of mentally-ill prisoners"), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975 (S.D. Tex. 2001); *Coleman v. Wilson*, 912 F. Supp. at 1320-21 ("defendants' present policies and practices with respect to housing of [prisoners with serious mental disorders] in administrative segregation and in segregated housing units violate the Eighth Amendment rights of class members"); *Madrid*, 889 F. Supp. at 1265-66 (holding prisoners with mental illness or those at high risk for suffering injury to mental health in "Security Housing Unit" is unconstitutional); *Casey*, 834 F. Supp. at 1549-50 (finding Eighth Amendment violation when "Despite their knowledge of the harm to seriously mentally ill inmates, ADOC routinely assigns or transfers seriously mentally ill inmates to [segregation units]"); *Arnold*, 803 F. Supp. at 254 ("prolonged lock down is inexcusable in the management of schizophrenia," and faulting Arizona DOC officials for failing to have policies delineating the "circumstances under which an inmate with mental illness can be locked down") (internal citations and quotation marks omitted); *Langley*, 715 F. Supp. at 540

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(holding that evidence of prison officials' failure to screen out from SHU "those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there" states an Eighth Amendment claim); *T.R. v. S.C. Dep't of Corr.*, C/A No. 2005-CP-40-2925 (S.C. Ct. Comm. Pleas 5th J. Cir. Jan. 8, 2014) (finding major deficiencies in the Department of Corrections' treatment of prisoners with mental illness, including solitary confinement, and ordering defendants to submit a remedial plan).

579. The United State Department of Justice has taken the position that prolonged isolated confinement of the seriously mentally ill is unconstitutional. *See* Letter from Jocelyn Samuels, Acting Assistant Att'y Gen., U.S. Dep't of Justice, Civil Rights Div. & David J. Hickton, U.S. Att'y, U.S. Att'y's Office, W.D. Penn. to Tom Corbett, Gov. of Pennsylvania, Re: Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities (Feb. 24, 2014), *available at* http://www.prisonpolicy.org/scans/DOJ_Findings_Letter_Issued_by_DOJ_2_24_2014.pdf (finding, after a system-wide investigation, that state prisons across Pennsylvania "use[] solitary confinement in ways that violate the rights of prisoners with SMI/ID," citing "conditions that are often unjustifiably harsh," and detailing a number of other Eighth Amendment violations stemming from the practice of holding prisoners with serious mental illness in solitary confinement); Letter from Thomas E. Perez, Assistant Att'y Gen., U.S. Dep't of Justice, Civil Rights Div. to Tom Corbett, Gov. of Pennsylvania, Regarding the Investigation of the State Correctional Institution at Cresson (May 31, 2013), *available at* http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf; Response of the United States of America to Defendants' Motion in Limine No.4: To Exclude the Statement of Interest 2-5, *Coleman v. Brown*, Case No. 2:90-cv-0520 LKK DAD PC, Doc. No. 4919 (E.D. Cal. Nov. 12, 2013) (summarizing the United States

government's position on the applicability of the Eighth Amendment to the placement of prisoners with serious mental illness in solitary confinement for prolonged periods of time).

580. Housing seriously mentally ill prisoners in isolated confinement with little or no meaningful therapeutic treatment amounts to deliberate indifference, even if done in a psychiatric unit. *Graves*, 2008 WL 4699770, at *31 ("Many of the pretrial detainees housed in the Lower Buckeye jail psychiatric unit are maintained in segregation lockdown with little or no meaningful therapeutic treatment, which results in needless suffering and deterioration.")

581. Conditions of confinement that expose inmates and detainees to "communicable diseases and identifiable health threats" implicate constitutional guarantees. *Wilson v. Lynaugh,* 878 F.2d 846, 849 (5th Cir. 1989); *see also Smith v. Sullivan,* 553 F.2d 373, 380 (5th Cir. 1977) (finding that allowing inmates with contagious diseases to be left untreated in the midst of other inmates violates the minimum standards for medical care); *DeGidio,* 920 F.2d at 531 (discussing prison's failure to take adequate measures to control the spread of tuberculosis and other infectious diseases).

582. The failure to screen incoming inmates for infectious diseases including tuberculosis amounts to deliberate indifference to a serious medical need. *Laureau v. Manson*, 651 F.2d 96, 109 (2d Cir. 1981) (failure to adequately screen newly admitted inmates for infectious diseases constituted a serious threat to the health of inmates "'sufficiently harmful to evidence deliberate indifference to serious medical needs'"); *Morales Feliciano*, 13 F. Supp. 2d at 210 ("The failure to screen incoming inmates for infectious diseases including tuberculosis" has been held to violate the Constitution); *Cody v. Hillard*, 599 F. Supp. 1025, 1059 (D.S.D. 1984) ("proper screening of inmates is a vital element of adequate medical services") (internal citations and quotation marks omitted); *see also Estelle*, 429 U.S. at 106 ("it is unnecessary to require evidence that

1 an infectious disease has actually spread in an overcrowded jail before issuing a
2 remedy").
3 583. Defendants argue that they cannot be found deliberately indifferent
4 regarding their tuberculosis policies since they purportedly "reflect government health
5 agency recommendations," including NCCHC guidelines. Doc. 2261 at 6. That a jail's
6 policies allegedly reflect professional guidelines does not mean that the resulting
7 treatment is constitutional. Rather, the test is whether Defendants' tuberculosis control
8 and treatment program creates an excessive risk of harm, both to prisoners who may
9 suffer from the disease, and for those who may unnecessarily become exposed to it. *See*
10 *Graves*, 2008 WL 4699770, at *25 ¶144 ("Although the NCCHC standards may be
11 helpful for a jail, the Court makes its findings based on the Eighth and Fourteenth
12 Amendments to the United States Constitution."); *see generally Farmer*, 511 U.S. 825.
13 The record in this case shows that Maricopa County has a high prevalence of
14 tuberculosis, that tuberculin skin testing at the Jail is unnecessarily delayed given the
15 risk of tuberculosis among newly admitted detainees, and that there have there have
16 been multiple cases of active tuberculosis at the Jail due to deficiencies in their TB
17 control program, exposing all prisoners to an unreasonable risk of harm. *See* Findings,
18 *supra*, ¶¶ 97-138.[31]
19 584. Opiate withdrawal is a serious medical need to which prison officials may
20 not be deliberately indifferent. *Foelker v. Outagamie County*, 394 F.3d 510, 513 (7th
21 Cir. 2005) (finding opiate withdrawal amounts to a serious medical need); *Gonzalez v.*
22 *Cecil County*, 221 F. Supp. 2d 611, 616 (D. Md. 2002) (heroin withdrawal a serious
23 medical need). Alcohol withdrawal is similarly a serious medical need. *Stefan v. Olson*,
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26 [31] Defendants rely on *Butler v. Fletcher*, 465 F.3d 340 (8th Cir. 2006) for the proposition that waiting up to 14 days before performing tuberculin skin testing is
27 constitutionally acceptable. Doc. 2261 at 6-7. However, in *Butler*, the jail at issue had not had a single case of active tuberculosis since 1999. 465 F.3d at 343. In contrast,
28 Maricopa County Jail experiences multiple active cases each year.

497 Fed. App'x 568, 577 (6th Cir. 2012); *Caiozzo v. Koreman*, 581 F.3d 63, 72 (2d Cir. 2009); *Lancaster*, 116 F.3d at 1429.

585. The Eighth Amendment requires that prisoners who are suffering from withdrawals receive medically required care. *Harper v. Lawrence County*, 592 F.3d 1227, 1237 (11th Cir. 2010) (explaining that delayed or inadequate treatment of alcohol withdrawal is "unlawful"); *Liscio v. Warren*, 901 F.2d 274, 275-77 (2d Cir. 1990) (finding deliberate indifference when staff ordered withdrawal regimen was inadequate because provider failed to examine prisoner for three days), *overruled in part on different grounds by Caiozzo*, 581 F.3d 63; *Morrison v. Washington County*, 700 F.2d 678, 686 (11th Cir. 1983) (deliberate indifference finding could be made where prison officials place or keep a chronic alcoholic in jail without any medical supervision when the defendants are aware that the alcoholic is suffering from a severe form of alcohol withdrawal); *Gonzalez*, 221 F. Supp. 2d at 617 (policy of refusing meaningful treatment for heroin withdrawal could lead to a finding of deliberate indifference).

586. Defendants cite *O'Bryan v. Saginaw County*, 437 F. Supp. 582 (E.D. Mich. 1977), to support their claim that they have never seen a jail ordered to do more than the Jail currently does to treat drug and alcohol withdrawal. (Doc. 2261). The sentence cited by Defendants merely orders the jail to develop a drug and alcohol withdrawal treatment program because none existed and gives them 30 days to develop a plan. *O'Bryan*, 437 F. Supp. at 598. The final injunctive order undermines Defendants' characterization of *O'Bryan*. It requires that

> [a]ny person . . . for whom symptoms of withdrawal from alcohol or controlled substances is observed . . . shall be . . . taken to the nearest medical center for diagnosis and prescribed treatment. If, in the opinion of the hospital's doctors, such inmate can be returned to the jail, such inmate shall be housed in the infirmary and placed under constant surveillance, and treatment shall be provided as prescribed by the hospital's physicians."

O'Bryan v. Saginaw County, 446 F. Supp. 436, 438 (E.D. Mich. 1978).

The final order also requires that "[n]arcotic addicts and alcoholics shall be housed separately from non-addicted inmates and provided special treatment as is prescribed by the jail physician or other physician." *Id.* at 439.

587. Defendants cite *Lancaster v. Monroe County* to argue that deliberate indifference exists only where a jail official is aware of but ignores dangers of acute alcohol withdrawal, and waits for a manifest emergency before obtaining medical care. Doc. 2261. at 10. This mischaracterizes *Lancaster*, which explains that "case law [makes] it clear that an official acts with deliberate indifference when he knows that an inmate is in serious need of medical care, but he fails or refuses to obtain medical treatment for the inmate." *Lancaster*, 116 F.2d at 1425.

588. Defendants cite *Fielder v. Bosshard* for the proposition that officials are not deliberately indifferent when they follow recognized protocols to treat withdrawal. Doc. 2261 at 10. *Fielder*, however, does not mention "recognized protocols" or any other method of treatment for withdrawal, nor does it say that deliberate indifference can only be found where an official is aware of the danger of acute alcohol withdrawal and waits for a manifest emergency before obtaining medical care. *See* 590 F.2d 105, 107 (5th Cir. 1979) (The Eighth Amendment is violated when conduct "runs counter to evolving standards of decency or involves the unnecessary and wanton infliction of pain") (citation and internal quotation marks omitted). That case merely found that a jury could find that prison officials were deliberately indifferent to a prisoner who started to deteriorate, received no medical care, and who died the next day. *Id.* at 107-09.

589. Co-payment requirements that impede prisoners from receiving medically necessary treatment may be unconstitutional. *Collins v. Romer*, 962 F.2d 1508, 1513-14 (10th Cir. 1992) (explaining district court's holding that $3.00 co-payment statute was unconstitutional as applied to chronically ill prisoners because "it was particularly harsh

for chronically ill people or people who had to attend a doctor on more than one occasion for a particular malady”).

590. Both medical and detention staff are liable for ensuring ready access to medical and mental health care. *Estelle*, 429 U.S. at 104-05 (1976) (explaining that deliberate indifference to serious medical needs of prisoners violates the Eighth Amendment “whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying access to medical care or intentionally interfering with the treatment once prescribed”); *Clement v. Gomez*, 298 F.3d 898, 905 (9th Cir. 2002) (finding that complaint alleging corrections officers failed to offer prisoners showers or medical attention for four hours after use of chemical spray stated a claim for Eighth Amendment violation); *Wakefield v. Thompson*, 177 F.3d 1160, 1165 (9th Cir. 1999) (finding that complaint alleging corrections officer failed to provide prisoner with psychotropic medication that prison doctor had prescribed stated claim for Eighth Amendment violation).

591. It is deliberate indifference to allow corrections officers to decide which prisoners will receive medical attention after a use of force. *Hoptowit*, 682 F.2d at 1252 (upholding finding of deliberate indifference where inadequately trained “[h]ospital supervisors” treated patients “even though they [were] not licensed to do [so]”); *Mitchell v. Aluisi*, 872 F.2d 577, 581 (4th Cir. 1989) (allegation of medical screening by untrained lay personnel supported a claim of deliberate indifference); *Boswell v. Sherburne County*, 849 F.2d 1117, 1123 (8th Cir. 1988) (deliberate indifference claim was supported by evidence that “inadequately trained jailers were directed to use their own judgment about the seriousness of prisoners’ medical needs”); *Carty v. Farrelly*, 957 F. Supp. 727, 738 (D.V.I. 1997) (citing sick call administered by security staff instead of medical staff in finding a constitutional violation); *Madrid*, 889 F. Supp. at 1258 (noting inadequate training and supervision of medical technical assistants in deciding whether prisoners may see a doctor).

592. Defendants argue that corrections deputies can decide whether a prisoner should be seen by medical staff after uses of force because the Constitution only requires treatment of medical needs that are "obvious to a layperson." Doc. 2261 at 18. This is not the correct standard. The Ninth Circuit has held repeatedly that "a prisoner has a 'serious' medical need if the failure to treat the condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" *Conn v. City of Reno*, 591 F.3d 1081, 1095 (9th Cir. 2010), *cert. granted, judgment vacated sub nom. City of Reno, Nev. v. Conn*, 131 S. Ct. 1812, 179 L. Ed. 2d 769 (U.S. 2011) *and opinion reinstated*, 658 F.3d 897 (9th Cir. 2011); *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006); *Clement v. Gomez*, 298 F.3d 898, 904 (9th Cir. 2002); *McGuckin*, 974 F.2d at 1059.

593. This standard of serious medical need has been satisfied by injuries that are not visible to the naked eye. *See, e.g.*, *Lolli v. County of Orange*, 351 F.3d 410, 420 (9th Cir. 2003) (diabetes gives rise to a serious medical need); *Portillo v. Johnson*, 94 Fed. App'x 457, 459 (9th Cir. 2004) (alleged delay in treating kidney stone states claim for deliberate indifference).

594. The record in this case establishes that uses of force on prisoners can result in internal injuries that can be significant, even life-threatening, and these injuries may not be obvious, and may grow acute without overt symptoms. *See* Findings, *supra* ¶¶ 207-08. To leave to corrections staff the decision whether a prisoner who may be suffering from internal injuries gets to be examined by medical staff amounts to deliberate indifference. *See Farmer*, 511 U.S. at 846 (deliberate indifference can be established by showing that Defendants are "knowingly and unreasonably disregarding an objectively intolerable risk of harm").

595. The Eighth Amendment prohibits punishing prisoners for behavior that is a product of their mental illness. *Graves*, 2008 WL 4699770 at *30 (noting that the Jail did not have a policy requiring that mental health staff be notified or involved in the

disciplinary process for mentally ill detainees); *Coleman v. Wilson*, 912 F. Supp. at 1320-22 (Eighth Amendment was violated by practices including punitive treatment of prisoners acting out because of their mental illness); *Arnold*, 803 F. Supp. at 256 (holding placement in lockdown "as punishment for the symptoms of [the plaintiff's] mental illness and as an alternative to providing mental health care" violated the Eighth Amendment); *Cameron v. Tomes*, 783 F. Supp. 1511, 1524-25 (D. Mass. 1992) (holding application of standard disciplinary procedures to a sex offender in a "Treatment Center for the Sexually Dangerous" amounted to punishing him for his psychological problems and, when done without consultation with mental health staff, violated the "professional judgment" standard applied to civilly committed persons), *aff'd as modified*, 990 F.2d 14, 21 (1st Cir. 1993); *cf. Pryor v. New Jersey Dep't of Corr.*, 672 A.2d 717, 718 (N.J. Sup. App. Div. 1996) (holding that rule against "abusive or obscene language to a staff member" could not be applied to statements made by a prisoner at a psychotherapy session), *cert. denied*, 145 N.J. 375, 678 A.2d 716 (N.J. 1996).

596. Punishment for behavior that is the product of mental illness is unconstitutional regardless of whether the practice is a result of "inadequate training of the custodial staff [such] that they are frequently unable to differentiate between inmates whose conduct is the result of mental illness and inmates whose conduct is unaffected by disease" or is the result of a "policy or custom of intentionally inflicting severe harm on mentally ill inmates." *Coleman v. Wilson*, 912 F. Supp. at 1320.

597. Failing to ensure the intervention of mental health staff, when possible, prior to a planned use of force on prisoners with mental illness violates the Eighth Amendment. *Coleman v. Brown*, No. CIV.S-90-520 LKK/DA (PC), 2014 WL 1400964, at *12-13 (E.D. Cal. Apr. 10, 2014) (finding that CDCR's policy requiring a mental health consultation prior to a planned use of force nonetheless violated the Eighth Amendment because it failed "to require consideration of the inmate's ability to

1 conform his or her conduct to the order or directive giving rise to the use of force," and
2 did not "vest mental health clinicians with sufficient authority in decisions concerning
3 use of force" because, "[i]n every instance, final decisionmaking responsibility and
4 authority for all uses of force rest[ed] with custodial staff"); *see also Thomas v. Bryant*,
5 614 F.3d 1288, 1315 (11th Cir. 2010) (finding that the Florida DOC's failure to adopt a
6 policy requiring consideration of an inmate's mental health history before a planned use
7 of force, through a mental health consultation or other means, supported a finding of
8 "more than mere or even gross negligence on the part of the DOC").
9 598. "[I]f [an] inmate cannot understand a command or cannot comply with it,
10 the force simply produces pain, except to the extent the inmate is (in some cases only
11 very temporarily) incapacitated by the force used." *Thomas v. McNeill*, No. 3:04-cv-
12 917-J-32JRK, 2009 WL 64616, at *23 (M.D. Fla., Jan. 9, 2009), *aff'd sub nom Thomas*
13 *v. Bryant*, 614 F.3d 1288 (11th Cir. 2010); *see also Hope*, 536 U.S. at 737 (holding that
14 punitive treatment levied against a restrained prisoner was unconstitutional gratuitous
15 infliction of wanton and unnecessary pain).
16 599. The Court concludes that Defendants are deliberately indifferent to
17 prisoners' serious medical and mental health needs, including those arising from or
18 exacerbated by conditions and practices that are likely to cause serious illness and
19 needless suffering by pretrial detainees now and in the future.
20 600. The Court concludes that the Defendants' failure to provide adequate
21 medical and mental health care, and related conditions and practices at the Jail
22 adversely affecting the health of pretrial detainees, amounts to punishment of pretrial
23 detainees in violation of the Fourteenth Amendment.
24 601. The Court concludes that Defendants' ongoing disobedience of the Third
25 Amended Judgment requires the Court to enter more specific remedies to ensure
26 compliance with the Constitution.
27
28

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602. The Court concludes that the prospective relief proposed by Plaintiffs is narrowly drawn, extends no further than necessary to correct current and ongoing violations of Plaintiffs' federal rights, and is the least intrusive means to correct the violations. 18 U.S.C. § 3626(b)(3).

DATED this 8th day of May, 2014.

ACLU NATIONAL PRISON PROJECT

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CERTIFICATE OF SERVICE

I hereby certify that on May 8, 2014, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

- Michele M. Iafrate
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I hereby certify that on May 8, 2014, I served the attached document by first-class mail on the Honorable Neil V. Wake, United States District Court, Sandra Day O'Connor U.S. Courthouse, Suite 524, 401 West Washington Street, SPC 52, Phoenix, AZ 85003.

s/ERIC BALABAN