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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

Shawn Jensen, et al.,
Plaintiffs,
v.
David Shinn, et al.,
Defendants.

No. CV-12-00601-PHX-ROS
ORDER

Prisoners held in government custody have a basic right to health care and humane conditions of confinement protected by the Eighth Amendment prohibiting cruel and unusual punishment.¹ These Eighth Amendment rights do not require the highest quality of health care, the community standard of health care, or the most pleasant accommodations possible. But the health care and conditions of confinement must reflect basic common decency and a recognition of the dignity the government must accord all human beings. This suit was brought by prisoners in the custody of the Arizona Department of Corrections, Rehabilitation, and Reentry (“ADCRR”), alleging systemic violations in providing minimally sufficient health care and minimally humane conditions in maximum custody units.

While this case involves an unusually large amount of evidence, there are only two basic questions. Are Defendants violating the constitutional rights of Arizona’s prisoners

¹ See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (holding government has “obligation to provide medical care for those whom it is punishing by incarceration”).

1 through the existing medical and mental health care system? And are Defendants violating
2 the constitutional rights of a subset of Arizona’s prisoners by almost round-the-clock
3 confinement in their cells? The answer is yes to both questions.

4 Defendants have failed to provide, and continue to refuse to provide, a
5 constitutionally adequate medical care and mental health care system for all prisoners.
6 Defendants’ health care system is plainly grossly inadequate. Defendants have been aware
7 of their failures for years and Defendants have refused to take necessary actions to remedy
8 the failures. Defendants’ years of inaction, despite Court intervention and imposition of
9 monetary sanctions, establish Defendants are acting with deliberate indifference to the
10 substantial risk of serious harm posed by the lack of adequate medical and mental health
11 care affecting all prisoners.

12 Further, Defendants keep thousands of prisoners in restrictive housing units where
13 they are not provided adequate nutrition, nor are they provided meaningful out-of-cell time
14 for exercise or social interaction. Defendants’ treatment of prisoners in restrictive housing
15 units results in the deprivation of basic human needs. For years, Defendants have known
16 of the deficiencies, highlighted by Court intervention and direction, and refused to take
17 meaningful remedial actions. Therefore, Defendants are acting with deliberate indifference
18 to the substantial risk of serious harm posed to prisoners in restrictive housing units.

19 Based on the 15-day bench trial that commenced on November 1, 2021, as well as
20 the parties post-trial briefing, the Court makes the following Findings of Fact and
21 Conclusions of Law. Fed. R. Civ. P. 52(a)(1).

22 **BACKGROUND**

23 There are over 4,300 docket entries in this case, reflecting a wide variety of motions,
24 hearings, and orders. A full recital of that background would be lengthy and would serve
25 little purpose. However, some background information is necessary to place in context the
26 events leading up to trial and to demonstrate Defendants’ recognition, for over a decade,
27 that they are systematically violating the constitutional rights of the prisoners.

28 **I. The Complaint and Class Certification**

1 ADCRR operates ten prison complexes across Arizona. In 2012, a group of
2 prisoners filed this class action, seeking only injunctive relief and challenging the provision
3 of medical, dental, and mental health care throughout the prison system. Plaintiffs also
4 challenged the conditions of confinement in “isolation units,” where prisoners are confined
5 to their cells for 22 or more hours each day. Plaintiffs named as defendants the Director
6 of Arizona’s prisons, currently David Shinn, and the Assistant Director of ADCRR’s
7 Medical Services Contract Monitoring Bureau, currently Larry Gann.

8 The complaint presented five claims for relief on behalf of what would subsequently
9 be identified as a main class and one subclass. The class consisted of all prisoners at
10 ADCRR’s ten complexes. According to the complaint, Defendants were subjecting class
11 members to a substantial risk of serious harm and injury from constitutionally deficient
12 health care, dental care, and mental health care. The subclass consisted of all prisoners
13 confined in their cells for 22 hours or more per day. Defendants allegedly were subjecting
14 subclass members to a substantial risk of serious harm and injury from various policies,
15 including constitutionally inadequate out-of-cell time, social isolation, nutrition, and
16 mental health treatment.

17 The Court certified the class and subclass in March 2013. (Doc. 372). The Ninth
18 Circuit affirmed certification of the class and subclass. *Parsons v. Ryan*, 754 F.3d 657 (9th
19 Cir. 2014). In doing so the court held the prisoners’ claims had sufficient commonality
20 because the class and subclass were allegedly subjected to practices that could be addressed
21 “in one stroke.” *Id.* at 678. In particular, the Ninth Circuit reasoned this Court could
22 determine whether the “statewide [ADCRR] policies and practices to which all members
23 of the class are subjected, and [particular] statewide [ADCRR] policies and practices which
24 affect all members of the subclass” exposed the class and subclass to “substantial risk of
25 serious future harm to which the defendants are allegedly deliberately indifferent.” *Id.*

26 **II. Settlement and Stipulation**

27 Before the mandate issued in the class certification appeal, the parties negotiated a
28 settlement agreement—the Stipulation—that was intended by the parties to eventually

1 resolve all claims. (Doc. 1185). The Stipulation contained 103 health care and 10
2 maximum custody performance measures.² With respect to health care, performance
3 measures were to be assessed pursuant to a “Monitoring Guide” and reported monthly for
4 each of the ten prison complexes. (Doc. 1185 at 3). Under the Stipulation, a performance
5 measure, for health care or maximum custody, could terminate (*i.e.*, free Defendants from
6 monitoring and reporting) if Defendants achieved, and maintained, specified thresholds:
7 75% compliance the first 12 months, 80% the second 12 months, and 85% thereafter. The
8 Stipulation was accepted by the Court in February 2015. (Doc. 1458).

9 **III. Stipulation Monitoring History**

10 In an Order dated July 16, 2021, the Court provided a detailed recital of the history
11 of the monitoring and enforcement of the Stipulation for the five years from 2016 through
12 2021. (Doc. 3921). Rather than repeat the history, the Court incorporates the factual
13 findings contained in the July 16, 2021, Order.

14 In brief, between 2016 and July 2021, Plaintiffs filed twelve motions to enforce the
15 Stipulation, the Court held multiple evidentiary hearings and status conferences, the Court
16 issued dozens of Orders with specific directions mandating Defendants comply with the
17 Stipulation, the Court issued three Orders to Show Cause why Defendants should not be
18 held in contempt, the Court appointed two experts, and the Court held Defendants in
19 contempt twice, resulting in millions of dollars in fines, which were upheld on appeal. At
20 the end of the five-year period, the Court concluded Defendants had consistently refused
21 to perform the obligations under the Stipulation and had offered baseless legal and factual
22 theories for their failures. Imposition of substantial fines, and threats of even more, did not
23 prompt Defendants to make required efforts to perform as they agreed under the
24 Stipulation.

25 Accordingly, as of July 2021, the Court resolved that attempting to enforce the
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28 ² As it happened, the Performance Measures were not comprehensive enough and under-
evaluated the alleged constitutional violations. Defendants used this to their advantage to
both subvert the Stipulation and continue violating prisoners’ constitutional rights.

1 Stipulation had proven futile and rescission of the Stipulation was required.³ (Doc. 3921
2 at 36-37). The Court vacated the settlement under Federal Rule of Civil Procedure 60(b)
3 and set the matter for trial to begin November 1, 2021. (Doc. 3921).

4 **IV. Trial Procedures**

5 The parties were given time after the Order vacating the Stipulation to engage in
6 discovery and prepare for trial. (Docs. 4006, 4009, 4011, 4012, 4019, 4019, 4021). In
7 early August 2021, Plaintiffs moved to present direct expert testimony by declaration to
8 preserve trial time. On September 2, 2021, the Court granted the motion over Defendants'
9 objection and directed both sides to present most of their experts' direct testimony by way
10 of written declaration.⁴ Defendants, however, if necessary, were allowed to file a motion
11 seeking permission to present all their experts' testimony in-court instead of through
12 written declarations. (Doc. 3952 at 3 n.1). Defendants chose not to file such a motion.

13 After considering the nature of the evidence for both parties, the Court directed the
14 parties to plan on 50 hours of trial time for each side, with the caveat that "adjustments, as
15 necessary" would be made to ensure "a fair trial to both parties." (Doc. 3952 at 3). Neither
16 party objected to the 50-hour limit nor asked for additional time at the conclusion of the
17 trial.

18
19 ³ Of significance, the Stipulation substantially favored Defendants because it expressly
20 provided by its terms that the Court was precluded from ordering Defendants "hire a
21 specific number or type of staff." (Doc. 1185 at 14-15). This provision was addressed in
22 one of Defendants' appeals. The Ninth Circuit held the provision meant the Court could
23 issue a "general staffing order" but could not issue an order requiring a "*specific* number
24 and type of personnel." *Parsons v. Ryan*, 912 F.3d 486, 498 (9th Cir. 2018). This
25 interpretation made enforcement difficult, and eventually completely impossible, because
26 any effective staffing plan would necessarily address the specific needs of specific
27 complexes. Further, the Court was consistently reminded Defendants placed great
28 importance on this limitation and were unwilling to hire additional staff. As this Order
demonstrates, failure to maintain adequate staff has been the fundamental cause of
Defendants' unconstitutional actions.

25 ⁴ A similar practice was used in another case involving challenges to prisoner healthcare.
26 *See Madrid v. Gomez*, 889 F. Supp. 1146, 1158 n.5 (N.D. Cal. 1995) ("The direct testimony
27 of all experts was submitted by way of declaration, supplemented by two hours of live
28 testimony. The parties were also permitted unlimited live cross examination and redirect
examination.").

1 Trial commenced on November 1, 2021 and proceeded for fifteen non-consecutive
2 days. The parties filed lengthy written testimony for each expert and they testified at trial.
3 Beyond the experts, the Court also heard testimony from class and subclass members, the
4 named defendants, deputy wardens in charge of isolation units, and others.⁵ Neither side
5 had exhausted their allotted time on the last day of trial or asked the Court to continue the
6 trial for additional days. The parties subsequently filed approximately 800 pages of
7 proposed findings of fact and conclusions of law as well more than 350 pages of responses
8 to the opposing side's filing. (Docs. 4308, 4309, 4314, 4315).

9 **V. Evidentiary Issues**

10 Most of the evidentiary issues were raised and resolved during trial but a few are
11 pending.

12 **A. Motion to Strike (Doc. 4219)**

13 After trial, Defendants filed a motion seeking to strike "portions of Plaintiffs'
14 experts' declarations." (Doc. 4219). That motion is confusing. For example, Defendants
15 argue the written testimony of one of Plaintiffs' experts was incorrectly presented such that
16 it must be excluded but then add, without explanation, that the expert's "entire trial
17 testimony" should also be stricken. (*Id.* at 2). Defendants also claim there is hearsay within
18 the experts' written testimony, that some offered legal conclusions, and maybe they offered
19 undisclosed opinions. Defendants' motion is baseless because the motion was untimely
20 and, as such, Plaintiffs were unable to cure any alleged deficiencies.

21 Defendants' motion was filed over a month after Defendants received the last
22 written testimony by one of Plaintiffs' experts. Federal Rule of Evidence 103 requires

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24 ⁵ The Court heard from the following witnesses: Prisoners Kendall Johnson, Ronald Slavin,
25 Laura Redmond, Rahim Muhammad, Jason Johnson, and Dustin Brislan; Staffing Expert
26 Robert Joy; Paralegal Jessica Carns; Deputy Wardens Travis Scott, Lori Stickley, and
27 Anthony Coleman; Mental Health Care Expert Pablo Stewart; Solitary Confinement Expert
28 Craig Haney; former Centurion Regional Mental Health Care Director Dr. Stefanie Platt;
Corrections Expert Martin Horn; Medical Care Expert Dr. Todd Wilcox; Defendants
ADCRR Director David Shinn and Assistant Director Larry Gann; ADCRR's Mental
Health Director Dr. Bobbie Pennington-Stallcup; Yuma Site Director Dr. Elijah Jordan;
Warden Jeffrey Van Winkle; ADCRR Medical Director Dr. Grant Phillips; Mental Health
Care Expert Dr. Joseph Penn; Medical Care Expert Dr. Owen Murray; and Centurion vice
president Tom Dolan.

1 objections or motions to strike be “timely.” As a general matter, “[a]n objection is ‘timely’
2 if it is made as soon as the opponent knows, or should know, that the objection is
3 applicable.” *Jerden v. Amstutz*, 430 F.3d 1231, 1236-37 (9th Cir. 2005) (quotation marks
4 and citation omitted). The Ninth Circuit has found an objection two days after a witness
5 testified untimely. *Id.* In another case, the Ninth Circuit found untimely an objection “not
6 raised until the end of the witness’s direct examination.” *San Antonio Cmty. Hosp. v. S.*
7 *California Dist. Council of Carpenters*, 125 F.3d 1230, 1238 (9th Cir. 1997). Defendants’
8 objections raised a month or more after they learned of the testimony are not timely. Thus,
9 the objections will be denied.

10 What is more, by waiting until the conclusion of trial to bring their belated motion,
11 Defendants deprived Plaintiffs of an opportunity to cure the alleged flaws in the testimony.
12 The Ninth Circuit made clear it is improper to exclude testimony based on an untimely
13 objection when the proponents of the testimony lack an “opportunity to cure the objection.”
14 *Jerden*, 430 F.3d at 1238. Defendants’ motion to strike will be denied. However, the
15 Court’s findings of fact are not reliant on patently inadmissible evidence, whether
16 contained in written testimony or elsewhere.⁶

17 **B. Motions to Admit Evidence (Docs. 4215, 4225)**

18 Plaintiffs moved to admit numerous court filings by both sides, a report by a court-
19 appointed expert, and previous reports by experts. (Doc. 4215). Plaintiffs also moved to
20 admit a report from the “Arizona Auditor General” and an excerpt of a prisoner’s electronic
21 medical records. (Doc. 4225). Defendants objected to most of these exhibits but agreed
22 that one exhibit, the electronic medical records, can be admitted provided additional
23 information is included. (Doc. 4247).

24 It is unnecessary to consider the documents and objections in detail because the
25 Court has not materially relied on the documents at issue. Plaintiffs’ motion regarding
26 court filings will be denied as moot but the motion regarding medical records will be

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28 ⁶ It is self-evident that both the prisoners and Defendants cannot be considered completely
neutral witnesses because prisoners as well as Defendants and their staff are obviously
interested in the outcome of this case.

1 granted, subject to Defendants' request to include additional information.

2 **C. Joint Motion to Admit (Doc. 4224)**⁷

3 The parties have agreed to admit certain exhibits, admit with modifications other
4 exhibits, and withdraw some exhibits. The stipulated motion will be granted and the
5 exhibits admitted or withdrawn as agreed to by the parties.

6 **D. Admissibility of Expert Witnesses' Testimony**

7 "Under Rule 702 of the Federal Rules of Evidence, [a] witness who is qualified as
8 an expert by knowledge, skill, experience, training, or education may testify in the form of
9 an opinion, provided the testimony meets certain criteria." *United States v. Gadson*, 763
10 F.3d 1189, 1202 (9th Cir. 2014) (quotation marks and citation omitted). An expert witness
11 may rely on information, such as hearsay evidence, that would not be admissible on its
12 own. Fed. R. Evid. 703. The time to raise a challenge to an expert's testimony is before
13 or occasionally during trial. "Failure to raise a *Daubert* challenge at trial causes a party to
14 waive the right to raise objections to the substance of expert testimony post-trial." *Skydive*
15 *Arizona, Inc. v. Quattrocchi*, 673 F.3d 1105, 1113 (9th Cir. 2012). Here, the parties waived
16 any *Daubert* challenges to the opposing party's expert witnesses. But even if they had not,
17 any such challenge would have failed.

18 Expert testimony is sufficiently "reliable if the knowledge underlying it has a
19 reliable basis in the knowledge and experience of [the relevant] discipline." *United States*
20 *v. Sandoval-Mendoza*, 472 F.3d 645, 654 (9th Cir. 2006) (quotation marks and citation
21 omitted). The test for admissibility "is not the correctness of the expert's conclusions but
22 the soundness of his methodology." *Primiano v. Cook*, 598 F.3d 558, 564 (9th Cir. 2010)
23 (quotation marks and citation omitted). Here, all the parties' experts have relevant
24 knowledge and experience. The parties disagree regarding the soundness of some experts'
25 methodologies but those disputes, as well as the appropriate weight to assign to each
26 expert's opinions, are addressed below. The Court has considered all the expert opinions

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28 ⁷ Plaintiffs motion to exclude evidence and testimony due to Defendants' Rule 30(b)(6)
designee's lack of knowledge is moot because no contrary testimony was offered during
trial. (Doc. 4163).

1 as well as the manner and demeanor of every witness’s testimony in assessing credibility.

2 **LEGAL STANDARD**

3 The Eighth Amendment “imposes duties on [prison] officials, who must provide
 4 humane conditions of confinement; prison officials must ensure that inmates receive
 5 adequate food, clothing, shelter, and medical care, and must take reasonable measures to
 6 guarantee the safety of the inmates.” *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).
 7 Prisons officials “violate[] the Eighth Amendment only when two requirement are met.”
 8 *Id.* at 834. “First, the deprivation alleged must be, objectively, sufficiently serious” such
 9 that it results “in the denial of the minimal civilized measure of life’s necessities.” *Id.*
 10 Second, “a prison official must have a sufficiently culpable state of mind.” *Id.* That state
 11 of mind is “deliberate indifference,” which requires a prison official “knows of and
 12 disregards an excessive risk to inmate health or safety.” *Id.* at 837. A prison official’s
 13 state of mind “is a question of fact subject to demonstration in the usual ways, including
 14 inference from circumstantial evidence, and a factfinder may conclude that a prison official
 15 knew of a substantial risk from the very fact that the risk was obvious.” *Id.* at 843.

16 **HEALTH CARE**

17 **I. Privatization and Current Contract**

18 When this lawsuit was filed in March 2012, ADCRR⁸ provided health services
 19 (medical and mental health care) directly to its prisoner population. But the Arizona State
 20 Legislature enacted legislation requiring “the privatization of all correctional health
 21 services, including all medical and dental services.” Arizona 2011 HB 2154. That
 22 legislation took effect on July 1, 2012, when Wexford Health Services assumed
 23 responsibility for all health services. On March 4, 2013, Corizon Health Incorporated took
 24 over for Wexford. Centurion of Arizona became the third private health care contractor on
 25 July 1, 2019. That contract is valued at approximately \$216 million per year. (Doc. 4274
 26 at 32). In June 2021, ADCRR extended its contract with Centurion for an additional fifteen
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28 ⁸ In 2019, the name was changed from “Arizona Department of Corrections” to “Arizona
 Department of Corrections, Rehabilitation, and Reentry.” (Doc. 4279 at 31).

1 months. (Doc. 4274 at 96). ADCRR is currently soliciting bids for the health care contract
2 to begin in August 2022. (Doc. 4287 at 25).

3 The current contract requires Centurion provide all health services at ADCRR's ten
4 complexes in the state. The table below reflects the prisoner population at each complex
5 as of September 30, 2021, the date discovery closed. The table also reflects the number of
6 "full time equivalents" or "FTEs" (*i.e.*, employees working 40 hours per week) required by
7 the contract and the number of filled FTE positions.⁹ These FTE numbers cover all
8 Centurion staff at that location, meaning medical, dental, and mental health staff as well as
9 administrative staff.

10 **Prison Population, Contract FTE, and Actual FTE**

11 Location	Population	Contract FTE	Actual FTE
12 Douglas	1,524	33.75	32.10
13 Eyman	5,219	132.50	110.85
14 Florence	2,534	152.00	96.76
15 Perryville	3,318	136.75	109.35
16 Phoenix	468	88.05	67.93
17 Lewis	4,421	150.00	115.00
18 Safford	1,035	34.75	36.85
19 Tucson	4,420	180.50	141.75
20 Winslow	1,481	31.00	37.10
21 Yuma	3,374	86.50	104.25

22 These numbers show an obvious and crucial amount of understaffing at certain
23 locations. For example, Tucson has approximately 40 fewer FTEs than required by the
24 contract. Defendants claim understaffing is alleviated by employees working overtime or
25 by recruiting temporary employees. Even if this occurred, the current staffing levels fall
26 significantly beneath what Centurion and Defendants intended at the time they entered into
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28 ⁹ The population figures are as of September 30, 2021, while the staffing figures are as of August 2021.

1 the contract.

2 **II. Differences Among Complexes**

3 The health services at the ten complexes are structured the same, subject to a few
4 caveats. Each complex has a medical unit staffed with Centurion medical personnel. (Doc.
5 4279 at 59). The medical units at every complex consist of exam rooms allowing for
6 treatment of prisoners on something like an “out-patient” basis. That is, prisoners go to
7 the medical unit, are seen by medical staff, and the prisoners then return to the housing
8 units. Beyond the standard medical units, some complexes have intensive health units for
9 prisoners with more significant medical needs. An inpatient care unit (also known as an
10 “inpatient component” or “IPC”) “is staffed 24/7 with a registered nurse” and is where
11 prisoners requiring a high level of care are housed. (Doc. 4279 at 61). A special needs
12 unit (“SNU”) provides a lower level of care and may be staffed “on an LPN level.” (Doc.
13 4279 at 61). The typical care in SNUs consists of care for prisoners who require assistance
14 with activities of daily living, or who have mobility or memory issues that preclude their
15 placement in the general population. (*Id.* at 61). In addition, seven of the complexes are
16 considered “corridor facilities” because they are located near larger population centers
17 where higher levels of off-site medical care are available. (*Id.* at 60). Finally, four
18 complexes have “mental health units” where prisoners with intensive mental health needs
19 are housed. The table below depicts the medical and mental health capabilities of each
20 complex. (Doc. 4279 at 60-64); (Doc. 4172 at 40-41). Of the ten complexes, nine are for
21 male prisoners and one, Perryville, is for female prisoners.

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1 **Medical and Mental Health Capabilities of Complexes**

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Complex	IPC	SNU	Corridor	Mental Health Units
Douglas	No	No	No	No
Eyman	No	No	Yes	Yes
Florence	Yes	Yes	Yes	No
Perryville	Yes	Yes	Yes	Yes
Phoenix	No	No	Yes	Yes
Lewis	Yes	No	Yes	No
Safford	No	No	No	No
Tucson	Yes	Yes	Yes	Yes
Winslow	No	No	No	No
Yuma	No	No	Yes	No

15 Based on the facilities and capabilities of each complex, male prisoners may be
 16 transferred between complexes depending on their needs. If a prisoner housed at Winslow
 17 were to develop a serious medical condition, it is unlikely Winslow would be capable of
 18 treating that condition. The prisoner might initially be transferred to a “corridor” facility
 19 to be closer to off-site medical resources. If the prisoner was transferred to a “corridor”
 20 facility without an IPC or SNU, but the prisoner deteriorated, the prisoner may need to be
 21 transferred again to a facility with an IPC or SNU. Similarly, if a prisoner at Yuma needed
 22 intensive mental health treatment, that prisoner would need to be transferred to a mental
 23 health unit at a different location.

24 The different capabilities and facilities between complexes provide significant
 25 support for examining the ADCRR medical and mental health care system as a whole,
 26 instead of on a complex-by-complex basis. For example, in order for a particular prisoner
 27 to receive adequate or critical care, transportation among complexes is often necessary,
 28 because of the health care diversification in facilities and the overall medical care provided

1 at ADCRR. A prisoner may become seriously injured or develop a serious medical or
2 mental health care condition at any time. If that prisoner is male, he may be assessed at
3 one complex, transferred to almost any other complex, and then transferred again if needed,
4 depending on bed availability and proximity to relevant specialists. Insufficient care
5 provided at the IPC in Lewis may, suddenly, be a matter of life or death to a prisoner
6 previously housed at Douglas who develops a need for a high level of care.

7 **III. Process to Obtain Care**

8 When a prisoner submits a “health needs request” (“HNR”) form, the response
9 typically informs the prisoner he is scheduled to be seen on the “nurse line,” meaning he
10 will be seen and evaluated by an RN. Alternatively, if the HNR requested mental health
11 services, he will be seen by mental health staff. (Doc. 4276 at 70-71).

12 **A. Overview of Medical Care**

13 When an RN sees a prisoner on the nurse line, the RN uses “protocols embedded in
14 Nursing Encounter Tools (NETS).” (Doc. 4138 ¶ 163). The NETS are “templates for care
15 that are supposed to guide the nurse’s exam and assessment of the patient, and help the
16 nurse formulate a plan of care, including whether to send the patient to a PCP [primary
17 care provider].” (Doc. 4138 ¶ 163). As set forth in Defendants’ policies, after examining
18 the prisoner, the RN will determine “[i]f the situation requires that the inmate be seen by
19 another discipline.” (Ex. 1305 at 155). If the RN concludes additional care is needed,
20 policy requires the RN “*immediately* initiate a referral to the appropriate area.” (Ex. 1305
21 at 155) (emphasis added). Significantly, this first evaluation by an RN always occurs
22 regardless of the seriousness of a prisoner’s asserted symptoms and regardless of how many
23 times the prisoner has previously been seen by an RN for the very same issue. (Doc. 4138
24 at 72 ¶ 171).

25 If the RN determines the prisoner’s situation requires evaluation by a higher-level
26 professional, the RN will arrange for the prisoner to see what the parties refer to as a
27 “provider.” As used by the parties, “provider” means a nurse practitioner, physician
28 assistant, or physician. A provider may order further testing or prescribe medication. A

1 provider may also determine specialist care is needed. In that situation, the provider is
 2 required to send a referral to Centurion’s Utilization Management department. (Doc. 4275
 3 at 13). That department, however, does not examine or evaluate the prisoner but based on
 4 the medical records, it “look[s] at the clinical indication to make sure [the referral is]
 5 appropriate,” which takes time. (Doc. 4279 at 84). If the referral is approved, the
 6 information is passed to one of Centurion’s “clinical coordinators” who will arrange a
 7 specialist appointment for the prisoner. (Doc. 4279 at 84). If Centurion denies the referral,
 8 the Utilization Management department often states the provider should pursue an
 9 “alternative treatment plan.” (Doc. 4138 ¶ 400).

10 The many prisoners who have chronic conditions are enrolled in ADCRR’s Chronic
 11 Care Clinics. (Doc. 4206 ¶ 201). A policy defines a chronic condition as “an illness or
 12 condition that affects an individual’s well-being for an extended interval, and generally is
 13 not curable, but can be managed to provide optimum functioning within any limitations the
 14 condition imposes on the individual.” (Ex. 1305 at 151). Prisoners’ chronic care
 15 conditions are monitored by chronic care appointments no less than every 180 days, unless
 16 a provider documents a longer time frame is appropriate. (Doc. 1185-1 at 27). These
 17 appointments are not on the “nurse line.” Rather, they are supposed to be with a provider
 18 although the overall records do not make clear whether that occurs. (Doc. 4287 at 59-60).

19 Defendants created a medical classification system to identify the housing needs for
 20 individual patients. The designations range from M-1 through M-5 with M-1 being the
 21 lowest needs patient and M-5 being the highest needs patient. (Doc. 4279 at 65).¹⁰

22 ¹⁰ The scores are:

23 M-1: Maximum sustained physical capacity consistent with age; no special requirements.

24 M-2: Sustained physical capacity consistent with age; stable physical illness or chronic
 25 condition, no special requirements.

26 M-3: Restricted physical capacity; requires special housing or reasonable accommodations.

27 M-4: Limited physical capacity and stamina; severe physical illness or chronic condition;
 28 requires housing in a corridor institution.

M-5: Severely limited physical capacity and stamina; requires assistance with Activities
 of Daily Living (ADLS); requires housing in Inpatient Component or Assisted Living area.
 (Doc. 4138 ¶ 484).

1 Defendants introduced testimony that as of trial there are approximately 22,000 prisoners
 2 classified as M-1 and M-2, 2,000 prisoners classified as M-3, between 400 and 500
 3 classified as M-4, and approximately 20 classified as M-5. (Doc. 4279 at 65-66). Those
 4 numbers, however, are clearly approximations as their sum is less than the total number of
 5 prisoners in the ten complexes.

6 **B. Overview of Mental Health Care**

7 Defendants created a standardized scoring system for classifying prisoners
 8 according to their mental health needs. MH-1 reflects the lowest level of need, and MH-5
 9 reflects the highest.¹¹ (Ex. 3025 (Mental Health Technical Manual “MHTM” Ch. 3 § 5.0)).

10 ¹¹ The scores are the following:

11 MH-1: Prisoners who have no history of mental health issues or receiving mental health
 12 treatment.

13 MH-2: Prisoners who have received mental health treatment in the past but do not currently
 14 have any mental health needs and have demonstrated behavioral and psychological stability
 15 for at least six months.

16 MH-3: Outpatient Treatment. Patients who have current mental health needs that require
 17 outpatient treatment. There are five sub-codes to MH-3.

18 MH-3A: Patients in acute distress who may require substantial intervention in order to
 19 remain stable. All patients classified as seriously mentally ill (“SMI”) are to be classified
 20 as MH-3A (unless admitted to a residential treatment or inpatient treatment program, and
 21 then classified as MH-4 or MH-5). Any patient under a Psychiatric Medication Review
 22 Board (“PMRB”) order for involuntary administration of psychiatric medication are to be
 23 classified as MH-3A (unless admitted to a residential treatment or inpatient treatment
 24 program, and then classified as MH-4 or MH-5).

25 MH-3B: Patients who are generally stable but need regular interventions because they are
 26 receiving psychiatric and psychological services.

27 MH-3C: Patients who are stable, have adequate coping skills, and are able to manage their
 28 mental health symptoms through medication only, and who need infrequent intervention.

MH-3D: Patients who were recently taken off psychotropic medications and need follow-
 up for six months thereafter to ensure stability over time.

MH-3E: Patients who recently arrived to ADCRR custody and are generally stable but may
 benefit from regular contacts with mental health clinicians, or patients participating only
 in outpatient group psychotherapy.

MH-4: Residential Treatment. Patients who are admitted to a residential mental health
 program.

MH-5: Inpatient Treatment. Patients who are admitted to the inpatient mental health
 treatment programs licensed by the Arizona Department of Health Services.
 (Ex. 3025 at 27-32).

1 These scores are assigned during “mental health intake assessments” which occur during
2 prisoners’ initial processing upon entering the system. (Doc. 4276 at 43).

3 Prisoners assigned a score of MH-3 or above are considered “on the mental health
4 caseload,” and must be housed at facilities with mental health staff. Prisoners assigned
5 scores of MH-1 or MH-2 are eligible to be housed at Douglas, Safford, or Winslow, which
6 each have a single staff person each to address any mental health needs that may arise.

7 In addition to learning of mental health needs through the HNR process, mental
8 health staff may learn of a prisoner in need of services through the prisoner’s friends or
9 families, or through prison officials who observe the prisoner. (Doc. 4276 at 71). In theory,
10 the system provides that if mental health services are requested through the HNR process,
11 an “urgent concern” will result in the prisoner being seen the same day the HNR is
12 processed. (Doc. 4276 at 70). If the HNR presents a “clinical mental health need,” the
13 prisoner is seen within five days. And if there is a “psychiatric concern” that is deemed
14 “non-urgent,” the prisoner is seen within 14 days. The record does not establish who is
15 responsible for categorizing the mental health HNRs.

16 **MEDICAL CARE**

17 It is undisputed the class members suffer from a wide variety of serious medical
18 needs. In fact, Bureau of Justice Statistics data show people who are “incarcerated tend to
19 be less healthy, to have more chronic illnesses including substance use disorder, and to
20 have additional stressors in their lives than people who live in the general community.”
21 (Doc. 4138 ¶ 252). Dr. Elijah Jordan, the Site Medical Director for the Yuma Complex,
22 testified prisoners often present unusual, and very serious, medical conditions. He
23 explained working in correctional health care “afforded [him] the opportunity to see a lot
24 of things that [he] read about and saw going through medical school that [he] was not able
25 to see during medical school as well as residency, because [he is] able to – [he] take[s] care
26 of patients that do not regularly go to the doctor. So these guys, when you do get a chance
27 to evaluate and see them, they are really bad off.” (Doc. 4277 at 56.) And Defendants
28 readily admit approximately two-thirds of class members are prescribed medications, and

1 approximately one quarter receive medication for mental health conditions. (Doc. 4275 at
2 16, 18). As a general matter, the class consists of thousands of individuals with significant
3 and very serious health needs requiring a high level of care to adequately manage and treat.

4 **I. Overview of Expert Testimony**

5 The parties presented competing experts to address the overall adequacy of the
6 medical care system. Dr. Todd Wilcox testified for Plaintiffs and Dr. Owen Murray
7 testified for Defendants. Dr. Wilcox's testimony was persuasive and credible. Dr.
8 Murray's overall opinions were generally unpersuasive though portions of his testimony
9 confirmed the medical care system is grossly insufficient.

10 **A. Dr. Wilcox**

11 Dr. Wilcox earned a bachelor's degree in biological psychology from Duke
12 University in 1988 and a medical degree from Vanderbilt University School of Medicine
13 in 1992. (Doc. 4138, Ex. A). After graduating from medical school, Dr. Wilcox completed
14 a residency in orthopedic surgery. (Doc. 4270 at 82). During that residency, Dr. Wilcox
15 began working as a staff physician for the Salt Lake County jail. In 1996, he became the
16 medical director for the Salt Lake County Jail System, where he remains today. He has
17 also performed other work, including serving as the Medical Director for the Maricopa
18 County Jail System. He is board certified in Urgent Care Medicine and board certified by
19 the American Academy of HIV Medicine. And he holds an advanced certification from
20 the National Commission on Correctional Healthcare as a Certified Correctional Health
21 Professional Administrator and Correctional Health Physician.

22 Dr. Wilcox has 27 years of experience in correctional health care and is well-
23 qualified to provide expert opinions on the quality of Defendants' health care delivery.
24 (Doc. 4138 ¶¶ 2, 4). He has served as Plaintiffs' expert since 2013, shortly after the lawsuit
25 was filed. (*Id.* ¶ 6). Defendants did not file a pretrial motion contesting Dr. Wilcox as an
26 expert witness, and he is qualified to offer expert opinions on the adequacy of the medical
27 care provided.

28 Dr. Wilcox was requested to "evaluate the adequacy of the current medical care

1 delivery system in the ADCRR.” (*Id.* ¶ 18). His current opinion is based on his experience
2 serving in this case since 2013, having submitted multiple reports and declarations
3 regarding the delivery of healthcare in the Arizona state prisons which document that since
4 2012 ADCRR’s healthcare delivery system has been seriously deficient. In preparing for
5 his testimony, he thoroughly reviewed many documents including the written policies and
6 procedures of ADCRR as well as the Department Orders and Medical Service Technical
7 Manual. He examined medical records for 120 patients. He visited all four IPCs and
8 interviewed a number of patients in IPCs, special needs units, and other housing units.

9 Dr. Wilcox explained why he did not review a completely random sample of
10 prisoners:

11 I did not review a random sample of all patients in ADCRR
12 custody. This is because when evaluating a healthcare delivery
13 system, it is generally not as helpful to examine care for healthy
14 people as it is to look at the treatment of sick patients,
15 particularly those with complex or chronic conditions that
16 require coordination, communication, and judgment. Healthy
17 patients or those with minimal needs can more readily get their
18 needs met even from systems that offer poor clinical care and
19 lack basic organizational structures; examining their records
20 tells us little. It is the complex patients who test the capacity
21 of staff and systems alike.¹²

22 (Doc. 4138 at ¶ 25). However, Dr. Wilcox’s tour of various locations and discussions with
23 prisoners at those locations meant he did not dictate the exact prisoners he would review:

24 I had no control over who was housed in those units. We tried
25 to speak to everybody in those units who was willing to speak
26 to us. So we got as big of a sample as we could with regards
27 to those random patients who were housed in those units and
28 then we went back and looked at their charts.

(Doc. 4270 at 12).

Overall, Dr. Wilcox attempted to evaluate the care provided to prisoners by looking
to prisoners “at the sicker end of the spectrum.” (Doc. 4270 at 11). He explained why this
approach was useful:

I also wanted to identify patients who are high-end utilizers of

¹² Dr. Wilcox elaborated on this point in his live testimony.

1 the health care system. And the reason that those patients are
2 important is because when you are doing a systems evaluation,
3 what you really want to evaluate are patients who put a little
4 strain on the system. They have a lot of transactions in their
5 health care. It's not particularly informative about a system if
6 you have a patient that has a one-time episodic visit for a
7 sprained ankle and then they're never seen again. That doesn't
8 give you very much data. But what does give you data is
9 patients that have frequent and ongoing interactions with the
10 healthcare system because you're able to see the coordination
11 nation of care, you're able to see all the different elements of
12 the system operating to care for that patient.

13 (Doc. 4270 at 11). Dr. Wilcox has used this methodology to evaluate care in other cases
14 and other experts use similar methodology. (Doc. 4270 at 15).

15 In his written testimony, Dr. Wilcox stated ADCRR's health care system provides
16 "grossly inadequate healthcare." (Doc. 4138 at ¶ 28). The entire health care system
17 "continues to harm many patients and continues to place all at substantial risk of serious
18 harm." (*Id.*). And "ADCRR has provided dangerously substandard care for years, both
19 before and during the pandemic, continuing to the present day." (*Id.* at ¶ 27). He testified
20 this problem stems from a variety of factors but the most fundamental being the lack of
21 appropriate qualified staffing. "By design, healthcare decisions in the [ADCRR system]
22 are pushed down to the lowest possible level – nurses who are practicing poorly and far
23 outside the scope of their licenses." (*Id.* ¶ 28). In Dr. Wilcox's view,

24 There is a clear pattern of failure by nurses to complete an
25 adequate nursing assessment, take patient reports seriously,
26 recognize dangerous symptoms, and elevate concerns to
27 providers. Too often, nurses simply send patients back to their
28 housing unit and tell them to submit another written sick call
request if symptoms worsen.

(Doc. 4138 at ¶ 28).

29 ADCRR's system also results in care for complex issues being "scattered
30 throughout the system so no one provider or physician is ultimately responsible for the
31 patient, resulting in serious deficits in care." (Doc. 4138 at ¶ 29). In addition, the system
32 lacks "the foundation of any credible healthcare practice: differential diagnosis." (Doc.
33 4138 at ¶ 30). Medical staff fail "to identify, test, and otherwise evaluate the underlying

1 cause of the symptom.” (*Id.*). Staff order testing “without a diagnostic strategy” and they
2 “fail to follow up on significantly abnormal results.” (*Id.*).

3 In his written testimony Dr. Wilcox identified the cause of the system’s failures:

4 [ADCRR’s] problems appear to the result of a combination of
5 factors, including inadequate staffing, inadequate physician-
6 level attention to problems, and poor attitude of medical staff,¹³
7 which probably is itself related to inadequate staffing and
8 demanding workloads. In addition, the electronic health record
in use within the ADCRR is poorly designed and greatly
impairs the clinician’s capacity to synthesize a comprehensive
picture of a patient’s healthcare.

9 (*Id.* ¶ 31).

10 During his in-court testimony, Dr. Wilcox summed up his opinion of the medical
11 care system in a simple and stark way:

12 My opinion is that the system as it exists is terrible. There are
13 so many blocks to care, barriers to care. There’s so many areas
14 where the care can get snagged up and not flow appropriately,
15 and the end result of that is that some patients within the
healthcare system, in fact many patients who have higher end
needs, end up getting terrible care.

16 (Doc. 4270 at 20). To ensure it had understood, the Court asked Dr. Wilcox to clarify. Dr.
17 Wilcox repeated prisoners “end up getting terrible care.” (Doc. 4270 at 20).

18 **B. Dr. Murray**

19 Dr. Murray earned a bachelor’s degree in biology from Boston College in 1983 and
20 a doctor of osteopathy degree from Chicago College of Osteopathic Medicine in 1988.
21 (Doc. 4206, Ex. 1). After medical school, Dr. Murray completed a residency in family
22 practice. From 1991 to 1994, Dr. Murray worked as medical director at various locations
23 in the Illinois Department of Corrections. From 1995 to the present, he has worked at the
24 University of Texas Medical Branch. (Doc. 4285 at 104). At present, he is Vice President
25 of Offender Health Services and oversees the provision of health care in the Texas
26

27 ¹³ Dr. Wilcox testified “[p]roviders’ notes suggest over and over that patients are lying and
28 malingering.” (Doc. 4271 at 79). In Dr. Wilcox’s opinion, this was evidence of “bias
against patients” which often “interferes with the providers’ capacity to recognize serious
medical conditions.”

1 Department of Criminal Justice and the Texas Juvenile Justice Department. (Doc. 4206
2 ¶¶ 3-4).

3 Dr. Murray understood he was to evaluate the “overall health care system” for
4 prisoners in ADCRR custody and determine whether there are “systemic deficiencies
5 which render the delivery of health care services below the community standard of care.”¹⁴
6 (*Id.* ¶ 10). He performed site visits at all ten complexes and focused his review on the
7 following components of medical care: (1) staffing, (2) access to care, (3) diagnostic
8 services, (4) records and facilities, (5) pharmacy services, and (6) quality monitoring. (*Id.*
9 ¶¶ 15, 17). Dr. Murray reviewed charts for 80 prisoners, focusing on prisoners with at least
10 two documented chronic care diagnoses. Dr. Murray evaluated those charts based on the
11 quality of chronic care documentation, quality of chronic care, and quality of episodic care.
12 (*Id.* ¶ 207). Dr. Murray’s overall conclusion was that:

13 ADCRR is delivering care that meets or exceeds the
14 community standard. While I have identified some areas for
15 improvement, most notably with eOMIS [the electronic
16 medical records system], PM [performance measure]
17 reporting, and the mortality review process, I did not find any
18 systemic deficiencies with the provision of health care to
ADCRR inmates. Even in the areas where I have noted
opportunities for improvement, it is clear that ADCRR
recognizes the issues and has been working towards improving
them.

19 (*Id.* ¶ 1082). Thus, Dr. Murray believes the medical care provided to class members is the
20 same or better than what members of the public receive from their medical providers. As
21 set forth below, this opinion is contradicted by the evidence produced at trial.

22 **II. Staffing is Significantly Below Contract Levels**

23 The core issue is that staffing levels are so inadequate that the provision of
24 constitutionally mandated care is impossible. Dr. Wilcox testified “staffing is the root of
25 the ADCRR’s healthcare deficiencies” (Doc. 4138 ¶ 160), which opinion was established

26
27 ¹⁴ The relevant standard is the Eighth Amendment, not the community standard of care.
28 *Balla v. Idaho*, 29 F.4th 1019, 1026 (9th Cir. 2022) (noting Eighth Amendment liability
must be predicated on something “beyond malpractice”). However, “[t]he community
standard of care outside of the prison context is highly relevant in determining what care
is medically acceptable and unacceptable.” *Id.* (quotation marks and citation omitted).

1 by the evidence at trial. The current staffing levels illustrate ADCRR does not have the
2 ability to address the varied and often complex needs of Arizona's prisoners.

3 The contract between ADCRR and Centurion requires 1052.75 full-time staff
4 members ("FTEs") to provide health care, mental health care, dental care, and perform all
5 related administrative tasks. (Doc. 4287 at 17). Plaintiffs contend, and the evidence
6 establishes, the contractually allotted staffing for each complex is definitely too low and,
7 because of current vacancies, each facility is profoundly understaffed. In fact, the evidence
8 establishes Centurion admitted staffing at the contractual level would be insufficient, even
9 if such staffing levels could be obtained.

10 Although ADCRR claimed that 1052.75 FTEs were necessary at some point,
11 Defendants failed to explain how they arrived at this number. Defendant Gann stated in
12 his Rule 30(b)(6) deposition "the [staffing] model has been in place for a number of years,
13 and it [is] not something that is negotiated by us ongoing." (Doc. 4146-1 at 221). In other
14 words, the staffing model was already in place at the time Centurion began providing
15 services. Defendant Gann also testified Centurion has been encouraged "to present an
16 alternative [staffing] plan if they so desire." (Doc. 4146-1 at 228). But at trial, Defendant
17 Gann incredibly contradicted his deposition testimony and claimed ADCRR relies on
18 Centurion to report how many health care staff are needed. (Doc. 4275 at 89). The
19 evidence establishes the staffing numbers were set by ADCRR, and it has refused to require
20 increased staffing.

21 Centurion Vice President Tom Dolan testified that, in July 2019, Centurion
22 performed its own staffing evaluation to determine the number and type of health care staff
23 necessary to perform adequately under the contract and determined Centurion would need
24 to increase the FTEs by 161.5 for a total of 1214.25 FTEs. (Ex. 2166). This was
25 specifically communicated to ADCRR officials. (Doc. 4287 at 29). But ADCRR "was not
26 open to amending the contract to add additional FTEs," despite the insufficiency noted by
27 Centurion. (Doc. 4287 at 30). Of greater significance, Centurion has never even fulfilled
28 the staffing level required by contract. (Doc. 4274 at 99). The current situation falls well

1 below the already-insufficient contract level.

2 The Court looks to the staffing levels of the most crucial personnel. The following
3 positions are responsible for providing direct patient care: Assistant Director of Nursing,
4 Director of Nursing, Licensed Practical Nurse/Medical Assistant, Medical Assistant,
5 Medical Director, Midlevel Practitioner (nurse practitioners or physician's assistants),
6 Nursing Assistant/Patient Care Technician, Registered Nurse, and Staff Physician. Using
7 these positions, the tables at Appendix 1 set forth the contract level, the hired level, and the
8 variance between the contract and hired levels as of August 2021. (Ex. 2167).

9 All told, there were 465.45 FTEs providing direct care as compared with the 601.75
10 FTEs required by the contract. The current staffing figures do not include overtime
11 performed by current staff or temporary staffing. A Centurion employee claims use of
12 overtime and temporary employees has allowed Centurion to work 90% of the hours
13 contemplated by the contract. (Doc. 4287 at 17). But that does not indicate 90% of the
14 hours contemplated by the contract for direct patient care were performed.

15 As established by the tables at Appendix 1, seven out of ten facilities are
16 understaffed, and some are severely understaffed. The numbers at Tucson, for example,
17 are striking. Tucson houses 4,420 prisoners. According to the Centurion contract, to
18 provide medical care to that population, 40 licensed practical nurses are required but there
19 are only 24.30. The contract requires 36 registered nurses but there are only 18.30. The
20 contract requires 2 staff physicians but there is only 0.75. To be clear, there is not a single
21 full-time physician to cover the 4,420 prisoners housed at Tucson. And even if there were
22 the 2 staff physicians contemplated by the contract, the physician to prisoner ratio would
23 be severely inadequate. Another court noted a physician to prisoner ratio of 1:1,166 was
24 far too large. *Madrid v. Gomez*, 889 F. Supp. 1146, 1201 (N.D. Cal. 1995). Even if Tucson
25 were "fully staffed" according to the contract, the physician to prisoner ratio would be
26 1:2,210.

27 Overall, there are 10 medical directors, 47.15 midlevel providers (who may only
28 work under the direction of a physician), and 5.5 staff physicians for the entire prisoner

1 population of over 27,000. Three complexes do not require a staff physician at all
2 (Douglas, Safford, and Winslow), two more do not have their staff physician positions
3 filled (Lewis and Phoenix), and two more have their staff physician allocations
4 understaffed by 50% (Florence and Tucson). These numbers, and the tables at Appendix
5 1, demonstrate the contract staffing levels require the vast majority of medical care be
6 provided by nurses, nursing assistants, and medical assistants. Given these undisputed
7 actual staffing numbers, Defendants' position that there is no cause for concern—and they
8 are providing care that meets or exceeds the community standard—is incredible.

9 Defendants argue this overview does not account for the various site medical
10 directors. Those positions are filled by physicians and Defendants claim they increase the
11 number of physicians providing direct patient care. First, the increase is insignificant and
12 trial testimony established the medical directors are ill-equipped to provide anything close
13 to full time direct patient care. Dr. Jordan, the site medical director at Yuma, testified he
14 spends between 40 and 50% of his time providing patient care, “because [he is] involved.”
15 (Doc. 4277 at 59-60). Dr. Jordan also confirmed he has acted as the site medical director
16 for the Winslow complex in addition to his duties at the Yuma complex on more than one
17 occasion for at least one month. But Dr. Jordan never provided direct patient care at
18 Winslow. (*Id.* at 70-71). Dr. Wilcox also stated that, during his tours of various locations,
19 he had learned “site medical directors did not do very much clinical work and they
20 substituted in for vacations.” (Doc. 4271 at 74).

21 Even if medical directors were not required, at times, to cover multiple locations, it
22 is inconceivable that each site medical director could provide anything close to full-time
23 direct patient care while supervising a staff of 20-100 and performing administrative
24 responsibilities. As such, based on this record, any participation by the site medical
25 directors in providing direct patient care is marginal and, therefore, inadequate.

26 Defendants effectively concede the current staffing levels are insufficient. In
27 addressing whether the current staffing levels are adequate, Dr. Murray's opinion was
28 based on information from “facility leadership teams” in terms of the hypothetical staffing

1 contemplated by the contract, not actual staff. They told Dr. Murray if “their vacancies
2 were filled, the current workload would be manageable with the current number of
3 healthcare positions.” (Doc. 4206 ¶ 197). Because Centurion has never filled all its
4 vacancies, it is completely unclear how the teams know full staffing would be sufficient.
5 But, more importantly, these comments by “facility leadership teams” effectively admitted
6 the current staffing levels are not sufficient. Moreover, the evidence establishes the
7 contract staffing levels would not be sufficient, even if they could be obtained. Facilities
8 currently considered “overstaffed” according to the contract level are unable to meet basic
9 thresholds for providing care.

10 The Yuma complex illustrates the contract staffing levels are insufficient. Yuma is
11 overstaffed by seventeen positions (nearly thirteen of which are nursing assistants, medical
12 assistants, or LPNs). Despite being “overstaffed” as contemplated by the contract, Yuma
13 was unable to perform numerous health care performance measures during the
14 Stipulation’s operative period. (Doc. 4277 at 75-76). From January 2021 through July
15 2021, Yuma was substantially noncompliant with PM 37, which requires a prisoner to be
16 seen within 24 hours of submitting an HNR, and PM 44, which requires the prison to review
17 a prisoner’s hospital discharge instructions within 24 hours of their return from the hospital.
18 In other words, even with Yuma substantially “overstaffed,” it was unable to see prisoners
19 within 24 hours or review discharge instructions within 24 hours, both tasks a well-staffed
20 facility should be able to accomplish. It was these types of critical failures that ultimately
21 destined the Stipulation to fail and mandated its rescission. (*Id.* at 78-83). In addition,
22 Yuma is one of the only complexes where Defendants claimed use of the eConsults service,
23 where prison providers can reach out virtually to specialists, explain a prisoner’s symptoms
24 and testing results, and seek specialized advice on how to proceed with a patient. (*Id.* at
25 60:8-21). While this may have been helpful, Yuma’s performance in obtaining specialty
26 consultations remained substantially noncompliant. (*Id.* at 75-76).

27 Significantly, Defendants offered no evidence the contract staffing levels, if
28 achieved, would be sufficient. They did not offer a statistical analysis demonstrating the

1 staffing allocation contemplated by the contract would be appropriate to meet prisoners'
2 needs. Instead, Defendants relied, almost exclusively, on their National Commission on
3 Correctional Health Care (“NCCHC”) accreditation. NCCHC accredits correctional
4 facilities for compliance with NCCHC’s standards regarding medical and mental health
5 care. (Doc. 4172 ¶¶ 59-61; Doc. 4279 at 101; Doc. 4270 at 110-111). Correctional
6 facilities initiate the accreditation process and the institution seeking accreditation pays an
7 initial fee, as well as an annual fee to maintain accreditation. (Doc. 4289 at 133-134).
8 NCCHC will accredit a facility if it finds that a facility meets all “essential” NCCHC
9 standards and 85% of all “important” NCCHC standards. (Doc. 4270 at 114:6-15; Doc.
10 4275 at 61:24-70:11).

11 ADCRR is fully accredited. But the evidence established that accreditation is of
12 very little value when determining actual performance of the ADCRR system. Dr. Wilcox
13 testified “NCCHC has never and does not now purport to assess the adequacy of staffing
14 levels as part of its accreditation process. In fact, the NCCHC has always declined to offer
15 any guidance on staffing other than to provide an umbrella statement that “[t]he
16 responsible health authority (RHA) ensures sufficient numbers and types of health care
17 staff to care for the inmate population.” (NCCHC Standards for Health Services in Prison,
18 2018, pg 61); (Doc. 4138 ¶ 158 n. 7). This was corroborated by Defendant Gann who
19 testified NCCHC will not provide a benchmark for staffing because every facility is
20 different. (Doc. 4275 at 33). Further, while Defendants claim NCCHC surveyors are
21 neutral and objective, the evidence established Centurion and Corizon are far from neutral
22 because they are prominent NCCHC sponsors. (Doc. 4283 at 5).

23 The Court finds Dr. Wilcox’s opinion that none of the NCCHC essential standards
24 incorporate a substantive review of the health care administered by ADCRR is credible.
25 Rather, these standards are exactly what Dr. Wilcox said they are—standards to ensure
26 some policies and procedures are in place to create a health care delivery system. (Doc.
27 4138 at page 66 n.7). And those systems do, in fact, exist, so it is not surprising ADCRR
28 was and remains accredited. But it has never been Plaintiffs’ claim that Defendants do not

1 have policies or procedures to provide health care. Rather, Plaintiffs have always claimed
2 the system was providing constitutionally inadequate health care.

3 If there were any remaining doubt about the utility of NCCHC accreditation, it is
4 dispelled by looking at Defendants' PM compliance from 2018-2021. As the Court
5 detailed in its July 16, 2021 Order, pervasive noncompliance with the Stipulation's
6 performance measures justified rescission of the Stipulation. Indeed, just one example,
7 PM 44 at Eyman—requiring prisoners returning from a hospital stay shall have the
8 hospital's treatment recommendations reviewed and acted upon within 24 hours—has been
9 noncompliant for years. Given that performance, it is implausible all ten complexes could
10 be 100% compliant with each "essential" NCCHC standard if those standards were based
11 on a qualitative assessment of the actual care provided to prisoners.

12 Ultimately, the evidence demonstrates current staffing is woefully insufficient. In
13 addition, as Dr. Wilcox stated "[t]hese staffing problems persist and recur because neither
14 the ADCRR nor Centurion adequately analyze, monitor, or take responsibility for
15 addressing them." (Doc. 4138 at ¶ 160). Based on the testimony and evidence, the only
16 reasonable conclusion is the current staffing level is inadequate, and even if all positions
17 contemplated by the contract were filled, it is more probable than not the staffing would be
18 insufficient. The Court need not decide the number of staff that would be necessary. It is
19 enough to know that even Centurion has admitted the contract staffing level, which has
20 never been achieved, is insufficient. The next issue is the impact that lack of staff has on
21 the care provided to prisoners.

22 **III. Intersection of Inadequate Staffing and Nursing**

23 The staffing levels contemplated by the contract tilt sharply toward support staff—
24 licensed practical nurses, medical assistants, nursing assistants, and patient care
25 technicians—and away from providers who can write orders and prescribe medication. All
26 positions are not created equal. Several witnesses attempted to put the staffing numbers
27 into context, and Dr. Wilcox's testimony was the most thorough and persuasive.

28 Dr. Wilcox explained the process by which prisoners seek care. The ADCRR

1 system requires every prisoner seeking medical care to be evaluated by a nurse who then
2 uses the nursing encounter tools (“NETS”) to formulate a plan of care, including whether
3 to send the prisoner to a provider—nurse practitioner, physician’s assistant, or physician.
4 (Doc. 4138 ¶ 163).

5 Dr. Wilcox’s undisputed characterization of ADCRR’s health care hierarchy is that
6 nurses are tasked with triaging prisoners but quite often prisoners do not obtain care beyond
7 that provided by a nurse. And of greater significance, this system requires nurses to
8 diagnose and treat far beyond their capabilities. Nurses are expected to work closely with
9 higher-level providers, but given the relatively few higher-level providers on staff, that is
10 simply not possible. In Dr. Wilcox’s expert opinion, “the poor quality of clinical decision-
11 making demonstrated by nurses and providers in the ADCRR harms patients and places
12 them at an unreasonable and substantial risk of serious harm.” (Doc. 4138 ¶ 17). During
13 his in-court testimony, Dr. Wilcox elaborated on this point and pointed out the strangeness
14 of ADCRR using nurses in this manner.

15 Dr. Wilcox was asked if he was “aware of any other health care settings where the
16 nurse serves as final decider when someone seeks to access their doctor.” He responded

17 No. Considering that it’s not really legal, you wouldn’t expect
18 to find any others. But, you know, can you imagine in the
19 community if you schedule an appointment with your doctor
20 and you’re met in the lobby by the nurse who does a little
assessment on you and then turns you around and sends you
home and you’re not allowed to see your doctor? That just
doesn’t exist in the scope of healthcare anywhere.”

21 (Doc. 4270 at 74). ADCRR’s decision to structure their system in this manner is, in Dr.
22 Wilcox’s credible opinion, an extreme outlier.

23 Dr. Murray attempted to counter Dr. Wilcox’s opinion by stating “[t]he nurses and
24 providers I interviewed felt comfortable with the supervision available, and I believe the
25 ratio of providers to nurses in the ADCRR system allows for adequate supervision.” But
26 Dr. Murray does not identify a single provider who explained how supervision is adequate
27 to protect prisoners. And with 5.5 staff physicians for the entire prison population of more
28 than 27,000, the evidence does not support a finding that the ratio is sufficient for adequate

1 supervision.

2 In essence, it is Defendants' position that access to any care, no matter how poor,
3 satisfies their constitutional obligations. In Defendants' view, prisoners have access to
4 nurses, and those nurses can in theory escalate matters to higher level providers when
5 appropriate. But the evidence shows that they do not do so. And in practice, it is never
6 enough to provide prisoners with serious medical needs access to health care staff who lack
7 the training and authority to address their needs. Access to health care necessarily involves
8 access to health care performed by competent staff. The staffing levels detailed above
9 make clear it would be impossible for nurses to meaningfully consult with or refer many
10 prisoners to providers because there are simply not enough higher-level providers available
11 to see them.

12 As credibly stated by Dr. Wilcox, "in a well-functioning system, a high percentage
13 of patients should pass through the triage process to see a provider, who can then diagnose
14 their condition and prescribe appropriate treatment." (Doc. 4138 ¶ 162). Instead, ADCRR
15 relies almost exclusively on nurses to "function outside the scope of their licenses and act
16 as providers." (Doc. 4138 ¶ 169). The basic staffing levels allow for nothing else.¹⁵ The
17 staffing levels require the vast majority of prisoners who submit HNRs to be seen by nurses,
18 and nurses only. And even the nurse lines are cancelled due to lack of staffing. Defendant
19 Gann admitted the nurse line was cancelled in Tucson more than twenty times in January
20 and February of 2021 due to insufficient staffing. (Doc. 4275 at 100:25-101:3).

21 Dr. Wilcox opines the inadequacy of ADCRR's system, including the overreliance
22 on nurses, is borne out by reviewing the numerous mortality reviews.¹⁶ Those reviews—

23 ¹⁵ For example, at the Tucson complex there are 18.3 registered nurses, 7.00 midlevel
24 practitioners and 0.75 staff physicians. There are 4,420 prisoners at that complex who
25 submit 200-300 HNRs per day. (Doc. 4206 at 7). It is not remotely possible for each
26 prisoner who submits an HNR to be seen by a midlevel practitioner or staff physician. The
ADCRR system documented a total of 300,000 HNRs across all complexes in 2020. (Doc.
4275 at 145). The staffing levels systemwide mean only the tiniest fraction of those HNRs
could possibly result in a visit with a midlevel practitioner or staff physician.

27 ¹⁶ Dr. Wilcox examined 94 mortality reviews of the 322 prisoners who died between
28 January 1, 2019, and September 26, 2021. Dr. Wilcox "focused primarily on more recent
deaths to gain the most accurate picture of the current state of affairs in the ADCRR
healthcare system." (Doc. 4167 at ¶ 21).

1 which Defendants did not controvert—document a lack of timely access to appropriate care
2 by the appropriately skilled professionals and they reflect numerous preventable deaths.

3 **A. Joseph Assyd¹⁷**

4 Joseph Assyd died on April 12, 2020, at the age of 64. On March 13, 2020, he
5 became unresponsive due to hypoglycemia. A nurse measured his glucose at a very low
6 level of 40, and Assyd reported abdominal pain, nausea, vomiting, and diarrhea. He was
7 provided “glucose gel 3 times over the next hour.” While he had “a fever of 102.3,
8 hypoglycemia, and abdominal pain,” he was transferred from the Lewis complex to the
9 Tucson complex. Assyd was not seen by a provider on March 13. It was not until March
10 27, 2020, that he saw a provider for complaints of “generalized weakness and pneumonia.”
11 He had an altered mental state and was transferred to the hospital. Assyd tested positive
12 for Covid-19 on April 7, 2020, developed sepsis, and died on April 12, 2020.

13 The mortality review reflected Assyd’s vital signs were not properly documented
14 on March 13, 2020, and, consequently, his assessment on that date did not prompt a referral
15 to a provider. In addition, there was no “clear cut documentation” why he was transferred
16 between facilities. Despite this, the mortality review found no issues with the care. Instead,
17 officials merely made “recommendations” that transfers between facilities be accompanied
18 by an explanation why the transfer was occurring and that referrals to providers “must be
19 authorized timely based on level of urgency.” (Ex. 155). In other words, the nurse
20 responsible for the assessment on March 13, 2020, should have concluded Assyd needed
21 to be seen by a higher-level provider.

22 **B. Kenneth Barker**

23 Kenneth Barker died on October 5, 2019, at the age of 68. He was housed in the
24 Tucson complex. He was seen by a nurse on May 29, 2019, because of “foot pain with
25 difficulty walking.” There is no indication his feet were examined at that time, but he was
26 referred to a provider. Before that provider visit, he was seen again by a nurse on June 10,

27 _____
28 ¹⁷ The Court uses the full names of prisoners who died in ADCRR custody as their deaths
are reported publicly. For prisoners who remain in custody, the Court will use their initials
unless the prisoner testified at trial.

1 2019, for foot pain. Barker was told a provider visit had been scheduled but his feet were
2 not examined.

3 On July 8, 2019, for the third time, he was seen by a nurse because of foot pain.
4 This time, his right foot was examined. He was seen by a nurse for the fourth and fifth
5 time on July 27 and August 6, with a note on August 6 as “unremarkable.” Finally, at his
6 sixth visit on August 21, 2019, a nurse examined his left foot and determined there was a
7 2.5 cm ulcer on the bottom of his left foot. He was referred a second time to a provider,
8 but the examination did not occur until September 3, 2019, when the wound on his foot
9 had become necrotic and he exhibited edema on his lower left leg between the knee and
10 ankle.

11 Barker was sent to the hospital, where it was determined the ulcer may have been
12 caused by several months of wearing ill-fitting shoes. Despite aggressive treatment,
13 including amputation of his lower left leg, Barker died on October 5, 2019. His mortality
14 review noted Barker should have been escalated to a provider in a “more timely manner”
15 after two HNRs were submitted by him for the same complaint. (Ex. 159). The mortality
16 review noted “[p]reventative measures not taken” and the diagnosis was “not timely.” The
17 mortality review recommended “[a]ll diabetic patients when seen for chronic care must
18 have a visual assessment [of] the feet.” The treatment of Barker illustrates the system relies
19 on nurses to assess patients, even when the patient makes repeated complaints for the same
20 issue.

21 **C. Cardinal Barnes**

22 Cardinal Barnes died on April 6, 2021, at the age of 37. He was housed in the
23 Eyman complex. He had a chronic care visit on March 17, 2021 for asthma. The following
24 week, on March 24, 2021, he saw a nurse for shortness of breath and an upper respiratory
25 infection. He told the nurse he had three asthma attacks the previous day, his inhaler was
26 not working, and he was so short of breath that it had taken him 30 minutes to get dressed.
27 The nurse did not refer him to a provider. Instead, the nurse instructed him to call ICS¹⁸ if

28 ¹⁸ Incident Command System, the health services’ emergency response system. (Ex. 1305 at 30).

1 he had another asthma attack and his inhalers were not working. Barnes collapsed and
2 became unresponsive on April 6, 2021. CPR was performed, but it was unsuccessful. The
3 autopsy found evidence of valley fever. The mortality review questioned whether “the
4 patient [should] have been referred to a provider for the complaints on shortness of breath
5 and diffuse pain,” but concluded “[t]he evaluation and recommendations by nursing were
6 appropriate given the clinical presentation.” (Ex. 160). Barnes is another example of a
7 prisoner being unable to access a provider and instead being subjected to cursory treatment
8 by a nurse.

9 **D. Andrew Barnhart**

10 Andrew Barnhart died on July 17, 2020, at the age of 72. He was housed in the
11 Eyman complex. During the two years preceding his death, he lost over thirty pounds and
12 had a body mass index of 15, demonstrating he was extremely underweight. A June 3,
13 2020, chest x-ray showed “near complete opacification [increased density] of the right
14 upper [lung] lobe.” Barnhart underwent a CT scan on June 26, 2020, which revealed a
15 14x10x12 cm mass. At that time, his blood pressure was 86/64, which was ignored. He
16 was transported to the hospital on July 8, 2020 to evaluate abdominal and back pain with
17 hypotension. He was taken into emergency surgery to address a perforated gastric ulcer,
18 and a lung mass was discovered. Barnhart developed post-surgical complications and died.
19 (Ex. 161). The mortality review stated the CT scan on June 26, 2020, presented “an
20 opportunity for additional questioning, a blood pressure recheck, and elevation to the
21 provider” regarding his blood pressure. But the record does not establish that the results
22 of the CT scan and the low blood pressure were reviewed by anyone, which may or may
23 not have resulted in a different outcome but certainly the lack of review presented a
24 substantial risk of serious harm.

25 **E. James Edwards**

26 James Edwards died on January 1, 2020, at the age of 29. He was housed in the
27 Eyman complex. He submitted his first HNR for leg and stomach pain on October 7, 2019
28 but did not see a nurse until November 8, 2019 and then a second time on November 17,

1 2019. It was noted he had a mass on his collar bone and an elevated heart rate. He was
2 referred to a provider who did not see him until November 23, 2019. He complained of
3 severe hip pain and the only diagnosis was mild osteoarthritis in his hip.

4 Twenty-four days later, on December 17, 2019, Edwards was seen by a provider
5 after an ICS was activated for “shoulder pain,” but the provider determined his shoulder
6 was “normal.” Another ICS followed on December 20, 2019, because Edwards felt
7 “weakness and discomfort” and he was also “unable to keep water down.” He was seen
8 by a nurse who instructed “to drink more water in slow sips.” Ten days later, Edwards
9 became unresponsive and was transferred to the hospital where he died of valley fever.
10 The mortality review accurately concluded nurses failed to recognize signs or symptoms,
11 delayed access to care, and failed to follow clinical guidelines. (Ex. 229).

12 **F. Gabriel Figueroa**

13 Gabriel Figueroa died on December 11, 2020, at the age of 55. He was housed in
14 the Tucson complex. He suffered from Hepatitis C and a variety of other conditions. He
15 had a chronic care visit on November 27, 2020, and two days later, on November 29, he
16 saw an RN because an LPN said he “did not sound good.” Figueroa reported a cough that
17 started the previous day, shortness of breath, and lethargy. His oxygen saturation was low
18 at 92%. The nurse advised him to submit an HNR or initiate an ICS if he continued to
19 experience shortness of breath. An ICS was initiated the next day when his oxygen
20 saturation was recorded as 62%. He was transported to the hospital, where he died on
21 December 11, 2020. His cause of death was listed as Covid-19 pneumonia.

22 The mortality review concluded the nurse who examined Figueroa on November 29
23 should have referred him to a provider “to determine the next steps” to determine the source
24 of his illness (Ex. 241). This reflects another instance where a nurse did not accurately
25 assess the prisoner’s needs and prevented him from seeing a provider.

26 **G. Bruce Manthey**

27 Bruce Manthey died on December 31, 2019, at the age of 71. He was housed in the
28 Tucson complex. He suffered from several preexisting conditions. An ICS was called on

1 November 29, 2019, because Manthey was experiencing painful edema bilaterally.
2 Medical staff provided medication and advised him to keep his feet clean. Several days
3 later, he saw health care staff to address a left shoulder abscess, but there was no mention
4 of edema. Thirteen days later, Manthey had a nurse visit on December 12, 2019 for
5 bilateral edema that began when he stood up in the morning. The record does not specify
6 a diagnosis or treatment and the December 18, 2019 provider note does not mention edema
7 or skin lesions. Another ICS was initiated on December 23, 2019, because Manthey could
8 not sit in his wheelchair because of pain from his bilateral edema, which had grown to over
9 6mm of swelling. He was in pain, and open wounds on both feet were “draining foul
10 discharge.” No beds were available in the IPC unit, and he was sent to the emergency
11 room. Manthey became septic, was admitted to the ICU, and he died on December 31,
12 2019 due to multiorgan failure secondary to sepsis. The mortality review set forth the
13 obvious: Manthey’s symptoms were not addressed according to the standard of care, and
14 the documentation in his medical record did not reflect Manthey’s actual condition. In
15 particular, Manthey’s “condition should have been elevated by nursing . . . due to obvious
16 symptoms (edema, odor, drainage) of something wrong.” There is no explanation how
17 nurses could have missed these “obvious symptoms.” (Ex. 327). This care illustrates the
18 dangers of setting up the system such that nurses are the first, and often only, medical
19 professional available to prisoners.

20 **H. Jose Miranda**

21 Jose Miranda died on August 4, 2019, at the age of 76. He had been housed in the
22 Tucson complex infirmary or SNU since 2015. On July 25, 2019, after he returned from
23 an off-site medical appointment, he was observed sitting up straight but seemed stiff on
24 one side, flaccid on the other, and was not speaking. Despite these issues, staff did not
25 send Miranda to a provider. The next day, he continued to have right side stiffness. He
26 opened his eyes, but he was aphasic, had a weak left grip, and a minimal response to
27 ammonia inhalant. He was sent to the hospital for stroke evaluation and died. The
28 mortality review noted that when nursing evaluated him following his return from his

1 appointment on July 25, 2019, “his altered mental status and vital signs should have
2 triggered the patient to be evaluated to the attention of a provider.” (Ex. 344). This reflects
3 yet another example of nurses missing obvious signs that merited referral to a higher-level
4 provider.

5 **I. Gilbert Molina**

6 Gilbert Molina died on February 15, 2021, at the age of 73. He was housed in the
7 Eyman complex. On January 11, 2021, he fell and was evaluated by nursing. At that time,
8 Molina reported “10/10 pain.” The nurse did not immediately contact a provider for
9 diagnosis. Instead, an appointment was set and occurred two days later. The provider
10 ordered x-rays, but not expedited and they occurred five days later. The x-rays revealed a
11 fractured femur. Molina underwent surgery, but he contracted Covid-19, developed
12 complications, and subsequently died. The mortality review noted “[a]n elderly patient
13 with severe pain after a fall should be escalated to a higher level of care immediately.” In
14 addition, the x-rays should have been ordered “stat” not “routine.” (Ex. 346). From the
15 records, it appears the nurse was insufficiently trained and skilled to treat the condition
16 Molina presented with on January 11.

17 **J. David Neville**

18 David Neville died on July 22, 2019, at the age of 59. He was housed in the Tucson
19 complex. He had a history of squamous cell carcinoma at the base of his tongue for which
20 he had received chemotherapy and radiation. In February 2017, a PET scan showed
21 “lymph nodes suspicious for recurrence” of cancer. At that time, Neville complained of
22 neck and throat pain. In October 2018, during a chronic care visit, he complained of
23 “unrelenting pain in [his] throat.” He was treated with pain medication for a short time,
24 but the medication was discontinued because the pain “was not a result of cancer.” Neville
25 continued to have difficulty swallowing.

26 Neville hung himself on July 22, 2019. The mortality review noted it was
27 “undetermined” if the death could have been prevented or delayed. The review also stated
28 Neville submitted several HNRs due to unrelenting pain but “[n]ursing staff [did] not

1 appreciate the level and severity of pain symptoms and therefore no referrals [were] made
2 to the health care practitioner.” (Ex. 355). This reflects another example of nurses being
3 insufficiently trained and skilled to fully diagnose and treat the presented condition.

4 **K. Pedro Rojas**

5 Pedro Rojas died on June 26, 2019, at the age of 51. He was housed in the Florence
6 complex. On May 6, 2015, he reported he had been suffering from hemorrhoids and rectal
7 bleeding for over a year. Results of three hemoccult tests ordered by a nurse were all
8 positive for occult (hidden) blood, but there was no follow-up ordered. Rojas continued to
9 complain of diarrhea and abdominal pain for years with no diagnosis. On April 19, 2017,
10 hemoccult tests were repeated and, again, all were positive for blood. He was diagnosed
11 with severe anemia and sent to the hospital.

12 At the hospital, a colonoscopy showed prominent hemorrhoids and a large
13 fungating, nearly obstructing tumor of the colon. “Chemo radiation” was recommended.
14 Rojas was transferred to Florence, and on May 17, 2017, he was seen by an oncologist.
15 The record does not indicate the result of that examination but Rojas continued to complain
16 of weakness. He was sent to the ER again and, upon his release, he was transferred to
17 Lewis. He had been scheduled for radiation on June 21, 2017, but the appointment was
18 overlooked. As of June 2017, his “abdominal pain continued to worsen” and he had to be
19 sent to the hospital repeatedly “for blood transfusions for anemia due to blood loss from
20 rectal bleed.” Chemotherapy was finally started on August 7, 2017. He had additional
21 hospitalizations for sepsis, pneumonia, and pyelonephritis, and underwent surgery in
22 October 2017. At that time, he was noted to have Stage 4 cancer.

23 In April 2019, Rojas completed chemotherapy and radiation treatments and
24 underwent a biopsy of a lung nodule, which showed necrotic adenocarcinoma consistent
25 with metastasis. In May 2019, he developed a small bowel obstruction, and he was
26 admitted to the infirmary on June 14, 2019. On June 21, 2019, Rojas developed
27 hypotension and died. The mortality review noted that Rojas should have been referred to
28 a health care practitioner in a timely manner after the initial positive hemoccult tests in

1 2015 and there were “significant delays from diagnosis to eventual treatment in addition to
2 delays during treatment of the patient’s cancer.”

3 ADCRR and Centurion officials recognize the failures in Rojas’ care. The mortality
4 review notes that prisoner health care had “improved dramatically” in recent years and
5 Rojas’ death “most likely would not have taken place in the current health care delivery
6 climate.” It is unclear to what “current health care delivery climate” Defendants refer to
7 as Rojas’ case is relatively recent. (Ex. 398).

8 **L. Kamaka Solo**

9 Kamaka Solo died on September 15, 2019, at the age of 58. He was housed in the
10 Tucson complex. On June 8, 2019, Solo began complaining of constipation. Solo’s
11 complaints worsened throughout June, and he complained of gastric distress, bloating, gas,
12 abdominal pain, cramping, and continued constipation. He was seen by nurses and given
13 laxatives. He returned in July 2019, complaining that “even drinking water causes pain,”
14 he was unable to eliminate despite trying and straining for hours, and he was unable to eat
15 or sleep. He was referred to a provider, who did not see him until July 9, 2019. The
16 provider ordered x-rays, which were deemed “normal.” Again, on July 19, 2019, Solo
17 returned with constipation, gas, bloating, constant pain due to abdominal cramps and
18 inability to sleep or eat. As required, he was seen first by a nurse on July 20 and, after a
19 referral, a provider saw him on July 25, who gave Solo medication for gas and heartburn
20 as well as a laxative.

21 On August 1, 2019, Solo requested to see a specialist for unresolved pain. He stated,
22 “I am in constant, excruciating pain, and all the treatment I have received so far has been
23 totally ineffective.” A nurse saw him and did nothing. On August 3, he submitted an HNR,
24 which stated “[t]he pain is unbelievable, definitely a ‘10’. Could I please have an enema?
25 I need help.” Nursing diagnosed “constipation” and gave him “nothing.”

26 On August 12, 2019, Solo submitted an HNR stating “[n]o human being deserves
27 to endure the pain I am in 24 hours a day. Can you help me?” That resulted in a provider
28 appointment on August 13, 2019. The provider repeated the x-ray order and ordered a

1 liquid diet but no diagnosis. Rather, on August 15, 2019, nursing again gave him a laxative.
2 On August 18, 2019, an ICS was called due to Solo's chest pain. A hemocult was ordered
3 then cancelled, and a helicobacter pylori test was ordered. That same day, a nurse noted
4 Solo's pain was "increasing" and he was sent to the IPC for observation.

5 While in the IPC, a provider requested a gallbladder ultrasound, but it was not
6 authorized until September 3, 2019, and was never done. Solo was returned to his normal
7 housing unit. On August 20, 2019, Solo reported to a provider that he had not eaten for 2
8 weeks. The provider once again gave a laxative and pain reliever.

9 Over the following days, ICS emergencies were called because of vomiting and
10 extreme pain. Solo's heartrate was irregular, and an EKG was done and read with "sinus
11 rhythm with occasional PVC, L anterior fascicular block and nonspecific T wave
12 abnormalities." But Solo was sent back to his cell. On August 26, 2019, Solo was seen by
13 nursing, who noted that Solo was "very uncomfortable, grimacing and moaning." On
14 August 27, 2019, another ICS was called for chest pain, Solo's blood pressure was 96/64,
15 and he was witnessed seizing and throwing up bile. Solo was finally sent to a hospital.

16 The emergency department performed a CT scan which revealed a large pancreatic
17 mass and multiple hepatic lesions, likely metastatic. On September 10, 2019, Solo suffered
18 a stroke while in the hospital. Solo was sent back to the prison on September 14, 2019 and
19 died on September 15, 2019.

20 Solo's mortality review noted his "symptoms were worked up routinely and a
21 diagnosis was attempted (as being H. pylori and constipation)." However, "[a]larming
22 symptoms were missed and/or not elevated, and pain was not addressed adequately." The
23 review recommended nursing staff "be provided education regarding multiple HNR[s] for
24 the same complaint to be elevated to the practitioner."

25 From June 2019 through September 2019, Solo complained of unremitting and
26 extreme pain. The response by nursing staff, on multiple occasions, was to do nothing.
27 And even when elevated to a provider, diagnostic tests were ordered but not performed and
28 Solo was given effectively no treatment for his pain. (Ex. 422).

1 **M. Macario Vela**

2 Macario Vela died on April 21, 2019, at the age of 43. He was housed in the Lewis
3 complex. On April 6, 2019, Vela was seen by a nurse for pain in his left breast radiating
4 to his back at the base of neck on the left side. The nurse identified a palpable lump in
5 Vela's left shoulder. On April 10, 2019, Vela was scheduled to see a provider, but the
6 record states "refused." On April 14, 2019, he returned to a nurse complaining of
7 increasing back pain in lumbar spine and radiating into left leg, stated he had not eaten in
8 3 days, and was walking stiffly. The nurse provided ice and "analgesic balm."

9 Vela was seen by nursing again on April 15, 2019, and after an abnormal urine dip,
10 a urine drug screen was returned positive for opiates. At that visit, Vela had a temperature
11 of 103 degrees. Vela was given fluids for some period but declined additional fluids and
12 refused to see the provider. On April 20, 2019, an ICS was called for a suspected overdose
13 and Vela died the next day.

14 Vela's autopsy revealed staphylococcus aureus sepsis due to chronic intravascular
15 drug use. His mortality review noted failure to recognize symptoms or signs and patient
16 non-adherence as contributing factors of Vela's death. But the review also noted Vela did
17 not receive a timely diagnosis or treatment. Diagnosis could have potentially been made
18 on the first visit given Vela's complaints, and the subsequent visits should have alerted the
19 nurses that Vela was very ill. The mortality review noted poor documentation, there was
20 no record of labs on April 15, 2019, and failure to closely monitor in that there was growing
21 evidence of possible endocarditis. (Ex. 442). Vela may have refused to see a provider
22 which is a complication, but given his symptoms, nurses should have been able to
23 determine he was at very significant risk.

24 **N. Michael Voden**

25 Michael Voden died on June 16, 2019, at the age of 77. He was housed in the
26 Florence complex. On intake on August 14, 2015, it was noted Voden had a history of
27 hypertension and COPD. A heart murmur was detected and described as aortic valve
28 dysfunction. On October 10, 2018, an ICS was initiated because Voden had "chest pain

1 10/10.” Voden reported recurrent chest pain for two months with recurrent nausea. An
2 EKG showed abnormalities and ischemia or subendocardial injury but no review by a
3 provider. Voden was given antacids.

4 On December 28, 2018, a second ICS was initialed for “man down,” and Voden
5 reported generally feeling unwell and chest discomfort, but there was no record of calling
6 a health care provider. On January 30, 2019, Voden reported chest pain with tightness and
7 difficulty breathing to a nurse and a provider diagnosed COPD exacerbation, GERD, and
8 pleuritic chest pain. On March 5, 2019, Voden had complained to a provider of a
9 progressive leg edema for three years, and bilateral edema was noted, but the provider said
10 it was due to sitting in a wheelchair. Voden’s continued shortness of breath was attributed
11 to COPD. On March 21, 2019, a third ICS was initiated for shortness of breath, crackles
12 were heard in Voden’s chest, and Voden had lowered pulse oxygen levels. Nursing staff
13 noted shortness of breath on a subsequent appointment, and on March 26, 2019, a provider
14 diagnosed possible congestive heart failure.

15 On April 14, 2019, Voden was seen by nursing for respiratory symptoms and edema
16 and was instructed to “increase fluid intake.” He was referred to a provider, who described
17 him as frail but in no acute distress. The provider recommended that Voden “drink plenty
18 of water,” with no follow-up appointment. On April 18, 2019, a fourth ICS was initiated
19 after prison staff witnessed Voden exhibiting labored breathing and nursing staff advised
20 him to “hydrate and . . . be seen on nursing line.” On April 20, Voden was seen on the
21 nursing line and “diagnosed” with “poor air exchange secondary to Asthma.” On April 29,
22 2019, the provider noted Voden had a “4+ edema” in his left leg with a loud murmur along
23 with lung wheezes and assessed poorly controlled COPD and poor compliance with
24 medication. On May 7, 2019, Voden reported “life threatening emergency respiratory,
25 circulatory function” and requested to be seen by a provider outside of ADCRR. Nursing
26 evaluated Voden and determined he had “fluid weeping from his [lower extremities] along
27 with difficulty breathing and a 25 lb. wt. gain.” Nursing referred him to a provider.

28 Voden was seen several times throughout May, and at the end of May, a cardiology

1 consult was requested. On June 5, 2019, Voden's condition had seriously deteriorated, and
2 he was diagnosed with heart failure and pleural effusions, possible aortic stenosis, cellulitis
3 of legs, and COPD, and was sent to the hospital. At the hospital, Voden was diagnosed
4 with severe non-rheumatic aortic stenosis and deemed a poor candidate for surgery. He
5 was also diagnosed with a number of other conditions, including acute renal failure. Voden
6 died in the hospital on June 16, 2019, after he suffered cardiac arrest.

7 Voden's mortality review noted a pattern of nursing staff acting beyond their
8 expertise and failing to recognize when referral to a provider was necessary. Nursing
9 should have contacted a provider in October 2018 based on Voden's complaints of chest
10 pains. Nursing should have contacted a provider on December 28, 2018, when Voden
11 again complained of chest pain. The initial diagnosis of congestive heart failure in March
12 2019 should have been accompanied by other diagnostic tests, such as an echocardiogram,
13 and further follow-up. The recommendation by nursing on April 14 to increase fluid intake
14 very likely was inappropriate because of the serious edema. The provider's exam on April
15 15, 2019, was inadequate in that the provider failed to note the "significance" of the
16 murmur accompanied by significant edema. Inexplicably, the provider also recommended
17 that Voden increase his fluid intake. During the remainder of April and May 2019, medical
18 staff repeatedly failed to properly diagnose Voden's condition. Overall, Voden's death
19 was possibly avoidable. (Ex. 445).

20 Voden's case presents a situation where nursing staff ineffectively repeatedly
21 attempted to treat him without referring him to a provider. In doing so, nursing staff missed
22 obvious signs of other conditions and gave wrong treatment advice.

23 **O. Conclusions Derived from Mortality Reviews**

24 The mortality reviews illustrate the harm that routinely befalls prisoners because
25 they do not receive timely and adequate health care. The common theme is nurses
26 repeatedly are unable to properly diagnose health care issues and fail to refer prisoners to
27 a provider. Despite these reviews, Defendants still maintain nurses act reasonably in
28 evaluating prisoners. Dr. Wendy Orm, the statewide medical director, testified during her

1 Rule 30(b)(6) deposition that she is satisfied nurses appropriately assess patients and
2 believes they accurately determine whether and when to refer patients to a provider for
3 care. (Doc. 4148 at 46). Dr. Orm admitted, however, her opinion was not supported by
4 any attempt on her part to validate nurses' assessments or prisoners' treatment. (Doc. 4148
5 at 47-49). Dr. Wilcox accurately found "Dr. Orm's failure to have conducted any quality
6 assurance studies on the accuracy and appropriateness of the nursing assessments and on
7 the limited throughput of patients to providers is an abrogation of her basic duties." (Doc.
8 4138 ¶ 146).

9 The reality that nurses do not, in fact, accurately assess prisoners and then refer them
10 to providers is further supported by evidence from the Yuma complex. That facility
11 conducted self-audits to determine whether nurses were selecting the correct NET
12 assessment tool when evaluating a prisoner on the nurse's line. The numbers for selecting
13 the correct assessment tool were as follows. At the La Paz Unit, the correct tool was
14 selected between 0 and 20% of the time from May through August 2021. (Ex. 825 at 25);
15 (Ex. 835 at 14); (Ex. 855 at 12); (Ex. 914 at 12). At other units, the correct tool was selected
16 43% and 58% of the time in September 2021. (Ex. 914 at 10); (Ex. 914 at 11).

17 This undisputed evidence shows nurses routinely selected the wrong NET when
18 evaluating a prisoner. That does not necessarily establish the nurses reached inappropriate
19 diagnoses. But if, as the evidence established, nurses are not using the diagnostic templates
20 properly, it is likely the nurses are not properly assessing conditions.

21 ADCRR's response to the mortality reviews shows deliberate indifference of the
22 deficient practice of placing nurses as the gatekeeper for diagnosis and treatment. Dr.
23 Wilcox explained:

24 It is clear, through my analysis of mortality reviews authored
25 in the last two years, that there are still significant deficiencies
26 in the process. I did not find the mortality reviews, on the
27 whole, to be honest, thorough, or effective. They minimized
28 the harm caused by healthcare staff, lacked the requisite
specificity, failed to identify clear errors in care, failed to offer
effective recommendations, and evidenced no staff
accountability, even after identification of serious errors that
led to a patient's death.

1 (Doc. 4138 ¶ 131). These reviews do not simply evaluate each prisoner’s final interaction
2 with ADCRR’s health care. The reviews show systemic failures as well as ADCRR’s
3 failure to “identify and address the core cause of many of these problems: nurses practicing
4 outside the scope of practice, insufficient physician-level oversight, and failure to refer the
5 patient to someone qualified to diagnose and treat them.” (Doc. 4138 at 56). Dr. Wilcox
6 believes “the response and the write up for the mortality reviews are tepid, and I think they
7 are very blunted and not really directive in any way to try to implement change that would
8 prevent a case like this from happening again.” (Doc. 4269 at 91). The mortality reviews
9 demonstrate that, despite ten years of litigation, ADCRR has never created and then
10 implemented a policy to identify systemic issues identified in mortality reviews and has
11 not taken steps to remedy them.

12 Dr. Orm testified during her deposition if ADCRR identifies an “actionable”
13 recommendation in a mortality review, then staff will develop a corrective action plan
14 (“CAP”). But there was no evidence Defendants developed even one CAP through
15 reviewing mortality reviews. Of significance, Dr. Murray agreed with the assessments of
16 prisoners’ care in the mortality reviews. (Doc. 4286 at 83). As part of his analysis, he also
17 asked Defendants for data to evaluate whether recommendations in the mortality reviews
18 were ever implemented but received none. (Doc. 4286 at 84). Dr. Murray was forced to
19 admit “there remains some room for improvement in terms of consistently identifying and
20 articulating actionable findings.” (Doc. 4206 ¶ 1040). That is an understatement. The
21 same failures arise in mortality reviews over and over and over—nurses not recognizing
22 conditions, nurses not referring prisoners to providers, and diagnostic testing not being
23 ordered or promptly obtained and reviewed—and yet not a single CAP was documented or
24 identified. This constitutes systemic conscious disregard of the risk prisoners face.

25 The deaths outlined above, some very recent, were not aberrations or corrective
26 action would have been implemented. No such evidence was introduced because it does
27 not exist. Defendants’ failure to take any action in response to such obvious deficiencies
28 up to the date of trial is evidence Defendants are content to continue using nurses

1 inappropriately and failing to require medically appropriate follow-up treatment.

2 Using nurses as the first line, and often last line, for providing care is medically
3 unacceptable. While using nurses in this way is driven by a lack of higher-level staffing,
4 that does not excuse Defendants from adopting a system that leads to preventable deaths.
5 Dr. Wilcox states—and Defendants do not contest—ADCRR’s high ratio of physicians to
6 mid-level providers is an extreme outlier among health care systems. Dr. Wilcox was
7 unaware of any “healthcare systems that provide primary care to patients on a large scale
8 where the physicians are overwhelmingly outnumbered by the mid-level providers.” (Doc.
9 4167 at ¶ 224). In Dr. Wilcox’s credible opinion, large systems do not have ratios similar
10 to what ADCRR has because “large systems inevitably have numerous patients who
11 require complex care beyond the scope of mid-level providers.” (Doc. 4167 at ¶ 224).
12 Indeed, ADCRR recognizes this deficiency by indicating the ratio of mid-level providers
13 to physicians set forth in their pending Request for Proposal is 2:1. (Doc. 4206 ¶ 1071). It
14 is obvious the present system of often allowing prisoners access only to nurses puts
15 prisoners at a substantial risk of serious harm.

16 **IV. Mismanagement of Complex Cases**

17 Another failure that stems from lack of staffing is ADCRR’s failure to employ a
18 differential diagnosis approach. Symptoms are treated without developing a “diagnostic
19 strategy” or attempting to test for the underlying cause. Recurring complaints by prisoners
20 are often treated as “new” issues at each appointment without taking account of previous
21 diagnoses and history. (Doc. 4138 ¶ 30). And Dr. Wilcox found “care for complex patients
22 is scattered throughout the system so no one provider or physician is ultimately responsible
23 for the patient[.]” (Doc. 4138 ¶ 29). Because it is impossible for providers with demanding
24 caseloads (due to insufficient staffing) to assess prisoners’ history and symptoms,
25 practitioners miss “with alarming frequency” serious and urgent medical symptoms. (Doc.
26 4138 ¶¶ 29, 31). “That impossibility translates directly into inadequate care” for all
27 prisoners but particularly for those with severe illness. (Doc. 4138 ¶ 29).

28 This leads to failures or delays in diagnosing serious conditions. What is entirely

1 absent from nearly every patient interaction is an objective approach to their symptoms.
2 The absence of differential diagnoses is particularly problematic because prisoners often
3 do not see the same health care provider. On top of this multi-provider problem, the
4 electronic health records system used does not provide health care providers with
5 information in an easily usable format to facilitate evaluation allowing an effective course
6 of treatment. (Doc. 4138 ¶ 31). The lack of differential diagnoses and progression through
7 ruling out ailments is pervasive and is shown through the treatment provided to many
8 prisoners. Dr. Wilcox reviewed the following prisoners' care and made extensive findings.
9 Defendants did not dispute any of them. Given Dr. Wilcox's ten years of experience in
10 this litigation, his expertise and credibility, and Defendants' failure to address Dr. Wilcox's
11 opinions, the Court adopts Dr. Wilcox's views that the care provided to the following
12 individuals was grossly inadequate.

13 **A. Kendall Johnson**

14 Johnson began her incarceration in 2015. In September 2017, Johnson submitted
15 an HNR complaining her feet and legs had been numb for weeks. (Doc. 4138 ¶ 100). A
16 nurse practitioner assessed her and indicated Johnson should be evaluated to rule out
17 multiple sclerosis vs. idiopathic neuropathy. (Doc. 4270 at 24:18-25). The nurse
18 practitioner, however, did not document Johnson's history or order any diagnostic tests.
19 (Doc. 4270 at 25:13-26:3). Johnson continued to submit HNRs for the next two years and
20 reported her symptoms were getting worse. (Doc. 4138 ¶ 104; Ex. 931 at 1-2). In response,
21 she saw nurses, a NP, and starting in September 2018 a physician, all of whom failed to do
22 proper physical exams or necessary imaging. (Doc. 4138 ¶ 105).

23 Again, in May 2019, Johnson told a physician she would stumble and fall to the
24 ground and was unable to catch herself. No MRI was ordered, and the physician concluded
25 she did not have MS, which, in Dr. Wilcox's view, was obviously incorrect. (Doc. 4138
26 ¶ 106). In July 2019, Johnson saw a physician again and recounted an ICS in June when
27 her knees locked up. The physician described her gait with "flopping feet almost as if foot
28 drop" and concluded she was likely suffering from "conversion disorder," which, in

1 essence, means she is delusional. It is an “extraordinarily rare condition . . . where
2 somebody believes that they have a disease and they act like they have a disease, but they
3 don’t really have the disease.” (Doc. 4270 at 26).

4 Adding to the absurdity, in October 2019, a nurse’s encounter note reflected
5 inconsistently “steady and even gait” and “IM [inmate] gait was unstable, IM was holding
6 onto anything she could while she was walking in.” (Doc. 4138 ¶ 108). Two months later
7 a physician ordered a diagnostic MRI after documenting that Johnson “walks almost as if
8 you would see in a Frankenstein movie. Very awkward and needs her hands for balance.”
9 (Doc. 4138 ¶ 109). Three months later, Johnson received the MRI on January 23, 2020,
10 which “strongly supported a diagnosis of MS.” (Doc. 4138 ¶ 110).

11 Johnson did not see a neurologist until two months later, who recommended
12 additional diagnostic imaging and lab tests and requested that Johnson return in one month.
13 She did not return to the neurologist until November 2020, when she was finally diagnosed
14 with MS. The neurologist recommended a follow up the following month, which did not
15 occur. Rather, Johnson returned to the neurologist at the end of January 2021, who noted
16 “mobility had progressively declined,” requiring her to use a wheelchair, as well as urinary
17 incontinence, and that she had not been given an MS medication. (Doc. 4138 ¶ 111). The
18 specialist recommended she be sent to an MS center to develop a treatment plan. Her
19 physician submitted a request to refer Johnson to an MS clinic, noting her “debilitating
20 muscle spasms,” but the referral was cancelled because Johnson was prescribed MS
21 medication to be received in the prison. Johnson did not start the medication, Ocrevus,
22 until May 28, 2021. (Doc. 4138 ¶ 108). Had that medication been started earlier, Johnson
23 “might have staved off her more severe symptoms for months or even years.” (Doc. 4138
24 ¶ 113).

25 Dr. Wilcox met with Johnson on August 31, 2021. He found her “profoundly
26 disabled” and is unable to feed or wash herself, walk, write, and her vision is failing. She
27 is entirely dependent on others to assist her with virtually every activity of daily living. Dr.
28 Wilcox criticized the treating providers who indicated Johnson’s symptoms were not

1 suggestive of MS and he opined they were classic MS symptoms. (Doc. 4138 at ¶¶ 100-
2 108). He noted Defendants have Johnson classified as an M3 although she is unable to
3 walk, feed, or care for herself. (Doc. 4138 ¶ 488). It is likely had Johnson received
4 continuity of care by seeing a consistent provider with more ready access to her medical
5 history, her repeated complaints would have resulted in a timely diagnosis and treatment,
6 which would have “staved off her more severe symptoms for months or even years.” (Doc.
7 4138 ¶ 113).

8 Johnson’s testimony at trial was profoundly disturbing. She confirmed she is unable
9 to perform any activities of daily living for herself. She cannot walk, brush her teeth, or
10 wash herself. (Doc. 4256 at 11:19-12:4). She must wear diapers, her vision is impaired,
11 and she can no longer read. (Doc. 4256 at 12:5-10). She testified she paid other prisoners
12 to assist her with self-care activities by ordering things for them from the prison store until
13 three days before her testimony when a medical employee first began to assist her. (Doc.
14 4256 at 12:11-13:11). Johnson explained she passes time in her housing unit by
15 “count[ing] the ceiling tiles” because she does not go outside. (Doc. 4256 at 13:12-23).

16 Defendants defend their treatment of Johnson by claiming “ADCRR and Centurion
17 were not, and are not, deliberately indifferent to Johnson’s medical needs. To the contrary,
18 they are actively and successfully treating Johnson’s multiple sclerosis.” (Doc. 4309
19 ¶ 236). According to Defendants, any delay in diagnosing Johnson was merely negligent.

20 Johnson’s treatment was far from negligent. It was—and may continue to be—a
21 paradigmatic example of the most callous and inhumane indifference. Defendants do not
22 address Johnson’s years of attempts without success to seek treatment for her progressing
23 illness. Instead of securing necessary diagnostic treatment, health care staff ignored
24 Johnson’s obvious and progressing symptoms, including neglecting her needs up to the day
25 of her pretrial deposition. Only after Johnson testified at her pretrial deposition that she
26 had to pay other prisoners to help her did prison staff begin providing her assistance with
27 her activities of daily living. To conclude that Johnson’s treatment has been appalling
28 substantially understates the pain and indifference she has suffered. And in the face of

1 unspeakable hardship, her testimony was clear and compelling. She could explain with
2 precision the evolution of her disease, her futile attempts to receive treatment, and the
3 permanent suffering she endures. Defendants' failure to rebut this testimony or to attempt
4 to explain why it is an aberration is a clear admission of significant irresponsibility. If
5 medical staff had tested differential diagnoses to evaluate the cause of her symptoms,
6 Johnson's current situation likely would be different.

7 **B. Prisoner A.D.**

8 Last year before trial, in February 2021, A.D., a 44-year-old male, began
9 complaining of severe neck pain. Verbal orders for an EKG, x-ray, and Toradol were noted
10 along with prednisone, diazepam, capsaicin cream, and ibuprofen. (Doc. 4138 ¶¶ 116-
11 117). Dr. Wilcox testified a combination of prednisone, ibuprofen, and Toradol is
12 dangerous in that it could lead to a gastric ulcer or rupture. (Doc. 4138 ¶ 117). Although
13 A.D. reported his pain at a 20 on a scale of 10, a provider, contacted by a nurse, denied the
14 request for diazepam and Toradol and suggested an ice pack and ibuprofen, which he
15 received. (Doc. 4138 ¶ 118). The next day, A.D. was back and seen by a different nurse
16 who determined no referral to a provider or follow-up was needed. (Doc. 4138 ¶ 118). Six
17 days later, an ICS was called for pain and A.D. was scheduled to see a provider. The
18 following day, A.D. was seen by a nurse practitioner, but she complained that he initiated
19 an ICS "inappropriately." (Doc. 4138 ¶ 119). The nurse practitioner did not perform a
20 neurological exam, did not test reflexes, and did not do an assessment for clonus—a
21 neurological condition causing involuntary muscle contractions—despite A.D.'s claims of
22 limited mobility and twinges of pain to the low back. (Doc. 4138 ¶ 119). On March 4,
23 2021, a rheumatoid panel was ordered, and the results showed acute inflammation, which
24 strongly suggested infection. The nurse practitioner noted the inflammation but failed to
25 note it was a sign of infection. Additional labs and studies should have been ordered after
26 the test results were received, but the nurse practitioner noted only "[follow-up] in 1-2
27 wks." (Doc. 4138 ¶ 120).

28 On March 16, 2021, A.D. was transferred from Florence to Eyman. Over the next

1 two days, three ICSs were called for severe pain that affected his mobility. He was given
2 two Toradol shots and had to be transported via wheelchair or gurney. (Doc. 4138 ¶ 121).
3 On March 19, 2021, a nurse practitioner documented A.D.'s deterioration and increasing
4 neurological dysfunction, including bladder incontinence and inability to ambulate for two
5 weeks. That nurse practitioner sent A.D. by ambulance to a community hospital
6 emergency room. (Doc. 4138 ¶ 122). At the hospital, A.D. was diagnosed with an epidural
7 abscess, which was growing and compressing his spinal cord, causing all of his symptoms.
8 A.D. had surgery and remained in the hospital for two months. (Doc. 4138 ¶ 123).

9 During the lengthy time the abscess had been allowed to grow, A.D.'s spinal cord
10 was compressed and the nerves began to die. (Doc. 4138 ¶ 123). This resulted in long-
11 term disability. As of September 2021, the close of discovery for trial, A.D. struggled to
12 walk, even using a walker. He probably will never regain normal functioning and will be
13 "substantially impaired the rest of his life." (Doc. 4138 ¶ 124). In Dr. Wilcox's un rebutted
14 opinion, A.D.'s condition was preventable. If Defendants had diagnosed and treated A.D.
15 competently, his disability could have been prevented. Instead, "all [A.D.'s] providers
16 failed him." (Doc. 4138 ¶ 125). It is more likely than not that the failure to test differential
17 diagnoses to understand what was happening with A.D. led to avoidable permanent
18 injuries.

19 **C. Jesse Boldrey**

20 As of 2013, Boldrey weighed 190 pounds. At a chronic care appointment in 2015,
21 he complained of weight loss and weighed only 146 pounds. The only treatment was to
22 provide him a "wasting diet" and liquid supplements. (Doc. 4138 ¶ 33). In 2017, he
23 complained of weight loss again and his records revealed that he had lost another 20 pounds
24 (down to 126 pounds), despite eating all his meals. Boldrey told a doctor he feared he had
25 cancer. Despite obvious warning signs for cancer, the physician ordered simple imaging,
26 stool blood testing, and told him to stop smoking. (Doc. 4138 ¶ 33).

27 On June 18, 2018, Boldrey again complained of weight loss, but after a chest x-ray
28 and HIV test, the nurse practitioner signed off on his case, continued his wasting diet and

1 ordered liquid nutritional supplements, and scheduled no follow-up. (Doc. 4138 ¶ 34). In
2 December 2018, Boldrey had another chronic care appointment. The records from that
3 appointment do not mention weight loss. (Doc. 4138 ¶ 35). In February 2019, Boldrey
4 submitted an HNR complaining of vomiting, nausea, and bloody bowel movements.
5 Boldrey complained he had lost 10 pounds in a week. When examined, his weight was
6 down to 110 pounds. The nurse practitioner sent Boldrey to the hospital. (Doc. 4138 ¶ 36).

7 At the hospital Boldrey was diagnosed with a bleeding duodenal ulcer. The hospital
8 obtained CT scan images of Boldrey's abdomen, which showed "scattered nodular
9 opacities in the bilateral lungs concerning for metastatic disease." This was a "new and
10 very serious finding" that demanded follow-up. (Doc. 4138 ¶ 36). When Boldrey returned
11 to prison, a nurse practitioner noted the CT findings but failed to schedule a further consult
12 or follow-up. (Doc. 4138 ¶ 37). And a few weeks later, a doctor discharged Boldrey to
13 return to general population. Inexplicably, the doctor made a note that Boldrey was "doing
14 well." The doctor made no mention of the abnormal lung findings. (Doc. 4138 ¶ 38).

15 In May 2019, Boldrey twice complained of a very sore throat. In response to the
16 first complaint, the nurse noted his throat was red and neck glands were palpable. The
17 nurse obtained a verbal order for an antibiotic from a nurse practitioner. The provider did
18 not examine Boldrey and prescribing an antibiotic was wrong. (Doc. 4138 ¶ 39). At the
19 second May visit, Boldrey complained of difficulty swallowing. The nurse noted the lung
20 nodules documented in Boldrey's chart and referred him to the provider line on an urgent
21 basis. (Doc. 4138 ¶ 40). On May 29, 2019, the doctor examined Boldrey and stated he
22 suspected cancer. (Doc. 4138 ¶¶ 40-41).

23 A nurse attempted to schedule a CT of the chest, but the request was denied because
24 "A CT of the chest was performed on 5/23/19," which was wrong. No CT had been ordered
25 or given on 5/23/19. (Doc. 4138 ¶ 42). Likely the reviewing committee had mixed up
26 patients. Despite that denial, somehow Boldrey was given CT scans on May 31 of his
27 brain, abdomen, and neck. The provider who reviewed the results on June 19, 2019, noted
28 probable metastatic disease. The provider noted Boldrey would be scheduled for the

1 earliest possible visit to review the CT results and develop a treatment plan. (Doc. 4138
2 ¶ 43). That visit did not happen. Instead, Boldrey and his obviously ominous diagnosis
3 were ignored.

4 Boldrey was not seen until almost three months later when he complained that his
5 throat hurt so badly he could not eat. (Doc. 4138 ¶ 44). At that appointment, Boldrey
6 weighed 100 pounds. Despite the scan results in his file and the loss of 90 pounds from
7 his original weight, the nurse practitioner instructed Boldrey to “eat slow and cut food into
8 small pieces.” (Doc. 4138 ¶ 45). The nurse practitioner did request a consult with an ear,
9 nose, and throat specialist because there was a possibility of “neck injury, chronic
10 pharyngitis/mass or tumor.” (Doc. 4138 ¶ 45). There was no mention of the CT scan
11 results. (Doc. 4138 ¶ 45).

12 On October 28, 2019, Boldrey was seen by a physician’s assistant. The records
13 from this encounter indicate the notes were completed in a “cut and paste” manner that
14 made no sense. (Doc. 4138 ¶ 46). In one section the PA noted Boldrey allegedly denied
15 weight loss, another section noted Boldrey had “significant weight loss,” and yet another
16 section reflected a box indicating “No” regarding “Recent weight/loss/cachexia.” (Doc.
17 4138 ¶ 46). As Dr. Wilcox noted, this level of sloppiness in charting indicates “providers
18 are just cycling patients through these visits as fast as possible with no intent to deliver
19 thorough care.” (Doc. 4138 ¶ 46). The lack of adequate staffing affects every interaction
20 with every prisoner.

21 The ENT appointment requested on September 10, 2019, did not occur until
22 November 5, 2019. At that appointment the ENT diagnosed Boldrey with an
23 otopharyngeal mass suspicious for cancer, and recommended a CT scan, biopsy, and
24 endoscopy. Due to Centurion’s policy of not informing prisoners about recommended
25 treatment and possible hospitalization for unidentified “security reasons,” Boldrey was not
26 informed of this diagnosis and was unaware of the recommended treatment. On his return
27 to prison, Boldrey inaccurately told a nurse his complaint was throat pain and unintentional
28 weight loss, not the throat and chest cancer he had just been diagnosed with. (Doc. 4138

1 ¶ 47).

2 Boldrey was not seen again until November 25, 2019, when an ICS was called for
3 coughing up blood. At that time, Boldrey's oxygen saturation was 77% and an ambulance
4 was called. (Doc. 4138 ¶ 48). At the hospital, Boldrey was diagnosed with malnutrition,
5 lung cancer, cervical lymphadenopathy, hypertension, anemia, and aortic aneurysm. The
6 hospital recommended a referral to oncology for palliative care. (Doc. 4138 ¶ 49). Boldrey
7 returned to prison on December 19, 2019. Upon his arrival, a nurse noted that the liquid
8 nutrition would need to be held "until appropriate tubing is available." (Doc. 4138 ¶ 50).
9 But strangely, a nurse practitioner significantly decreased the recommended pain
10 management. The next day, the physician decided to put Boldrey back on ibuprofen four
11 times a day without protection for his stomach, even though Boldrey previously had a life-
12 threatening GI bleed from NSAIDs. At this time, Boldrey weighed 96 pounds. (Doc. 4138
13 ¶ 51).

14 Despite his inability to swallow because of the mass in this throat, Boldrey was
15 prescribed pills (Tylenol #3) for pain. He was also started on another NSAID, Toradol.
16 Thus, he was on ibuprofen and Toradol or "double NSAIDs." (Doc. 4138 ¶ 52). Because
17 he could no longer swallow, Boldrey needed intravenous feeding. A patient receiving
18 intravenous feeding needs weekly electrolytes testing. That testing was not done, leaving
19 Boldrey subject to dangerous swings in electrolytes. (Doc. 4138 ¶ 52).

20 On December 25, 2019, a physician's assistant indicated Boldrey needed oncology
21 and ENT consults for possible radiation therapy and again recommended palliative care.
22 Centurion cancelled these referrals because Boldrey was designated "Do Not Resuscitate."
23 (Doc. 4138 ¶ 53). This denial requires emphasis. A physician's assistant recommended a
24 palliative care consult, but Centurion cancelled that referral because Boldrey had
25 determined he did not wish to be resuscitated in the event he died. A "Do Not Resuscitate"
26 directive has nothing to do with the need for palliative care. In other words, refusing
27 extraordinary measures in the event of death is not a request to die suffering, in excruciating
28 pain. In short, Centurion "cancelled palliative care for an end-stage cancer patient." (Doc.

1 4138 ¶ 53). The cruelty of Centurion’s behavior is hard to fathom. As Dr. Wilcox testified,

2 Mr. Boldrey’s end of life care does not conform to any standard
3 of care for palliative or hospice care. His cachetic body was
4 racked with pain, and he wasted away with no reasonable
5 assistance from medical science in the form of comfort or
6 compassionate pain control. . . . [And it was] shocking to see
7 how neglected he was in his end days when he was too weak
8 to advocate for himself.

9 (Doc. 4167 at ¶ 57).

10 As of January 2020, Boldrey was still alive, but obviously wasting away. He
11 continued to receive grotesquely inadequate pain medication. (Doc. 4138 ¶ 54).
12 Eventually, on March 16, 2020, medical providers finally ordered IV morphine. (Doc.
13 4138 ¶ 55). That morphine arrived the following day, but the records show it was
14 administered inadequately. Boldrey was supposed to receive doses four times per day. For
15 the six days prior to his death, he received those four doses on only one day. On one day,
16 he received only one dose. (Doc. 4138 ¶ 56). On March 22, 2020, Boldrey reported his
17 pain was 9/10 and that he had “pain all over.” Boldrey died on March 23, 2020. (Doc.
18 4138 ¶ 57). The mortality review determined the obvious: Boldrey’s death could have
19 either been prevented or delayed. (Doc. 4138 ¶ 58).

20 Unquestionably, Boldrey did not suffer from simple medical malpractice. Basic
21 testing of differential diagnoses would have resulted in a much earlier determination of the
22 cause for his complaints. A functioning health care delivery system would never suffer the
23 magnitude of breakdowns reflected in Boldrey’s seven-year odyssey of incompetence,
24 cruelty, and eventual death.

25 **D. Walter Nusz**

26 Nusz, who had long-standing Hepatitis C, died on April 30, 2020 at the age of 60.
27 (Doc. 4138 ¶ 60). On September 21, 2019, he had a lab test showing a fibrosis score of F-
28 3, indicating severe liver scarring. (Doc. 4138 ¶ 61). This should have prompted medical
providers to give Nusz liver ultrasounds and beta blockers, a pre-primary prophylaxis for
upper GI bleeds, but Nusz was never given a liver ultrasound or beta blockers. (Doc. 4138
¶ 61). Nusz also had a known platelet count of less than 150,00 per microliter, which

1 should have resulted in routine screening and surveillance for possible esophageal varices
2 via an upper endoscopy at least once per year and to have any varices banded, which would
3 prevent an upper gastrointestinal bleeding episode. Nusz was not given these screenings.
4 (Doc. 4138 ¶ 61).

5 Nusz had complained of low back pain. (Doc. 4138 ¶ 73). The nurse practitioner
6 overseeing his care managed those complaints with high doses of indomethacin, an
7 NSAID. This medication “is one of the highest risk non-steroidals with respect to causing
8 gastrointestinal bleeding.” (Doc. 4138 ¶ 62). Given Nusz’s underlying conditions, this
9 medication “was the worst possible choice.” (Doc. 4138 ¶ 64).

10 Between August 17, 2020 and January 15, 2021, Nusz’s hematocrit level dropped
11 from 46.3 to 38.2. This lab result suggested Nusz was bleeding internally after starting
12 indomethacin. Nothing was done to address the lab result. (Doc. 4138 ¶ 62). Blood
13 pressure readings also indicated his blood pressure was below the historical baseline, but
14 the providers did not make any note of the issue. (Doc. 4138 ¶ 63). Although Nusz’s pain
15 increased after he was prescribed indomethacin, the nurse practitioner tripled the dose on
16 March 23, 2021, without seeing him in person. (Doc. 4138 ¶ 64).

17 In the 42 days before his death, Nusz submitted five HNRs reporting severe pain,
18 difficulty breathing, bleeding, an inability to eat, an inability to use the restroom, and an
19 inability to walk. In a HNR dated March 24, 2021, Nusz complained he was in significant
20 pain. He stated “This isn’t a joke. It’s my life [you’re] playing with . . . Hurry before I
21 die?? Hurry please.” (Doc. 4138 ¶ 65). While Nusz recognized his condition was
22 significantly worsening, all the health providers did not. Nusz was seen by at least six
23 different registered nurses, who noted Nusz’s troubling symptoms, but none referred him
24 to a provider, and none identified the high dose of indomethacin was causing his symptoms.
25 (Doc. 4138 ¶¶ 67-71). Nusz died on April 23, 2021, one month after the indomethacin was
26 tripled, from a massive gastrointestinal bleed exacerbated by inappropriate indomethacin
27 dosing in a patient with multiple contraindications. (Doc. 4138 ¶ 71).

28 Clearly Nusz’s providers failed to monitor his fibrosis, failed to prescribe

1 preventative medications to minimize the chance of an esophageal bleed, failed to perform
2 preventive upper endoscopies to identify and treat dilated blood vessels in the esophagus,
3 failed to perform blood tests to monitor his coagulation state to see that his ability to clot
4 was significantly impaired, worsened Nusz's conditions by prescribing him a
5 contraindicated dose of indomethacin, failed to notice the change in Nusz's lab results (his
6 blood ammonia level was 350 (normal is 15-45) and his ability to clot was 2.06, (normal
7 is less than 1.1)), and did not take action when Nusz repeatedly reported significant changes
8 in his condition. (Doc. 4138 ¶¶ 72-74). Finally, despite the fact that Nusz's care was
9 plainly outside a nurse practitioner's scope of practice, there was no physician level
10 oversight. (Doc. 4138 ¶ 74).

11 The mortality review could not determine if Nusz's death was avoidable. In Dr.
12 Wilcox's credible opinion, that was "absurd." Medical providers gave Nusz a medication
13 "absolutely contraindicated for people with serious liver disease." Then, when that
14 medication caused significant problems, they increased his dose until his completely
15 predictable death resulted. (Doc. 4138 ¶ 75). Again, this is not a situation where a prisoner
16 had a single interaction with a single provider who did not accurately assess the situation.
17 Instead, Nusz had months of contact, with numerous providers, all of whom failed to
18 identify an obvious problem. The lack of meaningful attempts to diagnose Nusz's ongoing
19 complaints led to his death. Even a marginally functioning health system would not have
20 caused so many providers to get so much so wrong.

21 **E. Timothy Ashing**

22 Ashing, a 30 year-old, submitted an HNR on August 5, 2020, complaining of a
23 "super sensitive" lump on his left testicle that had been there for two months. The nurse
24 who evaluated him used the "musculoskeletal NET assessment" which, obviously, "has
25 nothing to do with the genitourinary system." (Doc. 4138 ¶ 76). Ashing complained of
26 testicular pain, but the nurse engaged only in assessing his handgrip, posture, and whether
27 his gait was symmetrical. She told Ashing to "go easy" on workouts and report if his
28 symptoms worsened. The notes inconsistently indicated that no follow-up was needed and

1 that he would be referred to the provider line. He was not referred. (Doc. 4138 ¶¶ 76-78).

2 On October 3, 2020, Ashing submitted a HNR stating his left testicle was swollen
3 and he reported severe abdominal pain. He was seen by a nurse a few days later who
4 referred him to Dr. Hines. Upon examination, Dr. Hines documented a 3 cm x 2 cm mass
5 on Ashing's left testicle with tenderness to palpation and swelling. The doctor entered an
6 order for an ultrasound but delayed an entire week to enter the lab orders. (Doc. 4138
7 ¶ 79). On October 23, 2020, an ultrasound was completed. The notes for that indicated a
8 2.6 cm left intratesticular mass "highly concerning for testicular malignancy. Recommend
9 an urgent urology consultation." (Doc. 4138 ¶ 80). Dr. Hines reviewed the ultrasound
10 report but noted she would discuss the issue with Ashing "at his next chronic care visit."
11 (Doc. 4138 ¶ 81). Dr. Hines' lack of urgency is "astound[ing]" and "unethical." (Doc.
12 4138 ¶ 81). Dr. Hines only ordered a urology consult on an urgent basis. (Doc. 4138 ¶ 82).

13 Ashing saw a urologist via telemedicine on November 25, 2020, who recommended
14 a radical orchiectomy STAT. Dr. Hines then waited three weeks, until December 13, 2020,
15 to order the orchiectomy on a *routine* basis. That order was cancelled on January 22, 2021,
16 because the urologist was no longer available. (Doc. 4138 ¶ 82). On February 16, 2021,
17 Ashing saw another urologist. That "visit was essentially worthless" because Centurion
18 did not provide the urologist with the previous ultrasound results or labs. Thus, the new
19 urologist recommended the tests be repeated. (Doc. 4138 ¶ 83).

20 After some delay, additional labs and another ultrasound were completed on March
21 16, 2021. A nurse practitioner reviewed a lab result and noted Ashing's Beta HCG level
22 of 81065 mIU/ml was "normal." In truth, the normal range for a male is <6.51 mIU/ml.
23 Thus, the test actually showed Ashing's result was "astronomically elevated" and
24 "massively abnormal." (Doc. 4138 ¶ 85). In Dr. Wilcox's view, the nurse practitioner's
25 determination the result was "normal" establishes "she did not understand anything about
26 the patient or the disease she was managing."¹⁹ (Doc. 4138 ¶ 85). The result suggested

27
28 ¹⁹ Dr. Wilcox also described the nurse's "determination that this is resolved is absolutely incorrect." (Doc. 4271 at 47-48).

1 advanced testicular tumor burden. The nurse practitioner, again showing she did not
2 understand, submitted a request for another “possible” urology consult. (Doc. 4138 ¶ 85).

3 The consult request was cancelled on March 30, 2021, when the urologist, who had
4 now obtained the test results, told Centurion that Ashing needed urgent surgery. Ashing
5 had a radical orchiectomy on April 8, 2021, but Centurion did not send Ashing back to the
6 surgeon for post-surgical follow-up. (Doc. 4138 ¶¶ 86-87). In May 2021, Ashing was seen
7 with obvious signs of gastrointestinal bleeding. (Doc. 4138 ¶¶ 89-90). On May 26, he
8 submitted a request saying his stomach was painful and his stools were “dark almost
9 black.” (Doc. 4138 ¶ 90). He was seen by a nurse who ordered an x-ray at some
10 unspecified time in the future. (Doc. 4138 ¶ 90). On May 29, Ashing submitted another
11 request stating he “puked up black bio 3 times so far today and my stools are liquid black.”
12 (Doc. 4138 ¶ 91). He was seen by a different nurse who documented black stools, dark
13 brown or black vomit, abdominal pain, and elevated heart rate. The nurse noted Ashing
14 looked “very pale, almost jaundiced” but the obvious signs of internal bleeding failed to
15 prompt additional treatment. Rather, the nurse sent Ashing back to his housing with fecal
16 occult blood tests and a container for vomit. (Doc. 4138 ¶ 91). Ashing returned the same
17 day with the vomit container which had “watery vomit with what appeared to be coagulated
18 blood in it.” (Doc. 4138 ¶ 92). Given the obvious indications of internal bleeding, Ashing
19 should have been sent to a hospital immediately. Instead, a follow-up nursing appointment
20 was made for the next day. (Doc. 4138 ¶ 92).

21 The follow-up appointment did not happen on May 30. On May 31, 2021, an ICS
22 was called. The nurse reported Ashing was vomiting, had watery stools “black in color”
23 and Ashing looked “*more* yellow today than yesterday.” (Doc. 4138 ¶ 93). The nurse
24 called a provider, who ordered that Ashing be sent to the emergency room. (Doc. 4138
25 ¶ 93). At the hospital, Ashing was diagnosed with a widely metastatic tumor and metastasis
26 to the stomach, causing gastrointestinal bleeding. Just a few months before trial, on June
27 10, 2021, Ashing died after internal bleeding could not be controlled. (Doc. 4138 ¶ 94).

28 The mortality review found Ashing’s death was preventable, there were repeated

1 failures to recognize symptoms, a delay in access to care, and failure to follow-up/identify
2 abnormal test results. (Doc. 4138 ¶ 96). The repeated failures and delays in treating
3 Ashing's cancer "cost him his life." (Doc. 4138 ¶ 96). As explained by Dr. Wilcox, when
4 caught early, testicular cancer "is one of the most curable cancers" and has a success rate
5 of 99% (Doc. 4138 ¶ 96; Doc. 4269 at 78:5-9). The repeated failure to diagnose the obvious
6 would not happen in a functioning health care system.

7 **F. Summary**

8 Defendants believe the treatment and outcomes for Johnson, A.D., Boldrey, Nusz,
9 and Ashing are simply isolated occurrences that do not establish a pattern or practice of
10 providing deficient health care. But the overwhelming evidence shows these cases indicate
11 the opposite. Given the number of encounters each of these individuals had with the
12 medical system, including many different personnel, it is impossible to conclude their
13 treatment represented isolated occurrences. Rather, these outcomes show that if a prisoner
14 develops a serious health condition while in ADCRR custody, he or she is at substantial
15 risk of grievous harm or death due to medical personnel's inability to accurately assess and
16 diagnose such conditions.

17 A prisoner such as Johnson may present with ongoing and consistent complaints
18 that need expertise to accurately assess and diagnose. Instead, the complaints may be
19 ignored until they are too serious not to require intensive intervention, often when it is too
20 late. Or a prisoner may present with recurrent complaints of pain that, if properly
21 diagnosed, could be remedied with no long-term effects. But such a prisoner may end up
22 like A.D., suffering from lifelong disabilities because multiple providers failed to diagnose
23 him accurately. A prisoner facing death might be in obvious need of pain medication.
24 Instead of providing relief, that prisoner may be treated like Boldrey, ignored and left to
25 waste away in extended horrifying pain. A prisoner might obtain inappropriate medication
26 to treat a condition, such as Nusz did. When that medication causes obvious, life-
27 threatening side-effects, providers might increase the dosage, ensuring death. Or a young
28 prisoner may present with complaints of testicular pain, as Ashing did. Staff might then

1 inexplicably assess his grip strength and, even if some treatment is provided, they will
2 ignore obvious signs of painful distress that merit emergency action. No legitimate humane
3 system would operate in this manner.

4 **V. Defendants' Challenges to Dr. Wilcox's Opinions Fail**

5 Defendants attempt to undermine Dr. Wilcox's conclusions regarding systemic
6 failures by challenging his methodology. Defendants complain Dr. Wilcox did not perform
7 a random sampling and review of care provided to prisoners.²⁰ As previously explained,
8 Dr. Wilcox's methodology, while not random, was appropriate and consistent with the
9 practice by other experts. Again, as Dr. Wilcox noted, healthy patients are not an indicator
10 of a system's capabilities. "It is the complex patients who test the capacity of staff and
11 systems alike." (Doc. 4167 ¶ 25). If the issue is whether prisoners are provided adequate
12 medical care, it makes sense to look to prisoners with serious needs and, in particular, those
13 who suffer adverse outcomes, not those prisoners who have no contact with the medical
14 system.

15 Defendants further attempted to counter Dr. Wilcox's opinions through their own
16 expert, Dr. Murray. To assess the quality of care provided to all prisoners, Dr. Murray
17 relied on Healthcare Effectiveness Data and Information Set ("HEDIS") metrics, which
18 were developed by the National Committee for Quality Assurance ("NCQA"). Dr. Murray
19 reviewed data from eOMIS utilizing the HEDIS parameters so he could evaluate the quality
20 of health care across the ADCRR system and make comparisons between ADCRR and
21 other health care systems. (Doc. 4206 ¶ 998). Dr. Murray selected the HEDIS metrics
22 regarding only blood pressure control and diabetic care for review because, in his view,
23 they represent two of the largest patient populations in both correctional and non-
24 correctional settings. (Doc. 4286 at 31:6-32:13, Doc. 4286 at 123:21-124:4). Dr. Murray
25 determined ADCRR's performance on HEDIS measurements for diabetes and

26
27 ²⁰ During cross-examination, Dr. Wilcox was asked "how many examples of delays in
28 obtaining specialty care do you need to see in a system of 28,000 patients for you to make
the determination that it's systemic?" Dr. Wilcox responded "Well, I don't know that
there's an actual magic answer for that, but you certainly see patterns with regards to those
delays in the medical records that I reviewed." (Doc. 4271 at 27).

1 hypertension are higher than those provided by private health plans. (Doc. 4206 ¶ 1077).
2 Dr. Murray concludes these scores are “reflective of a health system operating efficiently
3 and focused on best care for the patients.” (Doc. 4206 ¶ 1077). In other words, Dr. Murray
4 concludes allegedly adequate testing and treatment of diabetes and hypertension, once
5 those conditions have been accurately diagnosed, establish the entire prison health care
6 system is operating effectively.

7 There are two problems with Dr. Murray’s method and conclusion. First there is no
8 reliable evidence that selecting only these two criteria—treatment of hypertension and
9 diabetes—establishes the overall capabilities of a health care system like ADCRR’s. The
10 second is more fundamental. Dr. Murray’s assessment assumes ADCRR adequately
11 diagnoses and tracks the prisoners who suffer from hypertension and diabetes. And
12 Defendants offered no evidence to confirm this unique theory. Dr. Murray necessarily only
13 looks to data on prisoners who have previously been diagnosed with diabetes and
14 hypertension. There was no evidence showing this data represents the entire population of
15 prisoners actually suffering from these ailments and of course there could be prisoners with
16 undiagnosed hypertension or diabetes. Certainly Defendants could have attempted to
17 prove they had identified all such prisoners. But Defendants did not do so. In fact, given
18 the level of care provided to prisoners discussed previously, it is overwhelmingly likely
19 Dr. Murray’s data does not include the entire relevant population. Dr. Wilcox specifically
20 addressed this possibility during his testimony, indicating

21 My concern with the chronic care list and how they’re derived
22 and managed is that I found in my review of the medical
23 records that there frequently were . . . critical diagnoses
24 missing from the master problem list, which is most likely how
25 they’re generating the reports for the chronic care list.

26 (Doc. 4272 at 83:19-24). Further, every witness who testified, including Dr. Murray,
27 agrees ADCRR’s electronic health record system, eOMIS, is fatally limited and flawed.
28 The inadequacy of eOMIS is yet another reason to conclude ADCRR’s records do not
accurately represent all relevant prisoners or accurately represent prisoner health care

1 provided.

2 If that were not enough, Dr. Murray’s own opinions about care provided to prisoners
3 establish HEDIS scores are not a valid basis for assessing ADCRR’s system. In an attempt
4 to “validate” his HEDIS findings, Dr. Murray performed a random review of medical
5 records of ten prisoners with at least two chronic condition diagnoses at all complexes
6 except for Phoenix and Florence. Prisoners’ charts were evaluated for quality of
7 documentation, quality of chronic care, and quality of episodic care. A consultant reviewed
8 the charts using the scale set forth in Appendix 2.²¹

9 Dr. Murray created this unproven scale himself for evaluation of only ADCRR’s
10 health care system. Under this eccentric evaluation method, even “excellent” charts could
11 reveal a lack of preventative health care and very good charts may show delayed treatment.
12 Of greater concern are the charts considered “good, fair, or poor.” In particular, the
13 explanations for charts that were labeled “good” establish “good” was often profoundly
14 insufficient. The following are several examples of chronic care considered “good” by Dr.
15 Murray’s consultant.

16 Patient 1 in Tucson is an 81-year-old male who suffers from multiple chronic
17 conditions including hypertension, diabetes, coronary artery disease, peripheral arterial
18 disease, and other serious conditions. The chart review reflects “chronic care visits
19 sometimes addressed all of the patient’s problems and sometimes did not.” (Doc. 4206
20 ¶¶ 214-217). Further, his chart revealed a “notable lack of detailed foot exams . . . with
21 (later) documented severe peripheral arterial disease.” (Doc. 4206 ¶ 221). There are no
22 notes of an exam of the prisoner’s feet, although there is a note that he “has pedal pulses
23 [pulse found on top of a patient’s foot],” which Dr. Murray describes as “interesting.”
24 (Doc. 4206 ¶ 221). The Court interprets the chart as documenting a finding of pedal pulses
25 when the health care provider did not actually perform an exam. Dr. Murray muses that
26 “one could wonder if earlier foot exams would have identified an issue” before Patient 1
27 developed gangrene and lost a toe to amputation. (Doc. 4206 ¶ 221). The summary of

28 ²¹ Dr. Murray did not independently review the patient’s medical records prior to preparing
his expert report.

1 Patient 1's chronic care noted "a lag in treatment of some problems and a lapse in treatment
2 of various issues." (Doc. 4206 ¶ 224). This is not "good" health care. Rather, this
3 affirmatively documents health care that presents a substantial risk of serious harm to this
4 patient. The failure to conduct foot exams for a patient such as this creates a possibility of
5 a seriously adverse outcome.

6 Patient 4 in Yuma is a 78-year-old male with multiple chronic conditions. (Doc.
7 4206 ¶ 363). In 2015, the provider documented Patient 4 had been experiencing chest pains
8 monthly. (Doc. 4206 ¶ 366). But despite an abnormal EKG, nothing shows follow-up on
9 "a very great pre-test probability of having heart disease." (Doc. 4206 ¶ 366). Also in
10 2015, the provider noted Patient 4 needed colon cancer screening because of a positive
11 fecal occult blood test and low hemoglobin readings but no follow-up ever occurred. (Doc.
12 4206 ¶ 367). This is not "good" health care because it overlooks obvious, potentially
13 serious, conditions that might lead to death. In reviewing Dr. Murray's scale as applied to
14 this prisoner, the failure to follow-up on potential heart disease or abnormal colon cancer
15 screenings would "markedly increase" the risk of harm, indicating the score of "good" is
16 inaccurate.

17 Patient 2 in Douglas is a 44-year-old man with hypertension and a prior history of
18 lymphoma. (Doc. 4206 ¶ 459). Patient 2 was seen by a nurse practitioner in September
19 2020 to address persistent headaches following a head injury; the nurse practitioner noted
20 his blood pressure was 135/95 and prescribed a low-dose calcium channel blocker to
21 address his blood pressure without lowering his already-low heart rate. The medication
22 prescribed, however, was "inappropriate" and "should be avoided" if there is a concern
23 about bradycardia. (Doc. 4206 ¶¶ 461, 464). Hypertension was officially added to Patient
24 2's problem list a few weeks later, but an EKG was not ordered for another year. (Doc.
25 4206 ¶ 461). This is not "good" health care but merely another example of care that creates
26 a substantial risk of serious harm.

27 Patient 3 in Winslow is a 55-year-old male with multiple chronic conditions
28 including cirrhosis and thrombocytopenia (low platelet count). (Doc. 4206 ¶ 619). While

1 housed at Eyman, staff refrained from ordering NSAIDs, which are contraindicated for
2 Patient 3. (Doc. 4206 ¶ 624). But when he was transferred to Winslow, Patient 3 was
3 prescribed NSAIDs, despite the notations acknowledging cirrhosis, low platelets, and
4 “needing to add [chronic kidney disease] as a diagnosis.” (Doc. 4206 ¶ 624). Patient 3
5 soon developed gastrointestinal bleeding, fecal tests were positive for bleeding, but no
6 rectal exam was performed. (Doc. 4206 ¶ 625). Obviously this is not “good” health care.
7 Patient 3 is at substantial risk of serious harm.

8 Patient 7 in Perryville is a 59-year-old female with diabetes, hypertension, and
9 alcoholic cirrhosis. (Doc. 4206 ¶ 757). A July 2020 ultrasound showed “coarse
10 echotexture” of her liver, splenomegaly, and a slightly dilated inferior vena cava. She had
11 emergency nurse visits for abdominal pain in 2020. (Doc. 4206 ¶ 759). The consultant
12 notes that Patient 7 has “an elevated risk of esophageal variceal bleeding,” but “she has not
13 been referred to a gastroenterologist.” (Doc. 4206 ¶ 762). This is not “good” health care
14 but an example of a health care system that is affirmatively ignoring conditions that present
15 a substantial risk of serious harm.

16 Patient 4 in Safford is a 42-year-old male with several chronic conditions. He is
17 Hepatitis C positive but there is no “management plan [] for HCV.” (Doc. 4206 ¶ 824).
18 He “should be considered to have significant, active liver disease with fibrosis, if not
19 cirrhosis,” (Doc. 4206 ¶ 824), but that was not noted as a problem, and he was prescribed
20 contraindicated NSAIDs. (Doc. 4206 ¶ 824). This is not “good” health care but another
21 prisoner who is at risk of serious harm.

22 Patient 4 in Eyman is an 81-year-old male with multiple chronic conditions. (Doc.
23 4206 ¶ 915). He was diagnosed with rheumatoid arthritis during his incarceration. (Doc.
24 4206 ¶ 918). The consultant states Patient 4 should be referred to a rheumatologist and
25 concludes his “RA has not been well-managed.” (Doc. 4206 ¶ 923). This is not “good”
26 health care. Instead, the system has consigned Patient 4 to live with pain and limitations
27 that could, with treatment, be alleviated.

28 These examples from 7 out of 8 complexes reviewed do not “validate” Dr. Murray’s

1 HEDIS findings or his conclusion that the chart reviews establish a functioning system.
2 Rather, these examples show that “good” scores reflect patients in ill-health and receiving
3 deficient chronic care treatment.

4 There are additional takeaways from these chart reviews. 54 of the 79 prisoners
5 reviewed received scores of Good, Fair, or Poor—67% of the total.²² By Dr. Murray’s own
6 scoring system, a rating of Good presents highly questionable care, as outlined above. And
7 scores of Fair or Poor present care involving obvious substantial risks of serious harm.

8 Analyzing Dr. Murray’s chart reviews does not reveal a functioning health care
9 system. It reveals a system with an electronic records system that everyone agrees is
10 abysmal and must be replaced, a system that does not allow referral of patients who exhibit
11 serious symptoms to providers, and a system that administers contraindicated and
12 potentially deadly medications. Accepting Dr. Murray’s belief that his sample was
13 representative of ADCRR health care as a whole, the only possible conclusion is the system
14 puts prisoners at a substantial risk of harm.

15 In addition to inadvertently establishing the risk of harm to prisoners through the
16 chart review evaluation he chose to conduct, Dr. Murray did not evaluate the core
17 deficiencies Dr. Wilcox identified, including those related to medication administration,
18 specialty care, hospitalizations, discharge after hospitalizations, sick call, nursing care, and
19 access to providers. Dr. Murray testified:

20 **Question:** So, Doctor, you didn’t do a similar evaluation or
21 study or what you can call -- what you -- what Dr. Baillargeon²³
22 called critically important analysis on a number of other
23 components of the healthcare system, such as medication
24 administration; correct?

25 **Dr. Murray:** Not a direct study, no.

26 ²² The Court also discovered several errors in Dr. Murray’s chart reviews. Tucson only
27 listed nine patients instead of ten (Doc. 4206 ¶¶ 214-315); Patient 5 in Tucson received a
28 rating of Poor for chronic health care, but the score of 2 did not match the rating (Doc.
4206 ¶ 272); and Patient 10 in Winslow was determined to be not-applicable because he
did not have any chronic care diagnoses, which is puzzling because the criteria for review
of a patient was active chronic care diagnoses. (Doc. 4206 ¶¶ 700-701).

²³ Dr. Jacques Baillargeon is an epidemiologist at the University of Texas Medical Branch
with whom Dr. Murray works and consulted when developing his opinions for this case.
(Doc. 4286 at 53).

1 **Question:** You didn't do one on specialty care either?

2 **Dr. Murray:** Other than what we came across in the medical
3 records, but not a special -- not a special study on that, no.

4 **Question:** And you didn't do one on hospitalizations?

5 **Dr. Murray:** No.

6 **Question:** Or discharge after hospitalizations?

7 **Dr. Murray:** Not a special study, no.

8 **Question:** Sick call?

9 **Dr. Murray:** We did not do a special study on sick call.

10 **Question:** You didn't do a study about patients who didn't get
11 to see a provider?

12 **Dr. Murray:** We didn't do a special study on that, no.

13 **Question:** Utilization review, you didn't do that either?

14 **Dr. Murray:** Not a special study, no.

15 **Question:** Language interpretation?

16 **Dr. Murray:** Not a special study, no.

17 **Question:** Emergency care?

18 **Dr. Murray:** Not a special study.

19 **Question:** Nursing care?

20 **Dr. Murray:** Not a -- not a specific study, no.

21 **Question:** Radiology?

22 **Dr. Murray:** No, not a specific study.

23 **Question:** Preventive care?

24 **Dr. Murray:** Not a specific study.

25 (Doc. 4286 at 65:21-66:21). Dr. Murray use of HEDIS scores and his chart reviews have
26 not established a well-functioning health care system at ADCRR. And of crucial
27 importance, by offering and relying on Dr. Murray as their sole witness to establish a
28 functioning health care system, Defendants effectively demonstrate satisfaction with the
existing, completely highly inadequate system.

1 Dr. Murray's view that the health care system is operating appropriately is further
 2 undercut by the scores for Defendants' Performance Measures on fundamental components
 3 of any functioning health care system. These scores were monitored and reported by
 4 Defendants and are therefore undisputed evidence of random samples drawn from the
 5 complexes during 2021. The following scores reflect the success percentage for the
 6 monitored files at each complex.

7 Performance Measure 50 required urgent specialty consultations and urgent
 8 specialty diagnostic services be scheduled and completed within 30 calendar days of the
 9 consultation being requested by the provider. (Doc. 1185-1, Ex. B at 11). The table below
 10 reflects failures across the system but establishes some locations where "urgent" specialty
 11 consultations repeatedly did not occur within 30 days. The highlighted numbers are those
 12 that were less than the 85% performance required under the Stipulation.

13 **Performance Measure 50**

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	85	100	100	100	100	100	100
Eyman	58	76	69	82	86	90	100
Florence	69	83	74	81	79	85	93
Lewis	65	70	64	88	77	87	88
Perryville	85	90	81	95	89	89	97
Phoenix	75	100	100	100	100	100	100
Safford	100	100	80	100	100	100	100
Tucson	59	93	89	92	97	95	100
Winslow	100	86	100	100	100	100	100
Yuma	57	88	84	77	77	97	58

14 (Ex. 1263).

15 Performance Measure 51 required routine specialty consultations be scheduled and
 16 completed within 60 calendar days of the consultation being requested by the provider.
 17 (Doc. 1185-1, Ex. B at 11). The table below establishes prisoners were waiting at least two
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 19
 20
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1 months to obtain even routine consultations.

2 **Performance Measure 51**

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	86	97	95	100	100	100	100
Eyman	76	68	92	92	98	96	90
Florence	63	90	87	93	88	96	95
Lewis	60	82	83	84	83	92	93
Perryville	81	76	72	83	86	89	88
Phoenix	84	100	88	100	100	95	100
Safford	87	97	97	93	100	97	100
Tucson	80	83	85	90	94	95	93
Winslow	97	90	90	96	77	97	79
Yuma	72	86	86	80	88	88	86

14 (Ex. 1264).

15 Performance Measure 44 required prisoners returning from the hospital have the
16 hospital's treatment recommendations reviewed and acted upon by a medical provider
17 within 24 hours. (Doc. 1185-1, Ex. B at 11). The failures on this measure reflected below
18 are inexplicable if the system was properly functioning. This Performance Measure
19 involved some of the sickest prisoners in the system. As illustrated by Eyman, at times,
20 there was only approximately a 50% chance a prisoner's discharge recommendations
21 would even be reviewed, much less acted on, within 24 hours.

22 **Performance Measure 44**

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	100	86	100	100	75	100	100
Eyman	52	56	69	78	56	68	57
Florence	88	66	71	61	87	53	71
Lewis	81	88	66	72	71	76	76

Perryville	82	79	88	95	81	92	82
Phoenix	50	50	100	100	100	100	0
Safford	100	100	N/A	100	100	100	100
Tucson	74	60	59	67	65	34	66
Winslow	55	100	100	83	100	100	100
Yuma	40	80	38	80	85	65	70

(Ex. 1259).

Performance Measure 13 required chronic care and psychotropic medication renewals be completed such that there was no interruption or lapse in medication. (Doc. 1185-1, Ex. B at 8). The numbers reflected below establish Perryville, Tucson, and Yuma, in particular, were simply unable to provide medication refills in a timely manner.

Performance Measure 13

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	97	100	100	100	93	96	96
Eyman	86	84	84	80	92	88	92
Florence	88	65	77	86	88	88	75
Lewis	69	95	93	99	86	91	77
Perryville	84	82	86	79	74	73	86
Phoenix	94	91	91	97	98	95	100
Safford	90	90	100	90	100	97	100
Tucson	90	94	94	82	67	70	79
Winslow	100	100	100	100	93	100	100
Yuma	64	74	78	74	68	76	96

(Ex. 1256).

Performance Measure 37 required prisoners be seen by an RN within 24 hours after an HNR is received (or immediately if identified with an emergent need, or on the same day if identified as having an urgent need). (Doc. 1185-1, Ex. B at 8). The numbers below

1 establish prisoners experienced significant delays in being seen by a nurse. Given that
 2 nurses are treated as a mandatory first step in obtaining care, any delay in seeing a nurse
 3 will necessarily result in a significant delay in seeing a higher-level provider.

4 **Performance Measure 37**

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	85	100	100	100	100	100	100
Eyman	58	76	69	87	86	90	100
Florence	69	83	74	81	79	85	93
Lewis	65	70	64	88	77	87	88
Perryville	85	90	81	95	89	89	97
Phoenix	75	100	100	100	100	100	100
Safford	100	100	80	100	100	100	100
Tucson	59	93	89	92	97	95	100
Winslow	100	86	100	100	100	100	100
Yuma	57	88	84	77	77	97	58

16 (Ex. 1258).

17
 18 Dr. Murray did not address any of Defendants' own Performance Measure scores
 19 or explain why they do not undermine his claims of a functioning health care system.

20 **VI. Medical Care Conclusion**

21 There is patently insufficient, and more often than not incompetent, health care
 22 staffing to adequately meet prisoners' needs. The majority of medical care staff do not
 23 have necessary training or licensure to provide the type of care that is necessary to provide
 24 constitutionally adequate care. This is a completely ineffective and toxic combination.
 25 The patterns of delay and indifference are pervasive in ADCRR's own mortality reviews.
 26 Defendants have refused to remediate these practices to comply with their constitutional
 27 obligations.

28

MENTAL HEALTH CARE

1
2 In addition to serious medical care needs, it is undisputed Arizona's prisoners suffer
3 from serious mental health needs. Defendants' records reflect 8,548 prisoners on the
4 "mental health caseload," meaning they have scores of MH-3 or above and require ongoing
5 treatment for an active mental health diagnosis. (Ex. 3326). This large population
6 undoubtedly is difficult to manage. However, Defendants' failure to hire sufficient
7 competent staff means prisoners with serious mental health needs are ignored.

8 As with medical care, the parties presented competing experts on the issue of mental
9 health care. Again, Plaintiffs' expert was far more credible. He testified "it's hard for me
10 to adequately express how significantly ill the individuals that I encountered are. They
11 were among the most mentally ill individuals that I have seen throughout my 40 years of
12 being a psychiatrist." (Doc. 4260 at 36:2-6). The evidence at trial established Defendants'
13 system for the provision of mental health care creates a substantial risk of harm created by
14 their refusal to hire adequate staff to provide necessary mental health care.

I. Overview of Expert Testimony

A. Dr. Stewart

15
16
17 Plaintiffs' expert was Dr. Pablo Stewart. He earned a bachelor's degree in chemistry
18 from the U.S. Naval Academy in 1973 and, after serving in the U.S. Marine Corps for five
19 years, earned a medical degree from the University of California, San Francisco in 1982.
20 (Doc. 4109 ¶ 2). After graduating from medical school, Dr. Stewart received the Mead-
21 Johnson American Psychiatric Association Fellowship and became board-certified in
22 psychiatry. (Doc. 4109 ¶ 2). Dr. Stewart currently serves as a clinical professor and
23 psychiatrist at the Burns School of Medicine at the University of Hawai'i. (Doc. 4109 ¶
24 1). He serves as an attending psychiatrist at the Oahu Community Correctional Center and
25 supervises psychiatry residents. (Doc. 4109 ¶ 1). Dr. Stewart has served as Plaintiffs'
26 mental health care expert in this case since 2013.

27 In preparing for his trial testimony, Dr. Stewart reviewed current ADCRR and
28 Centurion policies, procedures, and practices; reviewed numerous documents and class

1 members' medical charts; and conducted on-site inspections and class member interviews
2 in September 2021 at Eyman, Perryville, Phoenix, and Tucson. During those inspections,
3 he visited housing units where people classified SMI are incarcerated, units designated for
4 people with mental health needs (regardless of classification), mental health watch units,
5 isolation units including maximum custody and detention units, and interviewed class
6 members incarcerated in these units. (Doc. 4109 ¶ 8). Dr. Stewart also followed up with
7 the people he originally evaluated in 2013. (Doc. 4260 at 16). All documents Dr. Stewart
8 reviewed are listed in Exhibit 4 to his written declaration. (*Id.* ¶ 15; *see* Doc. 4109-1, Ex.
9 4).

10 **B. Dr. Penn**

11 Dr. Joseph V. Penn testified for Defendants as their mental health care expert
12 witness. He earned a bachelor's degree in biology from the University of the Incarnate
13 Word in San Antonio, Texas in 1987. (Doc. 4172-1, Ex. 1). He earned his medical degree
14 from the University of Texas Medical Branch in 1992. (Doc. 4172 ¶ 9). After graduating
15 from medical school, Dr. Penn completed a fellowship in Forensic Psychiatry from Yale
16 University. (Doc. 4172 ¶ 9). Since 2008, Dr. Penn has served as the Director of Mental
17 Health Services for UTMB Correctional Managed Care. (Doc. 4172 ¶ 12). Dr. Penn has
18 served as Defendants' mental health care expert in this case since 2013. (Doc. 4172 ¶ 2).

19 Dr. Penn did not interview any class members.²⁴ Instead, he generated a random
20 selection of charts from prisoners at ADCRR's facilities that house prisoners with a MH
21 score of MH-3 or higher: Eyman (15 prisoners); Florence (15 prisoners); Lewis (15
22 prisoners); Perryville (30 prisoners); Phoenix (15 prisoners); Tucson (15 prisoners); and
23 Yuma (15 prisoners). (Doc. 4172 ¶ 48; *see* Doc. 4174, Ex. 4). Dr. Penn also conducted
24 tours of facilities that house prisoners on the mental health caseload: Phoenix, Eyman,
25 Lewis, Perryville, Yuma, and Tucson. Dr. Penn met with each facility's health care

26
27 ²⁴ Dr. Penn stated he "was not allowed to actually interview or evaluate any inmate[.]"
28 (Doc. 4289 at 28:1-2). This is untrue. Upon cross-examination Dr. Penn explained
Defendants' counsel told him he "was prohibited from speaking to inmates because they
said the plaintiffs didn't want me talking to inmates unless they were present." (Doc. 4283
at 11:21-24). Dr. Penn chose not to speak to the prisoners in the presence of their counsel.

1 leadership. (Doc. 4172 ¶ 52). All documents Dr. Penn reviewed are listed in Exhibits 2
2 and 3 to his written declaration. (*Id.* ¶ 47; *see* Doc. 4174-1, Exs. 2-3).

3 **II. Staffing is Chronically Insufficient**

4 As with medical care, Plaintiffs' primary claim regarding mental health care is
5 inadequate staffing. Therefore, the Court evaluated whether sufficient mental health care
6 staff are employed to address Arizona's prisoners' serious mental health needs. As stated,
7 the contract between ADCRR and Centurion requires 1052.75 FTEs. (Doc. 4287 at 17:11-
8 12). This overall staffing allocation includes health care, mental health care, dental care,
9 and administrative staff. Plaintiffs contend the mental health care staffing reflected in the
10 contract is too low and, because of current vacancies, many complexes are substantially
11 understaffed. Defendants contend current staffing levels, even though they are markedly
12 beneath the levels contemplated by the contract, are sufficient to meet their constitutional
13 obligations.²⁵

14 Centurion provides the following mental health care staff positions: Behavioral
15 Health Technician; Behavioral Specialist; Mental Health Lead; Mental Health Clerk;
16 Mental Health Midlevel (NP/PA); Mental Health Registered Nurse; Psychiatrist;
17 Psychologist; and Psychology Associate. The tables at Appendix 3 represent the number
18 of mental health care staff required by the contract, the number of hired staff, and the
19 difference between those two numbers. These figures are as of August 2021. (Ex. 2167).

20 As of August 2021, only 149.55 mental health care staff were hired in contrast with
21 199.00 required under the contract with Centurion, reflecting only 75% of positions are
22 filled. Every location is understaffed except for Winslow and Safford, which each have
23 only one psychology associate. Similar to medical care, Defendants have structured the
24 system to have the vast majority of care provided by lower-level individuals. Thus, the
25 majority of individuals providing mental health care are behavioral health technicians,
26 nurses, or psychological associates.

27
28 ²⁵ Defendants concede the staffing levels are too low and below contract requirements, but they argue they cover the deficiencies with overtime.

1 Based on the contract staffing level, at some point in time Defendants decided
2 199.00 mental health positions were actually necessary to provide adequate care to the
3 prisoner population. That staffing level has never been achieved. (Doc. 4264 at 99:17-
4 24). But the critical issue is not the contract staffing level. Rather, the issue is whether
5 the actual staffing numbers, which are far below the contract staffing level, present a
6 substantial risk of serious harm to prisoners. Dr. Stewart testified the number of filled
7 positions “is abysmally low.” (Doc. 4109 ¶ 20). In contrast, Dr. Penn concludes
8 “ADCRR’s contracted mental health services vendor, Centurion, has adequate numbers
9 and types of mental health staffing.” (Doc. 4172 ¶ 66). The Court first analyzes Dr. Penn’s
10 position.

11 Dr. Penn testified there is adequate staffing to meet the prisoner population’s needs.
12 But his opinion is not based on an accurate and careful analysis of the population’s needs.
13 Instead, Dr. Penn claimed it would be inappropriate to require a specific staffing formula
14 because doing so would deprive the system of “flexibility.” (Doc. 4289 at 40:16-22). He
15 claims “staffing levels should be assessed for a particular system based upon a clinical
16 determination that adequate mental health services may be, or are, provided by a particular
17 number of various types of professional staff.” (Doc. 4172 ¶ 65). In Dr. Penn’s opinion,
18 NCCHC’s allegedly straightforward staffing standard makes “perfect sense”—the health
19 care system or facility must merely have adequate staff to provide the services required or
20 needed. (Doc. 4289 at 41:9-17). This theory is simplistic. When applied to ADCRR, it
21 makes no sense.

22 According to Dr. Penn, because ADCRR created a specific staffing requirement of
23 approximately 199 FTEs, that number should automatically be accepted as adequate
24 without challenge. That is circular logic. Dr. Penn never testified to explain how ADCRR
25 developed its staffing allocation or why that arbitrary number was deemed sufficient to
26 “provide the services required or needed.” Based on the evidence, it is nothing more than
27 a number pulled out of thin air. This conclusion again encapsulates in one stroke the
28 absurdity of ADCRR’s reliance on NCCHC certification to establish the system is

1 functioning well. Under Dr. Penn's theory, if ADCRR decided that one mental health staff
2 position was needed for the entire prisoner population, then that decision could not be
3 challenged. But ADCRR's unexplained, unsupported, and unreliable opinion regarding
4 the adequacy of staffing for the entire prison mental health care system is contrary to the
5 evidence.

6 ADCRR failed to present evidence demonstrating that its contract staffing allocation
7 was based on an actual reliable assessment of the need for services. In fact, many
8 witnesses, including those from ADCRR, testified that more mental health care staff
9 beyond the contract staffing level are needed to provide adequate mental health care. Dr.
10 Stefanie Platt, Centurion's former regional mental health director for ADCRR, testified she
11 raised this concern to her superiors.

12 **Question:** And if even 100 percent of the contracted positions were filled,
13 was there still more patient need than the staffing plan could meet?

14 **Dr. Platt:** In my opinion, yes.

15 **Question:** Did you raise your concerns about this, about the adequacy of
16 the contract, with anybody?

17 **Dr. Platt:** Yes.

18 **Question:** With whom?

19 **Dr. Platt:** Dr. Carr, Mr. Dolan.

20 (Doc. 4264 at 100:2-10). Dr. Antonio Carr is Centurion's Statewide Psychiatric Director
21 and Tom Dolan is Centurion's Vice-President of Operations in Arizona. Dr. Platt further
22 testified mental health staff at the "vast majority" of complexes, including Eyman, Phoenix,
23 Lewis, Florence, Perryville, and Tucson, told her of their concerns about caseloads being
24 too high. (Doc. 4264 at 105:4-96). During his Rule 30(b)(6) deposition Dr. Carr confirmed
25 staff repeatedly told him additional staff were needed. (Doc. 4146-1 at 47:16-19 (testifying
26 that "it's not uncommon for a mental health nurse or psychology associate to say, 'Hey,
27 Carr, I think we need more staff'"). This was corroborated by Dr. Pennington-Stallcup,
28 ADCRR's Mental Health Program Director.

During Dr. Pennington-Stallcup's cross-examination, Plaintiffs introduced an

1 August 27, 2020 email Dr. Pennington-Stallcup sent to Defendant Gann, wherein she
2 expressed concerns about vacancies in mental health care provider positions. The staffing
3 numbers reflected in Appendix 4 were referenced in the email.

4 Based on these numbers, Dr. Pennington-Stallcup noted there are “significant
5 vacancies in clinical mental health staff who are primarily responsible for providing []
6 behavioral health contacts.” (Doc. 4276 at 93:25-94:3). Later in another email to Dr. Platt
7 on November 9, 2020, Dr. Pennington-Stallcup wrote, “I’m really concerned about the
8 vacancies at Florence and Eyman given the high-need and high-risk patient populations.”
9 (Doc. 4276 at 95:15-19).

10 During her direct testimony, however, Dr. Pennington-Stallcup retreated from her
11 original concerns about staffing, stating she was no longer concerned. (Doc. 4276 at 90:2-
12 8). She attempted to explain by testifying that she performed a “new analysis” based on
13 allocated staffing. Without explanation, she claimed during trial if all the positions were
14 filled, mental health caseloads would be manageable. (Doc. 4276 at 100:21-24). This
15 “new analysis” is incredible and nonsensical.

16 Comparing clinical mental health staffing levels from August 2020 until August
17 2021 shows the “significant vacancies” that originally concerned Dr. Pennington-Stallcup
18 have not meaningfully changed, and some are worse. More importantly, Dr. Pennington-
19 Stallcup never explained why it would be reasonable to rely on staffing levels that have
20 never been achieved. Accordingly, Dr. Pennington-Stallcup’s new opinion is unreliable
21 and not supported by evidence. In contrast, Dr. Stewart’s opinion which is based on
22 analysis of the substantial evidence before the Court that “systemic deficiencies in the
23 provision of mental health care are rooted, in whole or in part, in ADCRR’s chronically
24 inadequate health care staffing,” is credible. (Doc. 4109 ¶ 32).

25 **III. Inadequate Staffing and Failure to Provide Adequate Mental Health Care**

26 The lack of mental health staff negatively impacts the ability to provide adequate
27 mental health care. The staffing allocation reflects only seven allocated psychiatrist
28 positions for the entire ADCRR population, and the evidence reflects only two of them

1 physically work on-site. (Ex. 1531 May 2021 Staffing Report, Native Format at “All Staff”
2 tab showing “Psychiatrist TH” [Tele-Health] at Eyman, Florence, Lewis, Perryville,
3 Tucson, and Yuma, and two “Psychiatrists” (without the TH qualifier) at Phoenix and
4 Yuma complexes). Dr. Stewart specifically referenced Eyman’s two psychologists and
5 stated he does not “see how one or two psychologists could even begin to address the needs
6 at that [facility].” (Doc. 4260 at 21). The number of psychologists on staff varies from 0
7 (Douglas, Safford, Winslow, and Yuma), to 0.9 (Florence), to 1.75 (Perryville), to 2
8 (Eyman, Lewis), to 2.5 (Phoenix), to 3.9 (Tucson).

9 In addition to midlevel providers, psychology associates act as providers. But there
10 are 14 psychology associates (out of 59) who are listed as not being licensed, including 4
11 at Eyman, 2 at Florence, 3 at Lewis, 1 at Perryville, 2 at Phoenix, and 2 at Yuma. Dr.
12 Stewart explains that he observed a “disturbing pattern” of “mental health staff without
13 pharmacological training serv[ing] as de facto gatekeepers of patients’ access to psychiatric
14 prescribers.” (Doc. 4109 ¶ 22). Without sufficient mental health providers with
15 appropriate training, the outcome is the inability to provide varying levels of support for
16 mental health conditions.

17 **A. Inpatient Treatment Units and Inadequate Treatment at Existing Units**

18 Defendants have inpatient units for prisoners with the most serious and intensive
19 mental health needs. Dr. Stewart’s opinion is the current system reflects a lack of inpatient
20 intensive mental health care. For example, ADCRR provides inpatient psychiatric
21 treatment for prisoners with severe mental illness at the Phoenix complex. A review in
22 September 2021 just before trial reflected only one-third of the beds at that complex were
23 in use. (Doc. 4109 ¶ 46). Dr. Pennington-Stallcup testified the inpatient treatment units
24 are operating below capacity because, allegedly, there are not enough “patients in the
25 system who need those beds.” (Doc. 4277 at 34:15-20). During trial, however, the
26 evidence showed prisoners needing significant inpatient treatment who were denied such
27 treatment.

28 Dr. Pennington-Stallcup was specifically asked about a prisoner housed in Eyman,

1 a non-mental health treatment unit. On October 15, 2020, a mental health provider
2 indicated that the prisoner “appears to need more mental health resources than are available
3 at this location. He is a good candidate for a referral to the [residential treatment unit].”
4 (Doc. 4277 at 34:14-35:3). (Ex. 2401). While not entirely clear, it does not appear he was
5 ever transferred to an inpatient facility. It was clear, however, that approximately one year
6 later in 2021 this prisoner was housed in the same unit he had been housed in as of October
7 2020. And Dr. Stewart identified other prisoners that needed inpatient level care but were
8 not being housed in such facilities or their transfer to an inpatient facility had been delayed.
9 The explanation that follows of those prisoners’ diagnoses as well as Dr. Stewart’s opinion
10 illustrates that Defendants have failed to provide inpatient treatment for those who
11 seriously needed it.

12 T.A. is designated as seriously mentally ill and has a history of self-harm. Dr.
13 Stewart interviewed him when conducting a tour of the Eyman complex in September
14 2021. T.A. was on continuous watch and was laying on the floor. Dr. Stewart noted he
15 was “extremely disheveled and reported experiencing command hallucinations” telling
16 him to hurt himself. In June and July 2021, T.A. had repeatedly cut or otherwise harmed
17 himself with ICS responses being called on a regular basis. On one day, July 18, three ICS
18 were called for self-harm. On July 26, 2021, T.A. was found hanging with both feet off
19 the ground. After he was discovered, he was placed on suicide watch. The assessment and
20 diagnosis sections of the notes were blank. (Doc. 4109 ¶ 51). Dr. Stewart reliably testified
21 T.A. needed to be “urgently transferred to an inpatient hospital setting.” (Doc. 4109 at ¶
22 51).

23 D.V. was on suicide watch at the Eyman complex on September 8, 2021, when Dr.
24 Stewart encountered him. D.V. informed Dr. Stewart he previously took the mood
25 stabilizer Trileptal, but it was discontinued because staff told him “inmates abuse it.” (Doc.
26 4162 at ¶ 52). D.V. has a history of cutting himself, with one incident requiring he be sent
27 to an outside hospital because he lost a significant amount of blood. Dr. Stewart was so
28 alarmed by D.V. that he requested Plaintiffs’ counsel notify ADCRR and Centurion

1 immediately that D.V. required transfer to an inpatient mental health care. (Doc. 4109 ¶
2 52). Dr. Stewart’s urgent recommendation was ignored and the following week D.V. cut
3 himself again. A psych associate prepared a treatment plan the next day that failed to
4 address possible medication modification, or transfer to inpatient mental health care. (Doc.
5 4109 ¶ 53). Dr. Stewart credibly concluded the complexity of D.V.’s case exceeds the
6 skills of a psych associate and D.V. needed to be transferred to a higher level of care.

7 M.S. is a 32-year-old prisoner at Eyman who Dr. Stewart interviewed. He has
8 repeatedly hurt himself while on suicide watch. M.S. has had numerous hospitalizations
9 for self-harming behaviors, including “cutting open his abdominal cavity” and “attempting
10 to cut his own throat.” His current diagnosis is Schizoaffective Disorder, bipolar type. His
11 most recent hospitalization was “on September 4, 2021 [two months before trial], after
12 cutting a 7-inch long by one-inch-deep laceration to his right arm, swallowing three razor
13 blades, and inserting three spork handles into his abdominal scar – *all while on continuous*
14 *watch at Kasson.*” (Doc. 4109 ¶ 54) (emphasis in original). The psychiatry midlevel staff
15 member determined M.S. “does not respond to medications and continues to self-harm
16 regardless of therapy and medication interventions.” (Doc. 4109 ¶ 54). Absent from the
17 record is any indication he was evaluated for inpatient care. Dr. Stewart credibly concluded
18 M.S. needed inpatient care.

19 Finally, Dr. Stewart encountered K.C., a prisoner at Perryville on mental health
20 watch. K.C. reported hearing voices instructing her to kill herself, and her medical record
21 reflected multiple past diagnoses. ICS was initiated five times between September 3, 2021
22 and September 10, 2021 for bizarre behavior, including defecating and urinating on the
23 floor. She was eventually transferred to inpatient treatment just before trial on September
24 16, 2021 but follow-up with a psychiatric provider was not scheduled for 30 days. (Doc.
25 4109-1 at 46). Dr. Stewart notes her persistent psychotic and mood symptoms were
26 wrongly managed.

27 It is clear from the evidence these prisoners should have been placed in inpatient
28 units or, for K.C., placed much earlier. There is no basis to conclude the inpatient units are

1 at only 36% capacity because there are not enough seriously mentally ill prisoners. What
 2 is more, though inpatient facilities are meant for the most challenging prisoners, those
 3 facilities also suffer from lack of sufficient staff, as illustrated by a prisoner named I.C.
 4 The following email to former ADCRR Interim Division Director of Health Services
 5 Richard Pratt and ADCRR Monitoring Bureau employee Vanessa Headstream on February
 6 12, 2020, documents an appalling situation where ADCRR's own staff recognized urgent
 7 attention was needed for I.C. but the only trained mental health staff was "out of town."

8 This mental health patient at Phoenix has been self harming by
 9 banging his head for the past several days resulting in multiple
 10 ICS events and the use of OC spray. Mental health appears to
 be at a loss on how to deal with this inmate.

11 In an email sent today the Regional Director of Mental Health
 12 basically said to continue using OC spray as needed while the
 13 on site mental health team comes up with a treatment plan. We
 14 are told that Dr. Carr [the Regional Director of Psychiatry] has
 15 been consulted by phone but there is minimal documentation
 16 in the medical record to support any significant involvement
 by a psychiatrist. This inmate now has wounds on the back of
 his head and on his forehead from the head banging. There are
 staples holding the wound edges together on the back of his
 head but the forehead wound remains open as the two previous
 attempts to staple his frontal wound have failed because of the
 continuous head banging.

17 We just received a copy of an I/R [incident report] completed
 18 by security staff from last evening indicating that the mental
 19 health RN was encouraging the inmate to bang his head so that
 20 the restraint chair could be used. At the time of this
 21 nurse/patient encounter, the patient was NOT participating in
 head banging but began banging his head after the nurse told
 him to do so which resulted in a Use of Force event. This
 entire event was captured on video.

22 The FHA [Facility Health Administrator] and mental health
 23 apparently had a meeting this morning about this patient
 without having any input from Complex Operations. The FHA
 reported at the Warden Tracker meeting this afternoon that:

- 24 • the patient has allegedly lost 30 pounds since December
- 25 • Mental health staff and nursing staff are verbally reporting
 26 that the condition of this patient "is deteriorating" from his
 normal baseline standards
- 27 • When asked at the Tracker meeting this afternoon why this
 28 situation has not (apparently) been escalated to a
 psychiatric emergency with a Psychiatrist coming to
 Phoenix to complete a comprehensive examination and

1 evaluation of this patient, the FHA responded that Dr. Carr
2 would be coming on **February 24** to assess the patient.

3 Apparently Dr. Carr is out of town. When the Warden asked
4 the FHA if there is another Psychiatrist in the system who can
5 come to Phoenix to assess the patient, she did not know.

6 The Warden and I share the concern that this particular issue is
7 a true psychiatric emergency and that the response from the
8 Centurion mental health leaders at the Regional level is
9 inadequate. Warden Weiss is escalating this concern through
10 his chain of command and I am doing likewise.

11 (Doc. 4109 ¶ 191). Dr. Stewart expressed understandable outrage at I.C.'s treatment at the
12 Phoenix complex, ADCRR's inpatient treatment facility for the most acutely mentally ill
13 prisoners. I.C. needed emergency care but a psychiatrist was "out of town" until twelve
14 days later. Dr. Carr's response to this "true psychiatric emergency" was revelatory in its
15 confirmation of systemic deficiencies.

16 This unfortunate situation is a symptom of a larger problem.

17 Numerous elements impede timely intervention, quality of
18 care, implementation of a comprehensive treatment plan and
19 psychiatric stability.

20 Our inpatient unit needs a larger investment from Psychiatry,
21 Nursing, Mental Health, ADC and Medical.

22 As you know our inpatient unit is licensed by DHS. It is
23 imperative we model our clinical program according to clinical
24 guidelines and license rules/regulations.

25 [I.C.] is the immediate focus. However, barriers to care,
26 collaboration, education, training and communication need to
27 be addressed in order to implement a solid care plan.

28 (Doc. 4109 ¶ 195).

Dr. Penn did not address I.C.'s treatment. Rather he concluded "I found no evidence
that ADCRR or Centurion engaged in a planned or purposeful effort to effect inappropriate
uses of force on any of the above individuals identified as having mental illness." (Doc.
4172 ¶ 275). This means either Dr. Penn did not have knowledge of I.C.'s treatment,
including the email, or if he was aware of it, his opinion reflects a profound lack of concern.
And Defendants have not addressed the email or Dr. Carr's assessment of inadequate

1 mental health care.²⁶

2 The inadequate mental health staffing has led to prisoners who require inpatient
3 levels of care not receiving such care. As Dr. Stewart testified, many prisoners in obvious
4 need of competent intensive treatment are kept in other units that are ill-equipped to treat
5 their conditions. The inadequate staffing of inpatient facilities creates a substantial risk of
6 serious harm to prisoners.

7 **B. Inadequate Treatment for Suicidal Prisoners**

8 Inadequate mental health care staffing is demonstrated in the records of prisoners
9 who died by suicide in recent years. Dr. Stewart provided a review of some of the twenty-
10 three prisoners who died by suicide from 2019 until the close of discovery for trial in
11 September 2021. What follows are some of them.

12 **1. Reuben Neal**

13 Neal died by suicide on August 27, 2020 at the age of 29. He had five visits with
14 mental health staff in the months leading up to his death. On July 8, 2020, he had an eight-
15 minute encounter with a midlevel provider where he was prescribed subtherapeutic levels
16 of two medications to address his anxiety and insomnia. (Doc. 4109-1 at 103). He had
17 another encounter with a midlevel provider on July 16, 2020. That encounter lasted ten
18 minutes. Neal expressed his anxiety was causing a “racing heart” and he felt “backed up
19 against a wall.” He also reported feeling all alone. His medication was not adjusted,
20 despite his obvious and urgent need. His follow-up was kept to every 90 days or as needed.

21 Neal had a visit with a psych associate on July 22, 2020. He reported having a lot
22 of issues, but they were not addressed, and no follow-up plan was documented. His visit
23 on August 17, 2020 lasted five minutes. While the clinician inquired about suicidal
24 ideation, no therapy occurred. His final visit, on August 19, 2020, lasted ten minutes. The
25 notes reflect it was a superficial visit where nothing of substance was discussed. (Doc.

26
27 ²⁶ At times, Defendants attempted to tout telepsychiatry as an augment to the apparent
28 inadequate number of psychiatrists on-site. But telepsychiatry was, for unknown reasons,
not available for I.C.’s situation. If telepsychiatry could not help a situation as dire as this,
there is no evidence that telepsychiatry is a viable alternative to on-site personnel.

1 4109-1 at 104). Neal died by suicide eight days later.

2 The psychological autopsy noted Neal had been transferred to a higher custody level
3 unit eight days before his suicide. That transfer increased his anxiety level and negatively
4 affected his sleep and concentration. Dr. Stewart concludes Neal received “exceedingly
5 poor counseling care and psychiatric care in the weeks leading up to this death.” (Doc.
6 4109-1 at 103). In particular, Neal had encounters with staff who were not qualified to
7 accurately assess his needs. Neal needed “more frequent and thorough assessments” by
8 higher level staff. (Doc. 4109-1 at 103).

9 **2. Eric Haag**

10 Haag died by suicide on September 13, 2020 at the age of 25. (Doc. 4109-1 at 105).
11 The records from Haag’s initial psychiatric evaluation when he entered prison in 2016
12 establish that evaluation was effectively useless given how carelessly it was conducted.
13 The history indicated Haag admitted he had taken medications for paranoid schizophrenia,
14 but he attributed the voices he heard not to schizophrenia but to “drugs.” But the initial
15 evaluation stated he had no history of drug abuse and no history of psychiatric
16 hospitalization. Later records establish Haag began abusing drugs at age nine and had a
17 history of psychiatric hospitalization.

18 The records immediately prior to Haag’s death establish he was not on medication
19 for schizophrenia. On July 11, 2020, Haag had a five-minute visit with a psych associate
20 and reported being under a lot of stress at his prison job and requested to have his
21 medication restarted. (*Id.*). It appears that was ignored. On July 20, 2020, a midlevel
22 prescribing provider reported that Haag was experiencing irritability as well as depressive
23 and anxiety symptoms. There is no indication this provider knew of Haag’s earlier request
24 to restart medication. On August 12, 2020, Haag had his last mental health visit prior to
25 his suicide, which consisted of a three-minute visit with a psych associate who noted that
26 Haag allegedly was not willing to engage. Assuming that was correct, the psych associate
27 stated Haag was not at risk for self-harm. There is no explanation how that assessment
28 was possible due to Haag’s alleged unwillingness to engage.

1 Haag had a complicated mental health history and due to the abbreviated and the
2 brief nature of the mental health visits attributable to staffing issues, Haag was not provided
3 adequate care. Those brief visits combined with the lack of coordination between the
4 counselor and midlevel provider, and incomplete initial psychiatric assessment and
5 inconsistent medical records, contributed to Haag's suicide.

6 **3. Tracie Otero**

7 Otero died by suicide on September 22, 2020 at the age of 47. (Doc. 4109-1 at 107).
8 As of July 2020, Otero was in severe pain, which staff attributed to fibromyalgia. On July
9 31, 2020, Otero had an encounter with an unlicensed psych associate. That encounter
10 confirmed Otero was suicidal based on the amount of pain she was in. On August 6, 2020,
11 an unlicensed psych associate documented a flat affect, low appetite, and that Otero
12 reported she was "tired and in pain." Otero ended the session due to pain. On August 21,
13 2020, an unlicensed psych associate documented Otero was refusing medications and
14 struggling with anxiety. Otero again ended the session due to pain. On September 14,
15 2020, Otero had her last visit with any mental health staff prior to her suicide. That visit
16 with an unlicensed psych associate lasted three minutes before Otero ended the session due
17 to pain. The psych associate said Otero "does not appear to be a danger to self or others at
18 this time." But no explanation was given on how the psych associate, after a three-minute
19 visit that was terminated due to extreme pain, came to that conclusion. In Dr. Stewart's
20 view, a more experienced clinician would have recognized the extent of Otero's pain put
21 her at risk for self-harm.

22 Otero was extremely undermedicated for her pain leading up to her death, leaving
23 her in unremitting pain. Otero's risk of suicide due to pain was missed because of the
24 inexperience of the unlicensed and unsupervised clinicians as well as the abbreviated
25 nature of the visits. Sufficiently qualified staff able to spend the requisite amount of time
26 with Otero would have recognized the gravity of her situation.

27 **4. Austin Georgatos**

28 Georgatos died by suicide on January 28, 2021 at the age of 20. (Doc. 4162-1 at

1 110). Similar to Haag, Georgatos also experienced an initial incompetent assessment upon
2 arriving at prison. On January 14, 2021, Georgatos arrived from jail and had an initial
3 mental health assessment. That assessment lasted five minutes and determined Georgatos
4 had been on medications for anxiety and depression in jail, but those medications, without
5 explanation, had been discontinued two weeks prior. The assessment also documented
6 Georgatos' history of methamphetamine use and both sexual and physical abuse in
7 childhood. He was wrongly assessed to have "no emergent [mental health] issues" and no
8 subsequent mental health appointments were scheduled. (Doc. 4109-1 at 110).

9 On January 25, 2021, he submitted an HNR stating "I need to see psych doctor about
10 the voices I am hearing in my head. They returned since I stopped taking medications."
11 But Georgatos was never seen by health care staff. Instead, he committed suicide three
12 days later. The mortality review determined the death was possibly avoidable, with a
13 failure to recognize symptoms or signs and delay in access to care as contributing causes
14 of the suicide. Dr. Stewart opined Georgatos suicide was preventable. The inadequate
15 intake screening was far too brief, likely as a result of inadequate staffing. In addition,
16 inadequate follow-up based on the reports at intake and the significant delay in care after
17 reporting severe psychiatric symptoms contributed to Georgatos' death.

18 **5. Jason Rothlisberger**

19 Rothlisberger died by suicide on April 15, 2021 at the age of 45. His final week of
20 life demonstrated he was at grave risk of self-harm. (Doc. 4109-1 at 113). On April 7,
21 2021, Rothlisberger attended a "sick call" where he reported depression, anxiety, and not
22 sleeping for days. He also reported thoughts of harming others as well as concerns about
23 his own safety. That same day an ICS was initiated after Rothlisberger's sister called and
24 reported concerns that he may end his life. When asked, Rothlisberger admitted he had
25 placed a rope around his neck to get the attention of staff due to fear for his life and said
26 his anxiety was "10/10" as well as suicidal and homicidal ideations.

27 Between April 8, 2021, and April 12, 2021, Rothlisberger was placed on 10-minute
28 and 30-minute watches. He continued to report concerns regarding his own safety but also

1 started reporting auditory hallucinations. At one point, Rothlisberger told the “mental
2 health team” he was “genuinely terrified” of remaining in the suicide watch pod because
3 “they were raping, torturing, and killing sex offenders at 3 or 4 in the morning.”
4 Inconsistently, the very next day, April 12, 2021, Rothlisberger allegedly “did not endorse
5 significant psychiatric symptoms to the mental health worker.” At some point between
6 April 12 and April 15, Rothlisberger was discharged from crisis watch and there was no
7 record this occurred or why.

8 The mortality review determined contributing factors to Rothlisberger’s suicide
9 included failure to recognize symptoms or signs and failure to follow clinical guidelines.
10 In addition, there were no suicide risk assessments conducted upon placement or removal
11 from crisis watch and no crisis treatment plan developed within one day of placement into
12 crisis watch. In fact, the records established Rothlisberger’s “mental status was
13 significantly worse at the time of discontinuing [the] watch than when it was started.”
14 Rothlisberger did not receive an appropriate referral to a prescribing psychiatrist. In Dr.
15 Stewart’s opinion, because of “significant red flag symptoms” of psychosis, this suicide
16 was avoidable.

17 **6. Failures Discovered in Psychological Autopsies**

18 Dr. Stewart expressed significant concerns regarding the care leading up to these
19 suicides but his concerns were un rebutted by Defendants at trial. The Court asked Dr. Penn
20 about whether he had examined the mortality reviews of prisoners who died by suicide and
21 whether he had opinions about those prisoners’ treatment. (Doc. 4283 at 46:5-17). He said
22 he had reviewed some of them. (*Id.*). But Dr. Penn only pointed to his declaration where
23 he found that ADCRR performs mortality reviews, which he concluded establishes an
24 effective mental health care delivery system. He testified, “I noted, when rare suicides
25 occur, psychological autopsies and administrative suicide reviews are conducted,
26 morbidity and mortality reviews are completed. . . and I think that’s the important take
27 home point, is that all of the ADCRR facilities were found to be 100 percent compliant
28 with the essential standard of NCCCHC suicide prevention and intervention.” (Doc. 4283

1 at 47:7-10, 47:19-23). Again, Dr. Penn, without credible explanation, appears to be relying
2 entirely on the existence of certain ADCRR policies and the NCCHC policies. The
3 NCCHC standard determines only whether ADCRR performs mortality reviews or has
4 some suicide prevention policies. It is undisputed ADCRR performs reviews and has
5 prevention policies. But the existence of those reviews and policies does not establish the
6 reviews or policies are effective, thorough, or competent. And the evidence establishes
7 they are not.

8 When the Court asked Dr. Penn about his evaluations of the psychological autopsies
9 he said, “I definitely remember reviewing all of the morbidity and mortality reviews, but
10 as far as writing a specific analysis of each and every single adverse patient outcome, I
11 don’t recall writing something separate.” (Doc. 4283 at 48:22-49). What is more, Dr. Penn
12 failed to take a single note during his chart and record reviews. Rather, he kept all the
13 information “in [his] head.” (Doc. 4283 at 45:15-18). It was obvious from his testimony
14 that Dr. Penn did not retain sufficient information or conclusions about particular prisoners
15 to discuss them in helpful detail. Rather, Dr. Penn simply concluded all treatment was
16 appropriate. In effect, the Court has only Dr. Stewart’s reliable testimony where he
17 concluded the care was inadequate.

18 **C. Overburdened Staff Have Not Met the Demand Required**

19 **1. Prisoners Receive Either No Treatment Plans or Inadequate Ones** 20 **and Experience Long Term Symptoms Due to Insufficient** 21 **Treatment**

22 The overwhelming evidence demonstrates the lack of mental health staffing—both
23 in terms of overall staffing and insufficient higher-level staff—demonstrates inadequate
24 care. This results in prisoners receiving ineffective treatment leaving prisoners to remain
25 potentially, and unnecessarily, profoundly symptomatic for extended periods of time.
26 (Doc. 4260 at 54). This is established through instances of prisoners who remain
27 symptomatic despite the availability of other treatment options. Thus, prisoners often have
28 treatment options worthy of exploration but, due to staffing, they cannot be explored and
implemented. Dr. Stewart highlighted a few of these prisoners.

1 A.C. is presently housed at the inpatient facility in the Phoenix complex. Dr.
2 Stewart interviewed A.C. and assessed him as “extremely manic and agitated . . . yelling
3 at the custody staff and running around his cell naked.” (Doc. 4109 ¶ 115). A.C. had
4 bruises on the left side of his torso where custody staff had fired a paint ball gun at him
5 during a psychotic episode. He is prescribed Risperdal Consta, 37.5 mg every two weeks.
6 Dr. Stewart noted it “takes up to ten weeks for this long-acting antipsychotic medication to
7 reach therapeutic levels.” Dr. Stewart explained it is not appropriate to “attempt to stabilize
8 a highly agitated and psychotic patient using long-acting injectable antipsychotic
9 medication.” As a result, A.C. remains out of control and “is not receiving anything close
10 to inpatient level of care.” (Doc. 4109 ¶ 117).

11 D.W. is housed at Eyman. D.W. reported “persistent auditory hallucinations . . .
12 command[ing] him to hurt himself and others.” (Doc. 4109 ¶ 118). His medical records
13 reflected he has been prescribed the same 15 mg dose of Abilify for sixteen months despite
14 his ongoing auditory hallucinations commanding him to hurt himself and others. D.W. has
15 not been referred to a psychiatrist for medication adjustment or any other treatment. Dr.
16 Stewart noted 15 mg of Abilify is a “low dose” and a higher dose likely would be effective.

17 J.R. is housed at Eyman. When Dr. Stewart visited J.R., he was “overtly psychotic
18 with very loose associations, disorganized and rambling speech, responding to internal
19 stimuli and thought blocking.” (Doc. 4109 ¶ 114). J.R. was not currently prescribed or
20 taking a single medication despite a diagnosis of schizophrenia. In Dr. Stewart’s opinion,
21 J.R. represents “the ultimate example of deliberate indifference. That is, the staff
22 acknowledge that [J.R.] is psychotic but are not doing anything to address it.” (Doc. 4109
23 ¶ 114).

24 The appalling evidence regarding Rahim Muhammad’s treatment is the strongest
25 example of how prisoners receive inadequate treatment and, as a result, remain profoundly
26 symptomatic for extended periods of time. Muhammad has been diagnosed with
27 schizophrenia and schizoaffective disorder and has been placed on suicide and self-harm
28 watch “dozens” of times. (Doc. 4109 ¶ 181). Dr. Stewart noted Muhammad was

1 repeatedly on suicide watch and had chemical agents used against him on July 5, 2021
2 (twice), July 7, 2021, July 8, 2021, July 9, 2021, July 12, 2021, and July 13, 2021 (twice).
3 (Doc. 4109 ¶ 181). The Court observed some of these uses of force against Muhammad,
4 and they were nothing short of shocking. It is clear Muhammad was profoundly mentally
5 ill and Defendants only solution to his self-harming was to use chemical agents against
6 him.

7 Moreover, Deputy Warden Van Winkle testified that even though Muhammad was
8 housed in Florence-Kasson—a mental health unit—he approached mental health staff and
9 told them Muhammad needed “more care than what we’re able to provide here.” (Doc.
10 4279 at 34). Muhammad remained at Florence-Kasson for seven months while exhibiting
11 profoundly dangerous and symptomatic behavior. And because of the severity of his
12 illness, Dr. Stewart planned to interview him just prior to trial during his September 23,
13 2021 tour, but found that Muhammad had been transferred to a different facility “earlier
14 that very same morning.” (Doc. 4109 ¶ 181).

15 Dr. Penn did not meaningfully address these prisoners’ care. (Doc. 4172 ¶ 270).
16 Dr. Penn offered only that Dr. Stewart’s view of these prisoners was wrong because
17 “psychotherapy and psychotropic medications require treatment compliance, initiative,
18 time, and effort from the patient.” (Doc. 4172 ¶ 270). But Dr. Penn offered no analysis of
19 how his opinion applies to the unique illnesses for each of these prisoners. In short, Dr.
20 Penn’s opinion has no merit.

21 **2. Drive-By Mental Health Encounters**

22 Another consequence of insufficient staff is that mental health encounters are
23 extremely short in duration, remarkably so. This issue was repeatedly litigated during the
24 life of the Stipulation, without resolution. Defendants insisted extremely short encounters
25 were sufficient while Plaintiffs claimed encounters were so short that they could not
26 possibly have been efficacious. Eventually, because Defendants proved unreasonable, the
27 Court imposed minimum durations for visits, subject to exceptions if a mental health
28 clinician concluded visits of short duration were acceptable. (Doc. 3861 at 12). Defendants

1 refused to comply with that Court Order, which required another Order clarifying that
 2 durations shorter than the presumptive minimum were required to be assessed by a
 3 psychiatrist. (Doc. 3861 at 13). Defendants failed again to comply and ironically admitted
 4 they lacked sufficient qualified staff to conduct reviews of short-duration visits. (Doc.
 5 3907 at 6; Doc. 3921 at 16-17).

6 At trial, Dr. Stewart testified that “[i]t is simply not possible to assess a patient and
 7 determine their risk of self-harm or suicide in an encounter lasting five, three, or two
 8 minutes. Such an assessment requires more than literally ‘seeing’ a patient; it first requires
 9 establishing a therapeutic relationship.” (Doc. 4109 ¶ 60).²⁷ Dr. Penn insisted a mere one-
 10 minute encounter could be sufficient to determine if a prisoner was at risk of self-harm or
 11 suicide.

12 **Question:** Could it be one minute?

13 **Dr. Penn:** Yes, possibly.

14 **Question:** To determine that the person was no longer a risk of
 15 harm to themselves or others?

16 **Dr. Penn:** Yes, certainly, if the mental health staff member
 17 knows the inmate, has reviewed the chart, has spoken to staff,
 and is a qualified mental health professional, yes.

18 (Doc. 4283 at 100:12-18).

19 Dr. Penn went further, claiming a prohibition on extremely short visits would be
 20 counterproductive. In his view, “setting minimum required durations for mental health
 21 care encounters can hamper the clinician’s ability to provide mental health care.” (Doc.
 22 4172 ¶ 139). Dr. Penn, however, spoke entirely in generalities and did not point to a single
 23 actual encounter and then explain why it nonetheless was enough. Moreover, the history
 24 of this issue involves repeated Court Orders expressing hesitation at imposing minimums
 25

26 ²⁷ Dr. Stewart also explained that when mental health care providers attempt to speak with
 27 prisoners at their cell fronts, the lack of confidentiality inhibited communication. And
 28 many prisoners refused to be moved to the cage where confidential encounters were held
 because “they were very psychotic and paranoid and they were afraid that if they were to
 be taken out of their cells, that they would be at risk of being attacked by others.” (Doc.
 4260 at 45).

1 and always including a simple uncomplicated procedure whereby a qualified individual
 2 could assess if a short encounter was appropriate. Finally, Dr. Penn’s opinion that the
 3 extremely short encounters were sufficient is not credible for the simple reason that Dr.
 4 Pennington-Stallcup conceded such encounters were *never* sufficient in any circumstance.

5 **Question:** But a one-minute encounter would never be
 6 sufficient to determine that a patient is not at risk of self-harm;
 7 correct?

8 **Dr. Pennington-Stallcup:** Correct.

9 (Doc. 4276 at 125: 9-11).

10 The current prevalence of conducting extremely short duration mental health
 11 encounters is established by the numerous performance measures while the Stipulation was
 12 in effect. These performance measures required prisoners be “seen” at identified intervals.
 13 For example, Performance Measure 80 required a prisoner with a mental health score of
 14 MH-3A “be seen a minimum of every 30 days by a mental health clinician.” As stated,
 15 “seen” was finally interpreted to require an encounter meeting minimum duration
 16 requirements, subject to the exception for short encounters later deemed clinically
 17 appropriate by a qualified individual. The table below reflects Defendants were
 18 consistently unable to meet the duration requirements for April through July 2021.

19 **Performance Measures for Mental Health Durational Requirements**

20 Performance Measure	Complex	April 2021	May 2021	June 2021	July 2021
21 80	Lewis	88%	86%	24%	43%
22 80	Tucson	99%	87%	17%	42%
23 85	Eyman	95%	97%	25%	73%
24 85	Florence	83%	100%	50%	100%
25 85	Lewis	97%	97%	24%	69%
26 85	Perryville	92%	83%	0%	68%
27 85	Tucson	98%	100%	6%	69%
28 85	Yuma	97%	100%	5%	85%

91	Phoenix	100%	100%	80%	100%
94	Eyman	94%	100%	82%	91%
94	Florence	93%	100%	80%	93%
94	Tucson	100%	96%	80%	87%

(Exs. 1729-1732).

3. Inconsistent Distribution of Medications

It is undisputed that psychotropic medications require a sophisticated medication distribution system. Many medications require timed distribution or must be taken with meals. Dr. Stewart testified the “failure to provide timely and consistent delivery and administration of psychotropic medication places patients at substantial risk of serious harm, including pain and suffering, withdrawal symptoms, or deterioration.” (Doc. 4109 ¶ 136). Defendants’ own evidence consistently demonstrates their staffing failures result in prisoners not receiving timely and consistent delivery of psychotropic medications.

Performance Measure 13 required chronic care and psychotropic medication renewals be completed such that there was no interruption or lapse in medication. (Doc. 1185-1, Ex. B at 8). The performance numbers found below show that, for most of 2021, Perryville and Yuma in particular were unable to provide medication refills in a timely manner.

Performance Measure 13

	Jan. 2021	Feb. 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Douglas	97	100	100	100	93	96	96
Eyman	86	84	84	80	92	88	92
Florence	88	65	77	86	88	88	75
Lewis	69	95	93	99	86	91	77
Perryville	84	82	86	79	74	73	86
Phoenix	94	91	91	97	98	95	100
Safford	90	90	100	90	100	97	100

Tucson	90	94	94	82	67	70	79
Winslow	100	100	100	100	93	100	100
Yuma	64	74	78	74	68	76	96

(Ex. 1256).

Of significance, the failure to deliver medication when needed was well-known throughout the system, yet Defendants failed to prevent it. The Continuous Quality Improvement meeting minutes across multiple facilities document interruptions and delays in delivering medications to patients. And Dr. Stewart noted meeting minutes showed delays at Eyman, Perryville, and Tucson in March 2021. (Doc. 4109 ¶ 138). Similar issues also arose at the Phoenix inpatient complex in January and June 2021. (Ex. 905 at 13395 (Phoenix Complex January 2021: prisoners were erroneously given their medications at 4:00 p.m. and again at 8:00 p.m. “due to several breakdowns in communications”)); (Ex. 831 at 61889 (Phoenix Complex June 2021: “Medication errors were noted and discussed with individual staff.”). For many years, the lack of staffing has meant prisoners do not receive medication when they need them to achieve or maintain mental health.

IV. Defendants’ Challenges to Dr. Stewart’s Methodology and Opinions Fail

Dr. Stewart’s opinions focused on the most seriously mentally ill prisoners. Dr. Stewart explained he “wanted to focus [his] attention on the more seriously mentally ill . . . [because] one of the best measures of [] evaluating a system’s ability to care for mentally ill inmates is to look at the more serious mentally ill cases.” (Doc. 4260 at 17). Dr. Penn claimed this approach was unscientific and argued a random approach was preferable. Dr. Penn purported to conduct a “rigorous and representative analysis” but in essence his analysis supports Plaintiffs’ position.²⁸

Dr. Penn testified he reviewed, with the assistance of four practicing correctional psychiatrists, 120 randomly selected charts in addition to the 155 charts Dr. Stewart

²⁸ It is difficult to overstate Dr. Penn’s lack of credibility. He was evasive when asked direct, simple questions. He failed to take a single note during his medical records review. (Doc. 4283 at 21:16-19). His ignorance of fundamental aspects of Defendants’ health care system was obvious and his testimony contradicted the undisputed evidence at trial.

1 reviewed. Dr. Penn instructed each consultant to determine whether “access to care” was
2 provided for each of the prisoners reviewed.²⁹ Dr. Penn did not provide an entirely
3 coherent explanation of “access to care.” At one point, Dr. Penn said “access to care”
4 required consultants determine if the prisoner was given “timely, appropriate” care that
5 “met the standard of care.” (Doc. 4289 at 33:18-21). Later, Dr. Penn redefined it such that
6 a prisoner who had missed medications may or may not be labeled as having “access to
7 care.” (Doc. 4283 at 29:20-22). This method for defining “access to care” is far from
8 objective, and much less scientific. Dr. Penn’s methodology is further flawed because his
9 “access to care” standard does not carefully analyze if the care was medically acceptable.³⁰
10 In essence, it was ambiguous, inconsistent and of no value.³¹

11 Altogether, Dr. Penn and his consultants reviewed a total of 275 prisoner records,
12 consisting of 120 randomly selected prisoners and all of the 155 records reviewed by Dr.
13 Stewart. Defendants argue that of the 120 randomly selected prisoners, only 5% did not
14 have “access to care.” And because Defendants adopted Dr. Penn’s random selection, they

15 ²⁹ Dr. Penn’s consultants were not, however, provided copies of mortality reviews for
16 prisoners who died by suicide. (Doc. 4283 at 30).

17 ³⁰ For example, one prisoner who was placed on suicide watch for two weeks was
18 designated as having “access to care” despite having never been seen by a psychiatric
19 clinician during that time. Another patient’s care was reviewed and the consultant noted
20 “concern patient is not on meds and has diagnosis of schizophrenia or bipolar.” (Doc. 4283
21 at 65). Dr. Penn did not share his consultant’s “concern.” The Court asked Dr. Penn, “But
22 I am wondering in your report is there anything to indicate how you came about deciding
23 that despite what the concerns were from your reviewer the treatment that this patient
24 received was appropriate?” Dr. Penn only responded that because the patient continued to
25 be seen, despite receiving no treatment, his care was acceptable. The table of various
26 patients found at Appendix 5 shows those classified as not having access to care and those
27 marked as having access but the accompanying notes for those patients demonstrate
28 otherwise.

23 ³¹ During trial, Defendants attempted to address a patient, M.L., that Dr. Stewart
24 highlighted in his declaration. (Doc. 4109 ¶ 35). M.L. told Dr. Stewart he experienced
25 severe anxiety, depression, and auditory hallucinations, submitted multiple HNRs about
26 his symptoms, but did not receive a response. (Doc. 4109 ¶ 35). Dr. Stewart reviewed his
27 medical records and noted M.L. submitted an HNR on August 28, 2021, requesting to see
28 someone about getting his medication changed, but did not see a midlevel provider until
September 8, 2021. (Doc. 4109 ¶ 35). During trial, Defendants sought admission of
Exhibit 5315(a) for the purpose of demonstrating that M.L. was seen by a behavioral health
technician on August 30, 2021. (Doc. 4261 at 65-70). But as Plaintiffs noted, “There is
absolutely no reason why a patient would tell a behavioral health tech, who has no training
and no ability to help him, that he had put in an HNR the day earlier asking to see a
psychiatrist about his medications.” (Doc. 4261 at 69-70).

1 argue the Court should extrapolate that 5% to the entire prisoner population. Thus, they
2 contend 5% of the mentally ill prisoner population without access to care is adequate.

3 This conclusion is erroneous. Even if only 5% of mentally ill prisoners do not have
4 access to care, that is unconstitutional. But Dr. Penn's methodology is deeply flawed. In
5 addition to the prisoners who were deemed not to have access to care at all, six additional
6 prisoners' charts were reviewed and, despite being characterized as having "access to
7 care," they died by suicide (Patients 12, 13, 52, 115, 120, and 228). Others went weeks or
8 many months without seeing a provider (Patients 86, 95, and 272). And of significance,
9 combining Dr. Penn's random selection with the charts reviewed by Dr. Stewart results in
10 a total of 275 prisoners. Of those, 38—13.8%—did not have access to care as determined
11 by Dr. Penn's consultants. For another 26 prisoners the consultants determined they had
12 "access to care," but also found deficient treatment, sometimes with fatal consequences.
13 Ultimately, 64 out of 275—23.3%—of the records reflect either an outright denial of access
14 to care or serious deficiencies in mental health care administration.

15 A more fundamental flaw with Dr. Penn's analysis is that, in his opinion, the only
16 outcome that should qualify as "bad" is "death."³² And with death as the relevant threshold,
17 Dr. Penn identified only one case where he had concerns about the care, where a prisoner
18 submitted a request for mental health treatment, was not seen, and then committed suicide.
19 Even there, however, Dr. Penn ultimately concluded the prisoner "was afforded appropriate
20 mental health care." (Doc. 4285 at 61). As for the other 275 records reviewed, Dr. Penn
21 saw no cause for concern:

22 **Question:** Other than this particular patient [who committed
23 suicide], did you find any issues with respect to any of the other
24 275 records that you reviewed?

25 **Dr. Penn:** No, I did not find any gross deviations in standard
26 of care or any access to care or continuity of care that fell below

27 ³² Dr. Penn testified "I reviewed all of these charts, I didn't find any of these patients to be
28 -- to have death or morbidity or mortality resulting, so there wasn't a bad outcome with
these patients." (Doc. 4283 at 61:11-14). Thus, Dr. Penn believes death is the appropriate
metric for a "bad outcome." This establishes a callous indifference to the prisoners whose
charts did reflect inadequate mental health treatment but did not die.

1 the standard of care.

2 **The Court:** So when you -- I don't have the testimony in front
3 of me, but you said there was only one patient where you found
4 that the standard of care had not been up to what it should have
5 been; is this the one patient?

6 **Dr. Penn:** Yes, Your Honor.

7 (Doc. 4285 at 63:23-64:7).

8 Dr. Penn's opinion that only a single prisoner received possibly deficient mental
9 health care is appalling and overwhelmingly contradicted by the evidence at trial. Again,
10 Dr. Penn's handpicked consultants reviewed 275 files. (Doc. 4283 at 75) (stating Dr. Penn
11 chose the consultants). When testifying about the consultants' findings, Dr. Penn stated:

12 I think the question was, was access to care provided, and [the
13 consultants] opined no based on the document review. And
14 you are right, it was 38 out of the 275 charts.

15 (Doc. 4238 at 73). Thus, 13.8% of the prisoners reviewed by Dr. Penn's consultants did
16 not have access to care. Dr. Penn then attempted to claim that lack of access to care was
17 of no concern because only one prisoner suffered the "bad" outcome of "death." It is
18 unclear whether Dr. Penn truly believed that not a single prisoner other than the one he
19 discussed received deficient care or whether Dr. Penn believed he was hired to convey that
20 unsupported opinion. But, either way, that obstinance—and indifference—was devastating
21 to his credibility and renders his opinions unworthy of any weight.

22 **V. Mental Health Care Conclusion**

23 Excessively inadequate staffing pervades Defendants' lack of adequate mental
24 health care treatment. Every single complex is understaffed, except for two complexes
25 which have only a single individual to address prisoners' needs. Again, the consequences
26 of this understaffing are dire, as reflected in the mortality reviews and psychological
27 autopsies of prisoners who died by suicide. In Dr. Stewart's opinion,

28 the chronic shortage of mental health staff, delays in providing or the outright
failure to provide mental health treatment, the inadequacies in the provision
of psychiatric medications, and the other deficiencies identified in this report

1 are systemic problems, and incarcerated people who need mental health care
2 have already experienced, and will experience, a serious risk of injury to their
3 health if these problems are not addressed.

4 (Doc. 4260 at 18-19). And Defendants own evidence confirmed Dr. Stewart’s opinion.

5 **SYSTEMIC PRACTICES THAT IMPEDE HEALTH CARE**

6 There are two overarching aspects of ADCRR’s provision of medical and mental
7 health care that merit separate discussion. First, ADCRR’s health record system is difficult
8 to the point of being impossible to use. As such, it is a significant impediment to
9 constitutionally adequate care. Second, ADCRR’s failure to provide reliable language
10 interpretation services is another significant impediment to care.

11 **I. eOMIS Prevents Adequate Care**

12 It is undisputed that Defendants’ electronic health record system (“eOMIS”) is very
13 inefficient. Defendants’ expert, Dr. Murray, testified eOMIS “does not have the work flow
14 efficiencies, logistical safeguards, and data reporting capabilities necessary to produce
15 ADCRR’s best care. Without exception, the facility management teams at every complex
16 indicated that a new EHR or modernized eOMIS would drastically increase their ability to
17 see more patients.” (Doc. 4206 ¶ 1080).

18 Dr. Wilcox testified in detail how eOMIS’ limitations prevents staff from seeing
19 data in any usable format. eOMIS does not allow staff to view testing results or encounter
20 notes over time. Rather, providers must manually review each lab result and provider note.
21 Dr. Wilcox further testified lab results are reported alphabetically, but not by category.
22 Similar inefficiencies exist for medication administration and x-rays. As a result, staff are
23 not able to efficiently review a patient’s history, creating a significant barrier to appropriate
24 care.

25 This was demonstrated during trial. During Dr. Wilcox’s cross-examination,
26 counsel for Defendants struggled to maneuver through a patient’s medical record to find
27 the information they were seeking. To expect this from physicians who are expected to
28 see 18-20 patients per day is unreasonable.

Dr. Murray elaborated about the problems when treating complex patients. “[T]he

1 more complex the patient, the more fragmented the documentation in eOMIS and the more
2 challenging to follow their care plan. At times, it was difficult to discern what happened
3 in that patient’s care, and what was supposed to have happened.” (Doc. 4206 ¶ 990). He
4 continued, “[t]his fragmentation issue is due to using an EHR that does not support the
5 flow of patient care, does not push desired behavior and care, does not contribute to ideal
6 decision-making, and does not allow a rapid review of a patient’s history and health care
7 needs. In short, this EHR does not allow for the care of complex patients in a
8 comprehensive way and has become an impediment to the timely and efficient care of these
9 patients.” (Doc. 4206 at ¶ 990).

10 Thus, it is undisputed the very foundation of the health care delivery system—the
11 medical records—“does not allow” for “comprehensive” care. In terms of the relevant
12 issue for this case, eOMIS substantially contributes to a substantial risk of serious harm.

13 **II. Defendants Do Not Provide Adequate Language Interpretation Services**

14 Plaintiffs allege Defendants have a policy or practice of failing to provide adequate
15 language interpretation services to prisoners receiving medical or mental health care.
16 Plaintiffs’ experts stated “[c]ommunication with patients is essential to providing adequate
17 medical care.” (Doc. 4138 ¶ 442). And “[e]ffective communication is a fundamental
18 component of providing therapeutic [mental health] care” and mental health care
19 encounters without effective interpreter services are “largely meaningless and superficial.”
20 (Doc. 4109 ¶ 89). Dr. Wilcox explained that, ideally, both medical and mental health care
21 staff “who have been evaluated and determined to be qualified to conduct healthcare
22 encounters in the patient’s language would conduct the healthcare encounter in that
23 language.” (Doc. 4138 ¶ 443). Another option would be the use of “qualified interpreters
24 with experience with medical terminology.” (Doc. 4138 ¶ 443). It is not appropriate,
25 however, to use other prisoners as interpreters because the prisoner patient “may not be
26 comfortable disclosing sensitive, potentially embarrassing medical information” to the
27 prisoner acting as a translator. (Doc. 4138 ¶ 449). It is also inappropriate to use custody
28 staff as interpreters because prisoners may “self-censor or alter communications with the

1 provider” to prevent custody staff from learning sensitive information. (Doc. 4109 ¶ 91).

2 Defendants do not dispute that language interpretation services, in general, are a
3 crucial aspect of minimally sufficient medical and mental health care. Dr. Pennington-
4 Stallcup, agreed that “effective mental health diagnosis and treatment” requires “the
5 clinician and the patient . . . be able to communicate.” (Doc. 4277 at 21:1-5). But
6 Defendants claim the “various policies and practices” already in place are sufficient. (Doc.
7 4315 at 50). But the evidence establishes those policies and practices are far from
8 sufficient. Prisoners are routinely denied language interpretation services, necessarily
9 resulting in the deprivation of appropriate medical and mental health care. The absence of
10 interpretation services creates a substantial risk of serious harm.

11 The main policies Defendants cite as establishing adequate interpretation services
12 are found in the MSTM. The MSTM requires, during the initial intake process, every
13 prisoner be provided a handout, in both English and Spanish, that “outlines how they are
14 to access health care.” (Ex. 1305 at 122). Similar handouts must be provided whenever a
15 prisoner is transferred to a new complex. In addition, the MSTM requires the posting of
16 signs in the intake area of each complex explaining how to access health care. (Ex. 1305
17 at 122, 145). Per this policy, the information need only be in Spanish and English, meaning
18 the information would be useless to prisoners who speak other languages. (Ex. 1305 at
19 123).³³

20 In addition to those requirements, during the intake process each prisoner meets
21 “with nursing providers, dental, [and] mental health.” (Doc. 4231-1 at 97:2-3). During
22 those meetings, the prisoner’s primary language is identified and entered into the electronic
23 medical record. (Doc. 4231-1 at 97:3-7). The medical record system is programmed so
24 that, in the future, staff must always answer a question regarding the prisoner’s language
25 abilities before inputting any new information. The language question is a “hard stop,”
26 meaning the staff inputting information “cannot proceed any further until they answer the
27 question of whether a patient needs interpreter services or not.” (Doc. 4231-1 at 97:5-12).

28 ³³ There was no evidence presented whether the handout and signage policies are followed
in practice. The Court will assume they are.

1 The initial evaluation of language ability completed at intake is not governed by any written
2 policies or procedures. (Ex. 1976 at 2-3 No. 3). Rather, determining the need for
3 interpreter services apparently is left to the discretion of the intake personnel.

4 When a prisoner who is not fluent in English is seen by medical or mental health
5 care staff, interpretation services are supposed to be available through a “telephone or any
6 platform that has audio including a computer screen if [there is a] need [for] sign language
7 interpretation and a visual communication cue.” (Doc. 4231-1 at 100:6-10). This
8 translation service is referred to as the “LanguageLine.” Centurion “prefer[s]” that its staff
9 use the LanguageLine even when the staff speaks the same language as the prisoner.
10 However, that is not required, and staff may proceed without using the LanguageLine for
11 any language the staff are “comfortable” using. It is very common for staff to do so. (Doc.
12 4231 at 101:21-102:3; Doc. 4277 at 68). Centurion does not have policies regarding
13 assessing the language proficiency of its staff. (Doc. 4231-1 at 102:24-103:6). Centurion
14 does not document or know if a staff member can, in fact, converse sufficiently in the
15 language the staff member purports to speak and understand. (Doc. 4231-1 at 103:5-7).

16 In practice, the current policies and practices are ineffective and allow insufficient
17 communication between prisoners and health care staff. First, the absence of any formal
18 assessment process regarding prisoners’ interpretation needs creates a situation where staff
19 have no way of knowing “whether and how much a patient actually understands” when
20 being told information in English. (Doc. 4138 ¶ 454). This may lead to staff concluding a
21 prisoner understands when, in fact, he does not. An unknown language barrier may also
22 lead to “misdiagnosis [and] failure to follow treatment plans.” (Doc. 4138 ¶ 454). If,
23 during intake, a prisoner is not assessed as needing interpretation services, no notation is
24 made in the electronic medical record and future encounters likely will occur in English,
25 whether or not the prisoner can understand.

26 The evidence establishes the lack of any assessment leads to prisoners being
27 incorrectly identified as not needing an interpreter. Dr. Wilcox spoke with two
28 monolingual Spanish speakers at Tucson who were labeled in their health records as not

1 needing interpretation services. Based on his discussion with them, it was “clear” these
 2 two prisoners could not have any “meaningful healthcare encounter in English.” (Doc.
 3 4138 ¶ 448). In fact, other portions of those prisoners’ medical records made clear they
 4 needed interpretation services. (Doc. 4138 ¶ 448). According to these prisoners, they have
 5 not been provided interpreters for medical services and one of the prisoners stated a fellow
 6 prisoner had to act as an interpreter. (Doc. 4138 ¶ 449).

7 Even when the need for interpreter services is known, Defendants and Centurion
 8 may not provide one. A medical record for one prisoner showed staff had to use “google
 9 translation for interpretation of questions and responses.” (Ex. 928 at 1). In addition, Dr.
 10 Stewart, Plaintiffs’ expert on mental health care discussed in detail later, reviewed medical
 11 records of numerous hearing-impaired prisoners and concluded “they had gone months –
 12 if not years – unable to communicate meaningfully with health care staff.” (Doc. 4109 ¶
 13 100).

14 The language difficulties for deaf prisoners are especially pronounced. Dr. Stewart
 15 referenced a “written exchange” between a psych associate and a deaf prisoner when that
 16 prisoner was placed on suicide watch after the death of his brother. Interpretation services
 17 should have been provided. Instead, the written exchange consisted of simple questions
 18 by the psych associate and responses by the prisoner. (The handwritten document makes
 19 clear who wrote which portion. For ease of reading, the prisoner’s responses are bolded).

20 Homicidal? Kill Others? **No**

21 Hallucination **No**

22 Eating ok **ok**

23 Sleeping ok **ok**

24 Feeling anxious **no**

25 Depressed **no**

26 (Doc. 4109 ¶ 101). In Dr. Stewart’s opinion, this “is an awkward, stilted, and slow way to
 27 communicate, and does not provide an appropriate or adequate medium to engage the
 28 patient in discussion of sensitive and important mental health matters.” (Doc. 4109 ¶ 102).

1 That is an understatement. It is hard to believe Defendants think it was appropriate to
2 determine the mental status of a prisoner on suicide watch by passing him a note asking if
3 he felt “Homicidal? Kill Others?” and then accepting his monosyllabic answer.

4 Dr. Stewart also spoke with several monolingual Spanish speakers who had been
5 classified as seriously mentally ill. Those prisoners recounted significant difficulties in
6 communicating with mental health providers, including complaints about being unable to
7 convey difficulties with their medications. (Doc. 4109 ¶¶ 105-106). One prisoner did not
8 respond to Dr. Stewart’s questioning in English but, when Dr. Stewart switched to Spanish,
9 the prisoner “lifted his head off his bunk and look[ed]” at Dr. Stewart. (Doc. 4109 ¶ 109).
10 That prisoner’s medical records indicated he does not need interpretation services but there
11 is a plausible basis to conclude that is inaccurate. (Doc. 4109 ¶ 111)).

12 Reliance on LanguageLine may, in theory, suffice. However, the actual
13 implementation of LanguageLine establishes it does not solve the interpretation problems.
14 LanguageLine is not available in every location and, at times, there are no interpreters
15 available even when staff attempt to use LanguageLine. For example, when Dr. Wilcox
16 visited the IPC at Tucson, he attempted to speak with two monolingual Spanish speakers.
17 Dr. Wilcox asked to use the LanguageLine, but it could not be used where the patients were
18 located. (Doc. 4138 ¶ 462). The only location where it was available was in an office,
19 away from the prisoners. That office did not have an exam table and “would not have been
20 appropriate for a healthcare encounter.” (Doc. 4138 ¶ 462). Medical records also establish
21 instances of the LanguageLine being ineffective because of “poor reception” or no
22 interpreter being available when requested. (Doc. 4138 ¶ 466).

23 While Defendants seem to concede the need for interpretation services, they
24 presented opinions from Dr. Penn, Defendants’ expert on mental health care discussed in
25 detail later. Dr. Penn suggested the status quo is sufficient. But Dr. Penn’s testimony was
26 so flawed on this topic that the Court cannot credit any of his opinions. At the outset, Dr.
27 Penn began by misidentifying the issue. According to Dr. Penn, the “requisite standard of
28 care within a correctional setting” does not mandate “use of certified translators for all

1 healthcare interactions and/or for group psychotherapy.” (Doc. 4172 ¶ 171). Dr. Penn did
2 not explain, however, why he was evaluating whether “certified translators” were
3 necessary. Neither of Plaintiffs’ experts opined “certified translators” were necessary or
4 even possible. Rather, the issue is whether the current practice of having no interpreter
5 services when needed is appropriate. Dr. Penn’s initial opinion regarding the standard of
6 care, even if accepted, is meaningless.

7 Next, Dr. Penn testified the correct “standard of care in the community and in
8 correctional health care is for staff to assess their own level of comfort and proficiency
9 before determining whether a separate translator/interpreter or translator service is
10 required.” (Doc. 4172 ¶ 174). This opinion makes no sense. Whether a staff member can
11 communicate effectively in another language depends on an assessment by the prisoner,
12 not the staff member. That is, a staff member may believe he has native speaker fluency
13 while true native speakers cannot understand a word he says. The standard of care cannot
14 plausibly be based on the staff’s own subjective evaluation of their language skills.³⁴

15 Dr. Penn further attempts to explain away the absence of effective interpretation
16 policies and practices by opining the standard of care is that “use of an interpreter is
17 dependent upon the nature and extent of the encounter.” (Doc. 4172 ¶ 175). He gives the
18 example that a blood pressure measurement may not require an interpreter but “[a]n
19 interpreter would be necessary . . . where there are discussions regarding advance
20 directives.” (Doc. 4172 ¶ 175). At trial, Dr. Penn was asked to identify other types of
21 encounters when an interpreter “would be necessary.” Dr. Penn refused to do so:

22 **Question:** And so what about individual health care
23 counseling?

24 **Dr. Penn:** I would say it would depend.

25 _____
26 ³⁴ Dr. Penn also testified it would be “unreasonable” to require interpreters because “in
27 emergency situations, time is simply not available to have translators/interpreters and other
28 services available.” (Doc. 4172 ¶ 176). Plaintiffs’ experts did not state the standard of
care requires interpreters in “emergency situations.” No one is faulting Defendants for not
having interpreters available, at all hours, for every emergency. Dr. Penn’s testimony that
adequate interpreters need not be provided whenever possible because some emergencies
might occur when they are not available defies logic.

1 **Question:** Mental health groups?

2 **Dr. Penn:** Again, it would depend.

3 **Question:** Suicide watch checks?

4 **Dr. Penn:** Again, it would depend.

5 **Question:** Chronic care encounters?

6 **Dr. Penn:** Same answer, it would depend.

7 **Question:** Appointments with health care or mental health
8 providers?

9 **Dr. Penn:** It would depend.

10 (Doc. 4283 at 108:19-109:3). Dr. Penn explained he could not provide definitive answers
11 whether an interpreter would be needed for these encounters because “[s]ome individuals
12 are more fluent.” (Doc. 4283 at 110:5-6). But Dr. Penn’s testimony is nonsensical
13 considering he testified an interpreter “would be necessary” for discussing advance
14 directives without then stating that did not apply if the prisoner was fluent in English. The
15 reason his testimony did not include an exception for prisoners fluent in English is because
16 the relevant prisoner is one who is not fluent in English. Dr. Penn’s invocation of the
17 various degrees of fluency to avoid determining when interpreters should be provided was
18 a way for him to avoid conceding the obvious: all but the simplest of health care encounters
19 require an interpreter.

20 Finally, Dr. Penn testified that Dr. Stewart reported “he interviewed monolingual
21 Spanish speakers” but Dr. Penn’s review of their records “evidences [those prisoners’]
22 ability to communicate in English.” (Doc. 4172 ¶ 184). To reach this conclusion Dr. Penn
23 explained:

24 I base this -- and I am not questioning Dr. Stewart or his
25 Spanish proficiency. My first language was Spanish also. But
26 I reviewed the Health Needs Request from inmates, and many
27 of them were able to write in English.

28 (Doc. 4283 at 114:14-15). When pressed on this point at trial, Dr. Penn’s testimony became
absurd.

Dr. Penn was presented with a HNR written in Spanish and asked if that was written

1 by the prisoner. Dr. Penn stated he is “not a handwriting expert” and, therefore, he could
2 not tell if the prisoner identified in the HNR actually wrote that HNR. (Doc. 4283 at
3 115:17-19). Thus, Dr. Penn acknowledged his “opinion” based on reviewing HNRs may
4 not reflect the named prisoners’ fluency in English because the HNRs may have been
5 drafted by someone else. In addition, one of the prisoners identified by Dr. Stewart as a
6 monolingual Spanish speaker submitted an HNR in Spanish that, when translated, stated
7 in relevant part “If you do not understand Spanish, please tell me and I will find a way to
8 send this in English.” (Doc. 4283 at 118:1-3). After reviewing that HNR, Dr. Penn stated

9 So the patient is saying, I can find a way to get it translated to
10 English. So as we sit here today, without reviewing the chart
11 and without talking to the patient, I wouldn’t be able to answer
12 if the patient is fluent in English or not.

12 (Doc. 4283 at 118).

13 When pressed on how he had testified earlier that this patient could communicate in
14 English, Dr. Penn stated

15 So again, I would need to review the patient’s record in its
16 entirety and perhaps interview the patient to be able to
17 determine that.

17 (Doc. 4283 at 119). In other words, Dr. Penn contradicted his earlier testimony that this
18 prisoner could communicate in English. Instead, Dr. Penn stated he would need to review
19 the prisoner’s record and interview him before determining whether the prisoner can
20 communicate in English. And in any event, Dr. Penn’s testimony that this prisoner was
21 able to write in English cannot withstand the slightest scrutiny. The prisoner submitted the
22 HNR in Spanish and included a statement that he would “find a way” to send it in English,
23 if necessary. It is not plausible the prisoner would try to “find a way” to submit his HNR
24 in English if his own language abilities meant he could have submitted in English.

25 In general, Dr. Penn’s testimony on the topic of language interpretation was
26 unreliable and incredible. Dr. Penn’s opinion—the status quo of interpretation services is
27 sufficient—is rejected. The only credible evidence before the Court demonstrates
28 Defendants’ language interpretation policies and practices often lead to “largely

1 meaningless and superficial” health care encounters. And inability to communicate one’s
2 medical and mental condition creates a substantial risk of serious harm.

3 **LEGAL STANDARD FOR HEALTH CARE**

4 Eighth Amendment claims involving medical or mental health care requires a
5 prisoner prove an “objective prong” as well as a state-of-mind element, or “subjective
6 prong.” *See Disability Rts. Montana, Inc. v. Batista*, 930 F.3d 1090, 1098-1099 (9th Cir.
7 2019). For systemic challenges of policies and practices, “[t]he first, objective, prong
8 requires that the plaintiff show that the conditions of the prison pose a substantial risk of
9 serious harm.” *Id.* If the prison conditions present such a risk, “[t]he second, subjective,
10 prong requires that the plaintiff[s] show that a prison official was deliberately indifferent
11 by being aware of the facts from which the inference could be drawn that a substantial risk
12 of serious harm exists, and also draw[ing] the inference.” *Id.*

13 The “objective prong” involving a “substantial risk of serious harm” requires
14 prisoners establish they might suffer “further significant injury” or experience the
15 “unnecessary and wanton infliction of pain.” *Id.* The “subjective prong” requires prisoners
16 establish prison officials “knowingly and unreasonably disregarded” the risk of harm.
17 *Farmer*, 511 U.S. at 846. Put differently, prison officials must know “about the risk to
18 which prisoners were exposed” but then “deliberately choose to maintain the harmful
19 policies” or practices. *Batista*, 930 F.3d at 1099. The subjective prong can be met when
20 “prison officials deny, delay or intentionally interfere with medical treatment, or it may be
21 shown by the way in which prison physicians provide medical care.” *Colwell v. Bannister*,
22 763 F.3d 1060, 1066 (9th Cir. 2014) (quoting *Hutchinson v. United States*, 838 F.2d 390,
23 394 (9th Cir.1988)).

24 **CONDITIONS IMPOSED ON THE CLASS**

25 In its Order certifying the class, the Court identified the following six medical care
26 practices that allegedly exposed Plaintiffs to a substantial risk of serious harm in violation
27 of the Eighth Amendment:

- 28 (i) Insufficient health care staffing;

- 1 (ii) Failure to provide timely access to health care;
- 2 (iii) Failure to provide timely emergency treatment;
- 3 (iv) Failure to provide necessary medication and medical devices;
- 4 (v) Failure to provide for chronic diseases and protection from infectious disease; and
- 5 (vi) Failure to provide timely access to medically necessary specialty care.

6
7 The mental health care practices that allegedly subjected Plaintiffs to a substantial
8 risk of serious harm in violation of the Eighth Amendment were:

- 9 (i) Failure to provide mentally ill prisoners medically necessary mental health treatment (i.e., psychotropic medication, therapy, and inpatient treatment) and;
- 10 (ii) Failure to provide suicidal and self-harming prisoners basic mental health care.

11
12 The challenged practices significantly overlap. For example, “insufficient health
13 care staffing” relates to and affects “failure to provide timely access to health care.” That
14 is, insufficient health care staffing results in the failure to provide timely access to care.
15 As set forth above, inadequate staffing has resulted in a cascade of failures including other
16 discrete practices, including inadequate access to necessary medication and inadequate
17 access to specialty care. Similarly, the mental health care practices of failing “to provide
18 mentally ill prisoners medically necessary mental health treatment” overlaps with failing
19 “to provide suicidal and self-harming prisoners basic mental health care.” Accordingly,
20 some of the practices will be considered together to demonstrate Plaintiffs are being
21 subjected to a substantial risk of harm.

22 **I. ADCRR does not have sufficient health care staffing to provide prisoners with**
23 **timely access to health care, including emergency treatment, medication, treatment**
24 **for chronic disease, and specialty care.**³⁵

25 _____
26 ³⁵ This does not address some of the originally identified practices nor does it address
27 particular health care conditions. For example, Plaintiffs did not establish Defendants
28 failed to protect them from “infectious diseases” or that Defendants failed to provide access
to “medical devices.” And while Plaintiffs presented evidence regarding specific health
care conditions like Hepatitis C or Medically Assisted Therapy, this case is not about
particular diseases. Rather the focus must be on the overall provision of health and mental
health care and whether there is a substantial risk of serious harm.

1 Long ago, the Ninth Circuit established the basic requirements for a constitutionally
2 sufficient correctional health care system. It must “provide a system of ready access to
3 adequate medical care.” *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982) (citation
4 omitted), *overruled in part on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995).
5 Prisoners must be able “to make their medical problems known to the medical staff.” *Id.*
6 And that staff must be competent because “[a]ccess to the medical staff has no meaning if
7 the medical staff is not competent to deal with the prisoners’ problems.” *Id.* This requires
8 staff be competent enough “to examine prisoners and diagnose illnesses” and then “treat
9 medical problems or to refer prisoners to others who can.” *Id.*

10 The evidence demonstrates Defendants operate a system lacking sufficient numbers
11 of qualified medical staff to provide prisoners with “ready access to adequate medical
12 care.” *Id.* As discussed above, access to care necessarily requires access to competent
13 health care. The standard of care in the community is higher than the constitutional
14 minimum. But the “[a]ccepted standards of care and practice within the medical
15 community are highly relevant in determining what care is medically acceptable and
16 unacceptable.” *Edmo v. Corizon, Inc.*, 935 F.3d 757, 786 (9th Cir. 2019). The
17 overwhelming evidence establishes the health care available to prisoners is well below the
18 constitutional minimum, let alone the community standards. The current levels of staffing,
19 including the type of staff, are far from adequate to meet constitutional requirements.
20 Defendants’ insufficient hiring and retention of qualified staff create a substantial risk of
21 serious harm to all class members, which affects every aspect of health care delivery
22 because there is simply not enough time to provide the level of care that is necessary. The
23 broken electronic health record, the lack of time to employ differential diagnoses to
24 properly evaluate prisoners’ conditions, and nurses’ failure to refer prisoners to providers
25 are all predictable effects of a lack of staff.

26 **II. ADCRR does not provide mentally ill prisoners with medically necessary mental**
27 **health treatment and suicidal and self-harming prisoners with basic mental health**
28 **care.**

1 ADCRR and Centurion employees also confirmed insufficient staffing extends to
2 the provision of mental health care. The lack of staff—specifically, again, licensed staff
3 with the training to treat prisoners with serious mental health needs—impacts every aspect
4 of the provision of mental health care treatment. The evidence reflects the prisoners with
5 the highest acuity and most serious needs are not provided the medically appropriate level
6 of treatment. Inpatient units remain unfilled, and Centurion’s own officials confirmed the
7 reason was a lack of staffing. Defendants’ mental health care expert’s chart reviews
8 confirmed a lack of access to medically acceptable mental health care. And, again,
9 psychological autopsies reflect systemic deficiencies, but no follow up action was taken to
10 prevent such harm from reoccurring.

11 **III. Defendants Are Deliberately Indifferent**

12 The testimony from Dr. Wilcox and Dr. Stewart was credible while the testimony
13 from Dr. Murray and Dr. Penn was not. Therefore, as detailed above, the medical and
14 mental care available at ADCRR complexes presents a substantial risk of serious harm to
15 every prisoner. Therefore, the “objective prong” of the Eighth Amendment analysis is met.
16 The only remaining question is whether Defendants have acted, and continue to act, with
17 deliberate indifference to that risk.

18 The overwhelming evidence demonstrates Defendants Shinn and Gann are both
19 aware of insufficient staffing and the other conditions that present a substantial risk of
20 serious harm to prisoners. Defendants, however, have not taken effective actions to remedy
21 those conditions. Despite years of knowledge, driven by this litigation and Defendants’
22 monitoring of their private healthcare contractors’ performance, Defendants have in fact
23 made no significant attempts to substantively change the health care system and compel
24 sufficient staffing.³⁶ Thus, Defendants are acting with deliberate indifference to Plaintiff’s

25
26 ³⁶ Defendant Shinn, as ADCCR Director, is legally responsible for providing a
27 constitutionally adequate health care system. Ariz. Rev. Stat. § 31-201.01(D); *West v.*
28 *Atkins*, 487 U.S. 42, 56 (1988) (“Contracting out prison medical care does not relieve the
State of its constitutional duty to provide adequate medical treatment to those in its custody,
and it does not deprive the State’s prisoners of the means to vindicate their Eighth
Amendment rights.”). As the Court noted in Doc. 3940, when Defendant Shinn believes

1 serious medical and mental health care needs. The testimony from Defendants Shinn and
2 Gann provides compelling evidence of knowledge of the failures but a refusal to take
3 meaningful measures to correct systemic flaws.

4 During his testimony Defendant Shinn was asked about a letter he sent to the Chief
5 Executive Officer of Centurion on February 14, 2020. (Ex. 2165). That letter was
6 prompted by a Court Order that had threatened Defendants with contempt if they did not
7 perform their obligations under the Stipulation. Defendant Shinn's letter informed
8 Centurion of that Order and he identified the particular performance measures that were
9 the subject of possible contempt fines. Defendant Shinn explained ADCRR was facing
10 fines of up to \$14.6 million per month if Centurion did not improve. The letter then stated
11 "ADCRR expects and demands Centurion to immediately commit all necessary resources
12 to achieve and maintain compliance on every Performance Measure at every specific
13 location addressed in [the Court Order]." The letter further demanded Centurion "take all
14 reasonable steps to substantially comply" with the Court Order and it listed ten specific
15 steps Centurion had to take. Those steps included the relocation of existing "Arizona
16 healthcare personnel to locations that face challenges in achieving compliance," temporary
17 transfer of Centurion personnel from other states, scheduling additional meetings, filling
18 all vacant positions, and drafting "remedial plans for root causes that hinder compliance."
19 Defendant Shinn was asked about his actions after sending this letter.

20 When asked at trial if he knew "how many health care personnel Centurion
21 reallocated from one facility to another" following his letter, Defendant Shinn responded
22 "No, we were focused on outcomes." (Doc. 4274 at 90). And he failed to elaborate on
23 which specific outcomes were his focus and were achieved. He was then asked if he knew
24 "from which Arizona facilities Centurion reallocated health care staff" or "to which
25 facilities Centurion reallocated health care staff within Arizona." Defendant Shinn knew
26 neither. In fact, Defendant Shinn did not know if *any* health care staff had been reallocated
27 within Arizona. Defendant Shinn was asked if he knew of any health care staff transferred
28

his chosen vendor must provide health care in a different manner, he must enforce his rights
under the vendor contract.

1 to Arizona from other states. Defendant Shinn did not know. When asked if he knew
2 where Centurion had increased telemedicine availability, Defendant Shinn did not know.
3 On this point, Defendant Shinn volunteered his “expectation was [Centurion] get to 100
4 percent staffing across the board. I wasn’t concerned with individual pockets.” (Doc. 4274
5 at 93). When asked if he knew what actions Centurion had taken to recruit additional staff,
6 Defendant Shinn deflected:

7 What I am looking at is outcomes and are we moving the
8 needle forward. That’s exactly what I’m looking at, health care
9 delivery. I’m not necessarily looking at, did you move one
10 from this location to that location? I’m simply asking, provide
11 the services that were asked for and contracted and the Court
12 has demanded as well.

13 (Doc. 4274 at 94). When pressed, Defendant Shinn admitted he did not know of any efforts
14 to recruit more staff, nor did he know how many vacancies Centurion filled as a result of
15 his letter.

16 Based on Defendant Shinn’s testimony, he somehow determined he had no
17 obligation to follow-up with the demands he made in his letter. The only possible
18 conclusion to draw is that Defendant Shinn had little interest in changing the underlying
19 reality. Rather, his letter appears to have been nothing more than a half-hearted effort to
20 generate a piece of paper he could cite to avoid contempt. Obviously, the Court expected
21 Defendant Shinn to take more direct action than signing a letter. Defendant Shinn’s
22 disinterest in Centurion’s response to his letter shows he is knowingly ignoring the reality
23 of the fundamental problems with ADCRR’s health care system.

24 Defendant Shinn also evidenced little curiosity about the conditions at issue in this
25 case. Defendant Shinn agreed that if there were problems in ADCRR, he would want to
26 know of them. (Doc. 4274 at 100). But Defendant Shinn admitted he had not read any of
27 the expert declarations in this case. (Doc. 4274 at 100). There was no explanation why
28 Defendant Shinn, if he was interested in potential problems, chose to make no effort to
familiarize himself with Plaintiffs’ factual contentions.

Another crucial aspect of Defendant Shinn’s testimony that proved his knowledge

1 of ongoing systemic failures is found in the negotiation of an extension to Centurion's
2 contract. In June 2021, ADCRR negotiated an extension with Centurion for another year.
3 As part of that contract, ADCRR "agreed to cap the indemnification of Centurion at \$2
4 million for court ordered sanction and fees related to [this case]." (Doc. 4274 at 97). That
5 meant Centurion would be liable for no more than \$2 million in Court-ordered fines and
6 any amounts beyond that would be borne by ADCRR.

7 As explained by Defendant Gann, that indemnification cap was something
8 Centurion "wanted in the contract." (Doc. 4275 at 144). Accordingly, it can only be
9 assumed that it was clear to Defendant Shinn at the time of the contract renewal that
10 Centurion had significant concerns regarding its performance. More specifically,
11 Centurion apparently realized it would not be able to perform adequately and significant
12 contempt fines were likely. To avoid catastrophic liability, Centurion ensured ADCRR
13 would bear the brunt of nonperformance. Instead of looking into why Centurion was so
14 concerned with additional sanctions, and taking action to address the potential for
15 continued nonperformance, Defendant Shinn simply agreed to limit Centurion's liability
16 and insulated it from meaningful consequences for its failures.

17 Defendant Shinn's testimony also made clear he has adopted a strategy of
18 pretending the problems he knows about do not exist. According to Defendant Shinn,
19 Centurion has "done some great work" and in the 24 months leading up to trial, Centurion
20 "produced some extraordinary results." (Doc. 4274 at 101-02). When asked if "Centurion
21 has done extraordinary work," Defendant Shinn responded "Absolutely." (Doc. 4274 at
22 102). And despite his February 2020 letter, and his ignorance regarding any responsive
23 actions to that letter, Defendant Shinn was "overall" satisfied with Centurion's
24 performance under the contract. (Doc. 4274 at 102). In other words, "overall," Defendant
25 Shinn is satisfied with a system that presents a substantial risk of serious harm. That is
26 almost a perfect illustration of "deliberate indifference."

27 The Court pressed Defendant Shinn on his strange nonchalance regarding his 2020
28 letter to Centurion and Centurion's response. The Court asked him if he thought the

1 demands in the letter were “necessary in order to comply with the court order at that time.”
2 Defendant Shinn stated he believed the demands were necessary. (Doc. 4274 at 111). But
3 the Court then asked him about his testimony that he was only concerned with outcomes,
4 not performance of his demands. Defendant Shinn agreed he was primarily concerned with
5 outcomes, but he stated Centurion had experienced some limited success:

6 [Centurion] experienced success in a number of -- in a number
7 of performance measures at many locations throughout our
8 system. Have they failed at certain locations? There’s no
9 question about that. That’s not debatable. It’s just math, and
10 we are looking at that on a monthly basis. That’s what I’m
11 looking for, is for them to ultimately be 100 percent across the
12 board with all measures. But we’re looking in reductions of
13 failure as well as moving the needle from a systemic
14 perspective.

11 (Doc. 4274 at 112). That did not answer whether he continued to believe Centurion must
12 perform the demands in his letter. Thus, the Court asked Defendant Shinn if he was still
13 demanding Centurion perform. He responded “we are still asking for them to complete
14 [the letter’s demands].” When asked to clarify, Defendant Shinn admitted he “was less
15 concerned about how they do this and more concerned about the results that they produce,
16 in terms of delivery of health care.” (Doc. 4274 at 113). In sum, Defendant Shinn believed
17 the demands in his letter were important, except when that required him to follow up or
18 take additional action. He further believed the demands were still in effect, except he
19 actually only cared about “results.” Defendant Shinn’s actions are not the type of actions
20 a concerned administrator would have taken if he was actually interested in ensuring the
21 undisputed failures were being resolved.

22 Defendant Shinn’s state of mind is further illustrated by testimony that can only be
23 described as shocking.

24 **Question:** And you believe that the health care that’s currently
25 provided to the ADCRR prisoner population meets and often
26 exceeds the community standard of care?

27 **Defendant Shinn:** In some aspects, yes.

28 **Question:** And you believe that has been the case continuously
since your arrival at the Department two years ago?

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Defendant Shinn: Yes.

Question: Okay. And you believe that the access to care for Arizona prisoners exceeds access to care for people in the community?

Defendant Shinn: In terms of timeliness and immediate access in person, I know that from a personal perspective with my provider. It is not even close as a private citizen.

Question: You believe that in an overall sense, access to care for Arizona prisoners exceeds access to care for people in the community, correct?

Defendant Shinn: I know it exceeds my personal experience in Arizona, yes, sir.

Question: You believe that in an overall sense, access to care for Arizona prisoners exceeds access to care for people in the community, correct?

Defendant Shinn: I know it exceeds my personal experience in Arizona, yes, sir.

(Doc. 4274 at 102-03).

The claim that prisoners’ access to care “exceeds” the access to care enjoyed by people in the community is completely detached from reality. Given the overwhelming evidence and repeated instances of insufficient care leading to suffering and death, Defendant Shinn could not possibly believe prisoners have the same access to care as people in the community.³⁷ Defendant Shinn is acting with deliberate indifference to the substantial risk of serious harm posed by ADCRR’s health care system.

Defendant Gann’s testimony also contains overwhelming evidence he knows of ongoing systemic failures but refuses to take adequate remedial action. Defendant Gann

³⁷ There is no evidence of what medical conditions, if any, Defendant Shinn had at the time he testified. Charitably, Defendant Shinn’s opinion would have modest validity if his assessment of ADCRR medical care was based on Dr. Murray’s simplistic and incredible theory that the alleged periodic testing at ADCRR of blood pressure and sugar levels is adequate medical care. But Defendant Shinn’s opinion would have overlooked the overwhelming evidence of prisoners suffering from disabling psychosis, fatal cancers, fatal bleeding ulcers, multiple sclerosis, fatal Hepatitis C, and severe drug addiction. Because Defendant Shinn was aware of this evidence when he gave his opinion, he could not have plausibly believed Arizona prisoners’ access to care exceeds his own experience. And because he is responsible for ADCRR’s grossly inadequate health care system, his answer was a blatant admission of his flagrant dereliction of responsibilities as the Director of the Arizona prison system.

1 testified he had “prepared numerous staffing plans in [his] career.” (Doc. 4275 at 45). He
2 stated those plans are “extremely complicated” and require detailed analysis of each
3 facility, including physical layout, as well as determining the scope of services to be
4 provided and the attributes of the prisoner population. (Doc. 4275 at 48-60). He further
5 stated it is “impossible” to use a staffing analysis prepared for a particular facility and then
6 “overlay that” analysis to another facility. (Doc. 4275 at 53). In brief, Defendant Gann
7 testified that determining the health care needs of a particular prisoner population requires
8 a tremendous effort, including application of specialized knowledge.

9 Despite knowing a valid staffing analysis is critical for the delivery of health care,
10 Defendant Gann has not prepared any staffing analysis for the Arizona system as a whole
11 or for any individual complex. (Doc. 4275 at 124). Instead, Defendant Gann and ADCRR
12 have simply relied on Centurion to determine the appropriate staffing levels. (Doc. 4275
13 at 92). Defendant Gann admitted he did not know how Centurion “arrived at the current
14 staffing levels that they needed.” (Doc. 4275 at 92). Thus, there is no way Defendant
15 Gann could have a meaningful understanding of how the staffing numbers were originally
16 devised or why they were deemed sufficient. Despite his own knowledge that staffing
17 analyses are crucial, Defendant Gann has been uninterested in assessing the adequacy of
18 the current staffing levels.

19 Defendant Gann admitted ADCRR does not have any policies or procedures
20 “regarding the number of needed healthcare staff at each prison.” (Doc. 4275 at 92).
21 Defendant Gann further admitted he knew Centurion was not paying its employees what
22 they could command elsewhere. (Doc. 4275 at 97). But, at the same time, Defendant Gann
23 professed he had “no idea” what Centurion was paying its employees. When asked if he
24 had demanded Centurion increase employee pay, Defendant Gann responded “That’s a no.
25 That’s their business.” (Doc. 4275 at 97).

26 Defendant Gann testified insufficient staffing was not a “barrier” to complying with
27 the Stipulation. (Doc. 4275 at 98). But he then agreed insufficient staffing often leads to
28 cutting corners and inadequate documentation. He also agreed the complexes at Eyman,

1 Florence, Lewis, Tucson, and Yuma all had “compliance problems” with the Stipulation.
2 (Doc. 4275 at 101). Tucson in particular had canceled the nurse line many days, had a
3 backlog of HNRs, and was not delivering insulin to diabetics in a timely fashion.
4 Defendant Gann admitted these issues “seem to be related to staffing.” (Doc. 4275 at 109).
5 Defendant Gann also identified other failures, such as “pre-pouring medications.”³⁸
6 According to Defendant Gann, pre-pouring medications could be due to insufficient staff,
7 “laziness or poor culture.” (Doc. 4275 at 103-04). Given his acknowledgment that
8 inadequate staffing can lead to cutting corners, the lack of adequate staffing is the most
9 likely explanation for the pre-pouring problem.

10 When asked about specific staffing levels reported by Centurion, Defendant Gann
11 offered some revealing testimony. The Court asked Defendant Gann whether it was within
12 Centurion’s discretion to hire more individuals in a certain position than what the contract
13 specified. (Doc. 4275 at 115). Defendant Gann responded with a general overview of his
14 approach to staffing:

15 I think that [Centurion] really got into this contract in their best
16 and final offer and they came back six months later and
17 requested more staff. But you can’t come back six months later
18 and tell me – I’m just speaking --I wasn’t here. But you can’t
19 tell me six months later you need more staff, and much of it’s
20 clerical related, not clinical . . . and expect the taxpayers to just
21 go back and alter the contract by over 100 positions.

22 (Doc. 4275 at 115). In other words, Defendant Gann views the number of contracted
23 positions as an absolute upper limit. If Centurion determines it needs more staff to provide
24 adequate care, Defendant Gann is not interested. Rather than looking to the adequacy of
25 care being provided, Defendant Gann is interested in ensuring the contracted-for staffing
26 is not exceeded.

27 In addition to the testimony by Defendants Shinn and Gann, the undisputed
28 evidence from the time the Stipulation was in effect establishes officials had no interest in

27 ³⁸ This refers to a practice of staff removing medications “from the blister pack” and putting
28 them into envelopes for delivery to prisoners in the housing units. (Doc. 4275 at 103).
Defendant Gann agreed this was not an acceptable method of medication delivery.

1 taking sufficient actions to remedy known problems. During the Stipulation’s life and
2 beyond (discovery for trial went through September 2021), prison officials repeatedly
3 claimed they could improve performance on their own. As explained by Dr. Wilcox,
4 ADCRR identifies Corrective Action Plans allegedly as a mechanism to remedy
5 deficiencies in health care. But Dr. Wilcox identified CAPs that repeated for months or
6 years on end without improvement at Eyman (PM 13, PM 40, PM 44, PM 47, PM 52),
7 Florence (PM 44, PM 50), Lewis (PM 44), Perryville (PM 13, PM 44, PM 51), Tucson
8 (PM 37, PM 44, PM 47, PM 50, PM 51), Winslow (PM 44), and Yuma (PM 13, PM 37,
9 PM 40, PM 51). In other words, ADCRR identified problems and identified solutions, but
10 those solutions failed. Instead of trying different solutions, ADCRR simply repeated the
11 already-failed “solutions” for months or years. This is evidence Defendants knew of
12 failures but refused to take meaningful steps to those failures, often for years.

13 The foregoing evidence that Defendants Shinn and Gann knew of significant
14 failures in the health care system builds on a unique aspect of this case involving the
15 Stipulation. Defendants’ failures during the Stipulation are undisputed. After all, the
16 failures were based on Defendants’ own records. Given that, Defendants cannot credibly
17 claim they were unaware of the problems. Thus, Defendants only credible defense is to
18 rely on legal, rather than factual, arguments. Those arguments fail.

19 **IV. Defendants’ Legal Arguments are Unavailing**

20 One of Defendants’ main arguments against a finding of liability is their belief that
21 the “individual claims” brought by each of the named Plaintiffs fails. (Doc. 4309 at 98).
22 Defendants do not provide a coherent explanation for this approach. In fact, Defendants
23 even argue the named Plaintiffs’ “allegations were not raised in the Complaint.” (Doc.
24 4309 at 98). Defendants seem to believe this litigation consists of determining whether the
25 medical care provided to the named Plaintiffs was constitutional. But this case raises the
26 question of whether Defendants’ policies and practices create a substantial risk of harm to
27 all prisoners. As the Ninth Circuit stated when affirming class certification:

28 The cases cited in the defendants’ briefs, many of which
involve individuals challenging particular instances of medical

1 treatment or conditions of confinement, confirm that they
2 (erroneously) view the plaintiffs' claims as ultimately little
3 more than a conglomeration of many such individual claims,
4 rather than as a claim that central policies expose all inmates
5 to a risk of harm.

6 *Parsons v. Ryan*, 754 F. 3d 657, 675 n.17 (9th Cir. 2014). The Supreme Court has also
7 stated cases raising "systemwide deficiencies" do not turn on the care provided to a single
8 prisoner on any particular occasion.

9 In *Brown v. Plata*, the Supreme Court explained:

10 Because plaintiffs do not base their case on deficiencies in care
11 provided on any one occasion, this Court has no occasion to
12 consider whether these instances of delay-or any other
13 particular deficiency in medical care complained of by the
14 plaintiffs-would violate the Constitution under *Estelle v.*
15 *Gamble*, if considered in isolation. Plaintiffs rely on
16 systemwide deficiencies in the provision of medical and
17 mental health care that, taken as a whole, subject sick and
18 mentally ill prisoners in California to "substantial risk of
19 serious harm" and cause the delivery of care in the prisons to
20 fall below the evolving standards of decency that mark the
21 progress of a maturing society.

22 *Brown v. Plata*, 563 U.S. 493, 505 n.3 (2011). Defendants' insistence that discrete care
23 provided to particular prisoners forecloses their liability is misplaced. This case is not
24 about the care provided to, for example, Kendall Johnson. While Defendants maintain,
25 absurdly, that the care provided to her did not violate the Eighth Amendment, this case
26 does not turn on whether Ms. Johnson was mistreated. Rather, the question is whether the
27 policies and practices create a risk of harm to Ms. Johnson and all other prisoners. There
28 is no question they do.

Defendants also attempt to rely on the Ninth Circuit's recent decision in *Balla v.*
Idaho, 29 F.4th 1019 (9th Cir. 2022). There, the district court had terminated an injunction
that was ongoing since 1984 requiring the Idaho State Correctional Institution to make
changes in the areas of food preparation, medical facilities, safety, and many other aspects
of prison operations. In the years following the injunction's issuance, there was lengthy

1 litigation over Idaho officials' compliance with the district court's orders and an increased
2 focus on medical care and overcrowding. In 2020, Idaho officials moved to terminate the
3 injunction, maintaining there was insufficient evidence they remained deliberately
4 indifferent to the prisoners' serious medical needs. The district court "found no current
5 and ongoing constitutional violations" and terminated the injunction. The plaintiff
6 appealed, arguing violations were continuing and the injunction should not have been
7 terminated. The Ninth Circuit affirmed termination of the injunction.

8 *Balla* is distinguishable from the present case. Of significance, the plaintiffs' expert
9 in *Balla* was asked by the district judge whether the existing medical care resulted in injury
10 or the unnecessary and wanton infliction of pain. The expert answered, "I don't know if I
11 can answer that." *Balla v. Idaho State Board of Correction*, 2020 WL 2812564, at * 16
12 (D. Idaho May 30, 2020). Here, the evidence of constitutional violations is substantial.
13 Both Dr. Wilcox and Dr. Stewart made clear the current system for the provision of medical
14 and mental health care exposes all prisoners to a substantial risk of serious harm. Their
15 testimony was corroborated by chart reviews by Dr. Murray and Dr. Penn demonstrating
16 systemic deficiencies. *Balla* does not help Defendants.

17 Defendants offer a case from the Seventh Circuit, *Rasho v. Jeffreys*, 22 F.4th 703
18 (7th Cir. 2022), where an injunction regarding mental health care in the Illinois Department
19 of Corrections was vacated. The Seventh Circuit found the prison officials did not have
20 the required mental state to show they had acted with "deliberate indifference." *Id.* at 710.
21 The Seventh Circuit concluded the prison officials "made reasonable efforts to cure the
22 deficiencies identified" by the plaintiffs." *Id.* While those "efforts fell short" of actually
23 correcting the constitutional violation, the Seventh Circuit concluded "reasonable
24 measures," even if "ultimately unsuccessful," meant the officials had not acted with
25 deliberate indifference. *Id.* at 711.

26 It is important to note the extent of the "reasonable measures" undertaken in *Rasho*.
27 After the suit was filed, prison officials "spent \$45 million to build new residential
28 treatment units at several facilities and \$75 million to develop a new data system for intake

1 assessments; [they] procured another \$150 million to construct a new inpatient facility;
2 [they] delivered mental-health training to [their] entire staff; and [they] hired administrative
3 personnel to coordinate inmate care.” *Id.* at 707. There is nothing remotely similar in the
4 present suit. Defendants did not present evidence of new units being built or of requests to
5 the legislature for additional funding to ensure better medical and mental health care.
6 Defendants cannot be viewed as pursuing “reasonable measures” to correct the known
7 problems.

8 An additional reason to doubt the applicability of *Rasho* is that it adopts a view of
9 prison officials’ obligations that cannot be squared with existing Ninth Circuit law. In
10 *Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014), the en banc majority held a prison
11 dentist could not be held responsible for money damages in his individual capacity for
12 staffing conditions over which he had no control. But in prohibiting the award of money
13 damages, *Peralta* made clear “[l]ack of resources is not a defense to a claim for prospective
14 relief because prison officials may be compelled to expand the pool of existing resources
15 in order to remedy continuing Eighth Amendment violations.” *Id.* Accordingly, contrary
16 to *Rasho*’s analysis that ineffective remedies may suffice, *Peralta* holds that in a suit for
17 injunctive relief prison officials must remedy ongoing constitutional violations of which
18 they are aware. *Peralta* is binding and it ensures adherence to constitutional standards. In
19 the Ninth Circuit, state officials are not free to engage in ongoing violations of prisoner’s
20 constitutional rights merely because of policy decisions within the state officials’ control,
21 such as funding.

22 To be clear, the Court does not take issue with the uncontroversial principle that
23 prison officials can avoid liability by responding reasonably to a risk, even if the harm is
24 not ultimately averted. But that principle is primarily aimed at situations where the claim
25 is being viewed retrospectively and there is no ongoing constitutional violation to remedy.
26 In injunctive relief suits, it often will not be enough for prison officials to *attempt* to remedy
27 constitutional violations. They must actually do so.

28 Defendants also rely on *Fraihat v. ICE*, 16 F.4th 613 (9th Cir. 2021). In *Fraihat*,

1 five immigration detainees with serious underlying medical conditions filed suit claiming
2 ICE was acting with deliberate indifference to their medical needs and reckless disregard
3 of known health risks. The plaintiffs claimed they were at increased risk if they contracted
4 Covid-19 and they sought a nationwide preliminary injunction requiring ICE take actions
5 to protect them from infection. *Id.* at 618. The district court certified two nationwide
6 classes and issued a preliminary injunction that applied to all immigration detention
7 facilities nationwide. *Id.* The injunction required ICE identify and track detainees with
8 certain risk factors, required ICE issue a comprehensive performance standard regarding
9 Covid-19 issues, and promulgate directives for release of detainees. The court later
10 amended the preliminary injunction to impose more detailed requirements and procedures
11 designed to result in the release of “substantial numbers of detainees from ICE custody.
12 *Id.* The government appealed.

13 The Ninth Circuit set aside the injunction and held the plaintiffs had failed to
14 demonstrate a likelihood of success on the merits of their claims. *Id.* It noted the plaintiffs
15 had not sought individualized injunctive relief or relief specific to the conditions where
16 they were housed but had instead challenged ICE’s nationwide Covid-19 directives and
17 essentially asked the district court “to assume control of top-level policies governing ICE’s
18 efforts” to combat the pandemic. *Id.* The plaintiffs had failed to present evidence of
19 constitutional and statutory violations on a “programmatic, nationwide level.” *Id.* The
20 Ninth Circuit concluded “the slew of national guidance, directives, and mandatory
21 requirements that [ICE] issued and then frequently updated in the spring of 2020” belied
22 the notion that ICE had acted with “reckless disregard” necessary to support a finding of
23 unconstitutional, system-wide deliberate indifference.

24 Defendants’ reliance on *Frailhat* is misplaced. The ICE facilities in that case
25 consisted of “a nationwide network of over 250 detention facilities.” *Id.* at 620. Those
26 facilities differed dramatically from each other:

27 These facilities differ in various ways. ICE owns some of the detention
28 facilities; others are operated under contract with state or local agencies or
government contractors. Some of the centers are “dedicated” facilities,

1 which hold only ICE detainees, whereas others are “non-dedicated” facilities,
2 which also hold non-ICE detainees. ... Facilities also vary based on who
3 provides medical care. Government employees, as part of the ICE Health
4 Services Corps (IHSC), provide direct medical care at twenty facilities,
5 which together hold about 13,500 detainees. The remaining facilities employ
6 medical staff that the federal government does not directly employ.

7 *Id.* at 620. This type of analysis does not apply to the present case involving facilities
8 owned and operated by ADCRR.

9 Prisoners incarcerated in ADCRR’s ten complexes are subject to the same failed
10 practices, which expose all of them to a substantial risk of serious harm. Understaffing is
11 pervasive at every complex and the manner in which prisoners are assessed is common
12 systemwide. Moreover, prisoners are routinely transferred between ADCRR’s complexes.
13 A healthy prisoner at one location might be transferred to another location when he is
14 diagnosed with an illness or when he needs specialty care. Unlike *Fraihat*, ADCRR’s
15 complexes cannot be viewed as meaningfully distinct from each other.

16 Defendants’ legal arguments are no more persuasive than their factual arguments.
17 Defendants know prisoners face a substantial risk of serious harm due to the policies and
18 practices yet Defendants have refused for ten years to take the actions necessary to alleviate
19 that risk.

20 **CONCLUSION ON HEALTH CARE**

21 The current policies and practices, of which Defendants are aware, require prisoners
22 to repeatedly submit requests for treatment, with the response they will be seen on the nurse
23 line. And while nurses are a vital component of any health care system, they are not
24 substitutes for physicians, particularly for prisoners who develop serious conditions or
25 sustain serious injuries (which could be any of them, at any time, in any location). Yet,
26 despite these risks, Defendants provide no substantial explanation detailing why they have
27 persisted in pursuing the same policies and practices regarding staffing. In particular,
28 Defendants have not explained why they refuse to renegotiate the staffing matrix and,
inexplicably, Defendants did not even explain how the staffing numbers were derived in
the first instance.

1 Dr. Murray emphasized there is no evidence of indifference from individual health
2 care staff, and Defendant Shinn noted their “tremendous will to succeed.” (Doc. 4274 at
3 21:22-22:5). But this case is not about each individual health care provider’s will to
4 succeed. They are part of a system that is doomed to fail because, from the beginning, it
5 was not designed to succeed. This case is about whether *Defendants* have a willingness to
6 succeed. And Defendants remain deliberately indifferent not because they know about
7 individual deficiencies in treatment but because they know of the widespread failures to
8 provide care and still fail to take significant action. This has been evident since the
9 inception of this action. Defendants’ failure to comply with the Stipulation, failure to
10 undertake meaningful remedial action when their own mortality reviews reflect
11 preventable deaths, and failure to take any meaningful follow up actions to ensure
12 Centurion’s compliance is what transforms their knowledge into conscious disregard of the
13 risk of harm prisoners face.³⁹

14 The fundamental conclusion is that ADCRR prisoners who develop life-threatening
15 medical and mental health conditions are at a significant risk of serious harm. The ones
16 that do develop such conditions may die prematurely, suffer prolonged pain or symptoms,
17 or survive with lifelong disabilities. This risk is applicable to all prisoners because anyone
18 is susceptible to serious injury or illness at any time. Moreover, the medical and mental
19 health care systems are treated as interconnected such that prisoners housed at one location
20 often are transferred to other locations for treatment. No prisoner, at any location, is safe.

21 Defendants’ refusal to acknowledge any shortcomings is foundational to these
22 findings. If Defendants had admitted their obvious errors but attempted to demonstrate
23 that, despite those errors, they were still capable of providing constitutionally adequate
24 health care, that would have required a different analysis. If Defendants had acknowledged
25 deficient care and attempted to demonstrate those were violations of existing policies, that

26
27 ³⁹ Notably, the evidence demonstrates that the individual cases before the Court were the
28 product of deliberate indifference to serious medical needs and the root cause of the
deliberate indifference were the policies that prevented any substantive treatment of the
serious medical needs of the individuals.

1 would have required a different analysis. Instead, Defendants stubbornly maintain that
2 there is nothing amiss (other than the need for a new EHR). In a system that produces this
3 many catastrophic outcomes, where its own health care expert’s chart reviews reflect care
4 that meets the definition of deliberate indifference, when its mental health care expert’s
5 chart reviews reflected at least 23.8% of charts reviewed showed seriously deficient or an
6 outright denial of care, when not one witness could validate the existing staffing allocation,
7 and when nearly everyone agrees that ADCRR is critically understaffed, it is simply not
8 possible to draw any other conclusion than the health care delivery system poses a
9 substantial risk of serious harm to all prisoners. These issues are pervasive at all 10
10 ADCRR complexes. The overarching policies of critical understaffing, nurse-led health
11 care, lack of adequate interpretation services, and a disastrous EHR are system-wide.

12 **MAXIMUM CUSTODY**

13 **I. Subclass Definition and Admissibility of Expert Testimony**

14 The Court certified a subclass defined as:

15 All prisoners who are now, or will in the future be, subjected
16 by the ADC to isolation, defined as confinement in a cell for
17 22 hours or more each day or confinement in the following
18 housing units: Eyman–SMU 1; Eyman–Browning Unit;
19 Florence–Central Unit; Florence–Kasson Unit; or Perryville–
20 Lumley Special Management Area.

21 Two aspects of this class definition were subsequently addressed by the Ninth Circuit.
22 First, the definition’s reference to particular locations did not mean all prisoners housed at
23 those locations were automatically members of the subclass. As explained by the Ninth
24 Circuit, “[t]he touchstone for inclusion in the subclass is . . . the amount of isolation
25 experienced by inmates.” *Parsons v. Ryan*, 912 F.3d 486, 503 (9th Cir. 2018). Thus, the
26 crucial aspect is “the amount of time an inmate is ‘confine[d] in a cell’ each day,” not where
27 the prisoner is housed. *Id.* Those prisoners “who are confined in a cell for 22 hours or
28 more each day (i.e., inmates who receive less than 14 hours of out-of-cell time each week)”
are members of the subclass. *Id.* This clarification by the Ninth Circuit was important
because some of the listed locations, such as Florence-Central and Eyman-SMU I, may
house prisoners who receive offers to spend substantially more than 14 hours per week out

1 of their cells at varying levels of restrictive housing. *Id.* at 502.

2 The second aspect of the subclass definition addressed by the Ninth Circuit was a
3 prisoner's choice whether to leave his cell did not dictate membership in the subclass. In
4 the Ninth Circuit's view, "[c]onfinement . . . connotes a lack of control whether to leave a
5 particular place." *Id.* Thus, if an inmate is "given an opportunity to participate in out-of-
6 cell activities," he "cannot be considered 'confined' in a cell during that time even if the
7 inmate may theoretically decide not to take advantage of the opportunity." *Id.* For
8 example, if a prisoner were "offered 15 hours of out-of-cell time per week for education,
9 but turn[ed] it down," he would be excluded from the subclass. *Id.* This clarification was
10 useful to focus the subclass issues on whether prisoners were being "offered" out-of-cell
11 time. It is "offers," not whether prisoners accept those "offers," that matter for determining
12 out-of-cell time.

13 When the Ninth Circuit addressed "offers" for out-of-cell time, it was not asked to
14 address, and did not address, what this Court has previously described as "unreasonable
15 and unattainable offers" for out-of-cell time. (Doc. 3359 at 10). Offers for out-of-cell time
16 conveyed in unreasonable ways or accompanied by unreasonable conditions or
17 consequences could render such offers unavailable such that they cannot be used when
18 determining membership in the subclass; nor can they be used when calculating how much
19 out-of-cell time was available to prisoners. (Doc. 3359 at 9). For example, if a prisoner is
20 offered fifteen hours of out-of-cell time in a given week, but all of the offers are
21 accompanied by unreasonable consequences, the prisoner must be deemed as not being
22 offered any out-of-cell time. Therefore, while recognizing it is "offered" out-of-cell time
23 that matters, "offers" must be reasonable or else the offers are deemed not to have occurred.

24 Understanding the current conditions of confinement experienced by the subclass
25 requires examining Defendants' numerous policies regarding prisoner classification and
26 placement. Unfortunately, those policies are complex and difficult to understand.
27 Moreover, those policies routinely bear little resemblance to actual practices. Before
28 considering those policies, however, the Court must address the admissibility and

1 reliability of the testimony offered by two of Plaintiffs' experts.⁴⁰ Those experts, Martin
2 Horn and Dr. Craig Haney, testified extensively regarding the policies, practices, and other
3 conditions of confinement relevant to the subclass. Thus, it is essential to ensure the
4 admissibility of the experts' testimony before making factual findings regarding the
5 subclass.

6 **A. Martin Horn**

7 Martin Horn earned a bachelor's degree in government from Franklin & Marshall
8 College in 1969 and a master's degree in Criminal Justice from John Jay College in 1974.
9 In 1969, Horn began his career as a New York State Parole Officer. He worked in that
10 position for six years. From 1975 to 1977 he worked as an assistant professor of criminal
11 justice at the State University College in Utica, New York. From 1978 to 1985 he held
12 various positions in the New York State Department of Correctional Services, including
13 serving as Superintendent of the Hudson Correctional Facility. He then became the
14 Director of Parole Operations for the New York State Division of Parole where he served
15 from 1985 to 1991. He was that entity's Executive Director from 1991 to 1995. He then
16 became Pennsylvania's Secretary of Corrections until 2000.

17 As of January 1, 2002, Horn became Commissioner of the New York City
18 Department of Probation and, one year later, he became the Commissioner of the New
19 York City Department of Corrections. In that role he was responsible for "literally
20 everything that happened in the agency." (Doc. 4266 at 135). He was responsible for "the
21 health, safety and welfare of the inmates [and] for the security of the city jails." (Doc. 4266
22 at 135). He held the two New York City positions until July 31, 2009. Over the course of
23 his career, Horn has published articles, delivered lectures, and testified before state and
24 federal legislative bodies as well as state and federal courts. (Doc. 4166 at 4-6).

25 In preparation for his testimony, Horn visited ADCRR facilities at Eyman and
26 Lewis, and interviewed more than 60 prisoners. (Doc. 4166 at 4). He took photographs to
27 document the conditions. Plaintiffs offered Horn as an expert regarding the conditions of

28 ⁴⁰ Defendants did not offer any controverting expert testimony.

1 confinement and the operation of prisons. In particular, Horn was offered as an expert in
2 the appropriate classification and housing of prisoners, including the impact of isolation on
3 prisoners.

4 In their post-trial submissions, Defendants summarily argue “Horn does not have
5 the requisite background, knowledge, or experience to provide opinions regarding the
6 effects of isolation or other conditions of confinement on ADCRR inmates.” (Doc. 4309).
7 Without meaningful elaboration Defendants state only that Horn’s “knowledge, skill,
8 experience, training, or education” are insufficient to provide the opinions he offers.⁴¹
9 Pursuant to Federal Rule of Evidence 702, Horn is qualified because he has sufficient
10 knowledge, training, and experience such that his opinions are admissible. The Court may
11 or may not credit those opinions, but that is irrelevant to the admissibility issue. *See*
12 *Primiano*, 598 F.3d 558, 564-65 (9th Cir. 2010) (“Under *Daubert*, the district judge is a
13 gatekeeper, not a fact finder.”).

14 **B. Dr. Craig Haney**

15 Craig Haney, Ph.D., is a Professor of Psychology at the University of California,
16 Santa Cruz. (Doc. 4122 at 3). He has a bachelor’s degree in psychology from the
17 University of Pennsylvania, an M.A. and Ph.D. in psychology and a J.D. degree from
18 Stanford University. Dr. Haney describes his area of specialization as “psychology and
19 law” which he defines as “the application of psychological data and principles to legal
20 issues.” (Doc. 4122 at 3). He has published numerous articles and book chapters in law
21 and psychology, with some emphasis on “the nature and consequences of solitary or
22 ‘supermax’-type confinement.” (Doc. 4122 at 3). Dr. Haney has served as a consultant to
23 police departments, the California legislature, and the United States Department of Justice.

24 A special focus of his career has been “the psychological effects of living and
25 working in real (as opposed to simulated) institutional environments, including juvenile

26 ⁴¹ Defendants also request the Court make strange findings regarding Horn’s testimony.
27 For example, Defendants request the Court find “Horn admits that per ADCRR’s DO 812
28 governing maximum custody management, ADCRR maximum custody inmates are
offered 7.5 hours a week of outdoor recreation.” (Doc. 4309 at 340). There is no dispute
what DO 812 clearly states and it is simply not true that Horn “admitted” prisoners in
maximum custody were always being offered 7.5 hours each week of outdoor recreation.

1 facilities, mainline adult prison and jail settings, and specialized correctional housing units
2 (such as solitary and ‘supermax’-type confinement).” (Doc. 4122 at 5). In performing his
3 professional work, he has toured state prison facilities in twenty-nine states, multiple
4 federal facilities, and international facilities in eight other countries. He has been qualified
5 as an expert and testified in many state and federal courts. His work has been cited
6 approvingly by the United States Supreme Court. *Brown v. Plata*, 563 U.S. 493, 518
7 (2011).

8 Dr. Haney has been involved in this case since 2012. Over the years, he has toured
9 Arizona facilities multiple times and spoken with many prisoners. He often selected
10 prisoners at random but, over the years, he has made efforts to interview the same prisoners
11 previously interviewed if they were still housed in facilities he visits. (Doc. 4122 at 9). He
12 also reviewed medical and mental health records of the prisoners he interviewed. Finally,
13 during his tours he took photographs. During this case, Dr. Haney filed numerous
14 declarations containing his opinions regarding Arizona’s policies and practices. (Doc.
15 4122 at 7).

16 In September 2021, Dr. Haney toured the following housing units: Eyman-SMU I,
17 Eyman-Browning, Lewis-Rast Max, Lewis-Barchey and Morey (medium security units),
18 Lewis-Stiner detention, and Lewis-Sunrise. During these tours, Dr. Haney interviewed
19 approximately 75 prisoners. Dr. Haney attempted to re-interview prisoners he had
20 previously interviewed but his selection of other prisoners to interview was “quasi
21 random.” (Doc. 4306 at 58). Those interviews did not follow a rigid structure. Rather,
22 Dr. Haney asked each prisoner “what your life is like and how you feel you’re being
23 affected by the conditions and the procedures and your treatment.” (Doc. 4306 at 121).
24 Plaintiffs offered Dr. Haney as an expert regarding the subclass’s conditions of
25 confinement and, in particular, whether those conditions present a substantial risk of
26 serious harm to the subclass members’ mental health.

27 As for Dr. Haney, Defendants again offered the summary argument that he “does
28 not have the requisite background, knowledge, or experience to provide opinions regarding

1 the psychological effects of isolation,” without any meaningful detail. (Doc. 4309 at 327).
2 Given Dr. Haney’s knowledge, training, and experience, this argument is preposterous.
3 Pursuant to Federal Rule of Civil Procedure 702, Dr. Haney has precisely the qualifications
4 to testify to the exact subject matter in which he offers his opinions.

5 Further, Defendants did not bring timely motions to exclude Horn or Dr. Haney and,
6 therefore, they have waived such challenges. *See Skydive Arizona, Inc. v. Quattrocchi*, 673
7 F.3d 1105, 1113 (9th Cir. 2012). The Court finds both Horn and Haney were credible. As
8 appropriate, the Court will rely on Horn and Haney’s testimony to describe the policies and
9 conditions of confinement imposed on the subclass.

10 **II. Policies Applied to Subclass**

11 Defendants choose where to house prisoners, and the conditions at those locations,
12 using five policies known as “Department Orders” (“DOs”). The five DOs relevant to the
13 subclass issues are DO 801, DO 804, DO 807, DO 812, and DO 813.

14 **A. DO 801**

15 DO 801 sets forth Defendants’ “Classification Policy.” (Ex. 1309). As explained
16 by Horn, “classification is a term that is used very widely in prisons and jails all over the
17 country” and it is “a fundamental building block of operating prisons and jails that are safe
18 and secure.” (Doc. 4266 at 159). The underlying premise of classification is to identify
19 prisoners who can be placed in “the least restrictive situations” versus those prisoners who
20 must be housed in more restrictive environments. (Doc. 4266 at 159-160). DO 801
21 requires each prisoner be assigned two scores, known as a “Custody Level” and an
22 “Internal Risk Level.” In general, the “Custody Level” “refers to that sort of gross
23 discrimination between minimum custody and maximum custody and gradations in
24 between.” (Doc. 4266 at 163). The “Internal Risk Level” refers to “when an inmate is at
25 a prison, how much independence of movement the inmate can have within that particular
26 [prison].” (Doc. 4266 at 163).

27 **1. Custody Classification**

28 DO 801 outlines “four custody levels”: Maximum Custody; Close Custody;

1 Medium Custody; and Minimum Custody. (Ex. 1309 at 5). Determining a prisoner's
2 custody level requires an individualized analysis using a document titled "Objective
3 Classification: Custody & Internal Risk Technical Manual." (Ex. 1310). The criteria used
4 in this process are:

- 5 (i) Most serious current offense;
- 6 (ii) Most serious prior/other offense;
- 7 (iii) Escape History;
- 8 (iv) History Institutional Violence;
- 9 (v) Gang Affiliation Status; and
- 10 (vi) Current Age.

11 (Ex. 1310 at 12). The technical manual assigns numeric "points" for gradations within
12 each of the six criteria. The total number of points is then used to determine the appropriate
13 custody level. For example, an inmate who scores a total of thirty-eight points under the
14 six criteria likely will be assigned to maximum custody while an inmate who scores zero
15 to nine points likely will be assigned to minimum custody. (Ex. 1310 at 60).

16 2. Internal Risk Level

17 A prisoner's "Internal Risk Level" is determined based on a process very similar to
18 that regarding custody classification. The same six criteria used to determine the custody
19 level are also used to determine the internal risk level. (Ex. 1309 at 15). And using those
20 criteria, each inmate is assigned one of five risk levels. A score of 5 represents the highest
21 risk and a score of 1 the lowest. (Ex. 1309 at 14-15). There are certain guidelines, however,
22 that impose a particular internal risk level regardless of how the inmate otherwise scores.
23 For example, a minimum custody inmate that has "a current or prior conviction for Murder
24 or Kidnapping" must receive an internal risk level of no lower than 3. (Ex. 1309 at 15).

25 The custody classification and internal risk level scores are meant to address slightly
26 different aspects of each prisoner's appropriate housing location but, given that they are
27 using some of the same characteristics of each prisoner, the scores often overlap.
28 Moreover, the internal risk level is secondary to the custody level in that a prisoner placed
in maximum custody will have his movement drastically limited regardless of his internal

1 risk level. (Doc. 4266 at 164).

2 **3. Overrides**

3 The custody classification and internal risk level scores are both subject to
4 “overrides.”⁴² “[O]verrides are basically exceptions,” meant to address situations where
5 the classification scheme may not be reliable. (Doc. 4266 at 165). For example, there may
6 be “confidential information that is not reflected in the criminal history or in the crime
7 itself” that should be considered when deciding how to classify a prisoner. (Doc. 4266 at
8 165). Overrides are either “discretionary” or “non-discretionary.”

9 Discretionary overrides that increase custody level are appropriate “whenever the
10 inmate’s behavior or new information indicates increased security measures are
11 appropriate to ensure the safety of the public, staff, and/or other inmates.” (Ex. 1309 at
12 11). Discretionary overrides may be appropriate if an inmate is a high-profile individual,
13 his crimes were “depicted as heinous,” or if there is some “other major reason.” (Ex. 1309
14 at 12). There was no testimony or evidence offered at trial how these determinations are
15 made. For example, there was no explanation which crimes will be deemed “heinous” for
16 purposes of a discretionary override.

17 In addition to discretionary overrides, DO 801 provides for “non-discretionary
18 overrides.” (Ex. 1309 at 6). The non-discretionary overrides impose simple bright-line
19 rules based on particular characteristics. Thus, regardless of how the technical manual
20 would score a death-sentenced prisoner, he must always be classified as either maximum
21 or close custody. (Ex. 1309 at 6). Another non-discretionary override is that an adult male,
22 regardless of crime, who is serving a life sentence must always serve the first two years in
23 maximum custody. This is the default starting point, but reduction to close custody is,
24 allegedly, possible “on a case-by-case basis.” (Ex. 1309 at 6). However, it was undisputed
25 at trial that as a matter of practice, prisoners beginning a life sentence are never eligible to
26 be reclassified until they have served two years in maximum custody. (Doc. 4268 at 49).

27 Defendants’ approach to overrides creates the possibility prisoners will be

28 ⁴² Pursuant to policy, internal risk level overrides may decrease, but not increase, a
prisoner’s internal risk level. (Ex. 1310 at 45).

1 “overclassifie[d] . . . based on who he or she is or who he or she harmed.” (Doc. 4266 at
2 169). The classification and override processes also create the situation where a single
3 characteristic is used repeatedly. For example, escape history is used when calculating a
4 prisoner’s custody classification as well as his internal risk level. But escape history can
5 also be used to determine if an override is appropriate. (Doc. 4267 at 8). Defendants
6 offered no evidence at trial explaining the reason their classification policies use the same
7 characteristics over and over again. Overall, DO 801 is drafted and implemented with a
8 strong predisposition towards housing prisoners in very restrictive housing.

9 **B. DO 804**

10 DO 804 sets forth Defendants’ “Inmate Behavior Control” policy. (Ex. 1312). DO
11 804 “describes the operation of prison Detention Units as a means to temporarily or
12 permanently separate inmates from the general population to preserve the safe, secure and
13 orderly operation of an institution.” (Ex. 1312 at 3). The policy allows for an inmate to be
14 placed “in detention status” if certain criteria are met.⁴³ There was no evidence offered at
15 trial to explain the exact meaning behind each of the seven criteria for placement in
16 detention status. A Deputy Warden testified DO 804’s reference to “observation status” is
17 implicated when a prisoner is acting strange “but mental health does not place them on a
18 mental health watch.” (Doc. 4273 at 53). That Deputy Warden did not know, however,
19 what “to fulfill disciplinary sanctions” meant because ADCRR allegedly does not have
20

21 ⁴³ Detention may be merited:

- 22 1. To ensure the safe, secure and orderly operation of the institution/facility.
- 23 2. To ensure the integrity, and pending completion, of an ongoing investigation.
- 24 3. While determining eligibility for Protective Custody.
- 25 4. For observation status, to identify, minimize and intervene in the possibility of self-
26 destructive behaviors.
- 27 5. Pending institutional review and classification placement, such as pending transfer
28 to a higher custody level.
6. Pending revocation of parole, work furlough, home arrest, or temporary, mandatory
or provisional release.
7. To fulfill disciplinary sanctions. (Ex. 1312 at 4).

1 “disciplinary detention.” (Doc. 4273 at 54).

2 Detention status pursuant to DO 804 is technically distinct from being classified as
3 maximum custody. However, they are very similar in practice. As explained by a Deputy
4 Warden, “[p]eople who are in detention are treated like they’re in max custody.” (Doc.
5 4264 at 184-185). In fact, prisoners in detention are treated as having the highest possible
6 custody classification as well as the highest internal risk level. (Doc. 4264 at 185).

7 Significantly, pursuant to DO 804, meals for prisoners in detention units should be
8 provided at the same time, and of the same quality, as meals provided to prisoners in
9 general population. In addition, DO 804 states prisoners in detention will be given the
10 opportunity to shower three times per week and the opportunity to exercise outside of their
11 cell for two hours on three different days each week. (Ex. 1312 at 5). Thus, if DO 804
12 were followed, prisoners in detention would be offered three showers and no less than six
13 hours of out-of-cell recreation per week.

14 **C. DO 807**

15 DO 807 is the policy regarding “Inmate Suicide Prevention, Mental Health Watches,
16 and Progressive Mental Health Restraints.” (Ex. 1315). DO 807 sets forth the training
17 requirements for correctional officials regarding suicide prevention and outlines the
18 various types of “Mental Health Watches” an at-risk prisoner may be subjected to when
19 appropriate. For example, depending on a prisoner’s needs, he or she may be placed on
20 “Continuous Mental Health Watch,” “10-Minute Mental Health Watch,” or “30-Minute
21 Mental Health Watch.” (Ex. 1315 at 12-15). Those watches require observation by a
22 correctional officer either continuously or at the specified intervals (*i.e.*, ten or thirty
23 minutes).

24 DO 807 states all prisoners on a mental health watch should be served meals “of the
25 same quantity and nutritional quality as meals served to the general population.” (Ex. 1315
26 at 11). And, “[u]nless determined contraindicated by a licensed mental health professional;
27 [sic] showers, telephone privileges, recreation, and visitation shall be made available to the
28 inmate.” (Ex. 1315 at 12). DO 807 does not state the amount of recreation that should be

1 provided to prisoners on a mental health watch.⁴⁴

2 **D. DO 812**

3 DO 812 is the “Inmate Maximum Custody Management and Incentive System.”
4 (Ex. 1318). It establishes “a system that requires inmates in Maximum Custody to work
5 through a program, utilizing a step incentive system, providing the opportunity to
6 participate in jobs, programs, and other out of cell activities.” (Ex. 1318 at 3). Prisoners
7 in maximum custody “begin the program in Step I, with Step I being the most restrictive,
8 and Step III being the least.” (Ex. 1318 at 5). There are many different varieties of
9 “maximum custody” and some varieties are subject to different limitations.⁴⁵ For the most
10 common type of maximum custody, a prisoner must spend a minimum of 30 calendar days
11 at Steps I or II before being eligible for advancement to the next step. And prisoners who
12 maintain “Step III for a minimum of 30 consecutive days, without incident, are eligible for
13 consideration for placement in a Close Custody housing location.” (Ex. 1318 at 6). DO
14 812 is effectively a program whereby prisoners in maximum custody are told they can earn
15 their way into more privileges and, eventually, be placed in less-restrictive housing
16 settings.

17 DO 812 specifies the exact privileges for prisoners at each step and those privileges
18 vary slightly based on location. For example, prisoners in the Eyman-Browning unit who
19 are at Step I are allowed one phone call per week as well as one non-contact visit. Prisoners
20 at Step III at the same location are allowed three phone calls per week as well as three non-
21 contacts visits. (Ex. 1318 at 11). The same limits apply to prisoners in the Lewis-Rast unit
22 with the exception that Rast prisoners at Step III are allowed a weekly contact visit. (Ex.
23 1318 at 13). For present purposes, the most relevant aspect of DO 812 involves the amount

24 _____
25 ⁴⁴ Prisoners often “go back and forth between [mental health] watch and their maximum
26 custody location.” Those prisoners are called “frequent fliers.” (Doc. 4273 at 110). One
27 Deputy Warden knew of “between five and ten” prisoners who have gone back and forth
28 between maximum custody and mental health watch. (Doc. 4261 at 114).

⁴⁵ DO 812 identifies one set of procedures and benefits for the “maximum custody
population” and different procedures and benefits for prisoners in “restrictive/enhanced
status housing program.” (Ex. 1318 at 5). Because the vast majority of prisoners in
maximum custody are not in the “restrictive/enhanced status housing program,” the Court
will focus on the policy’s application to “maximum custody.”

1 and type of recreation opportunities each prisoner is supposed to be provided. Pursuant to
2 DO 812, the table at Appendix 6 identifies the recreation that should be offered to a
3 maximum custody prisoner at a particular location and at a particular step. The most crucial
4 aspect of DO 812 is that *no* prisoner in maximum custody should be offered less than 7.5
5 hours of recreation per week while prisoners may, some weeks, receive up to 12.5 hours of
6 recreation in a single week.

7 When asked at trial about DO 812's requirements, a Deputy Warden stated, with the
8 exception of Step II prisoners at Browning, recreation opportunities must be in the
9 enclosures of the size specified.⁴⁶ (Doc. 4259 at 104-05). Thus, if DO 812 were being
10 faithfully applied, a general population Step III prisoner at Browning would receive one
11 2.5-hour block in a 20x40 enclosure every month as well as, each week, one 2.5-hour block
12 in a 10x10 enclosure and two other blocks in the standard enclosure or larger. (Doc. 4259
13 at 105). That would mean at least 7.5 hours of out-of-cell recreation every week, some of
14 which would be with other inmates to allow for socialization.

15 DO 812 contemplates "periodic classification reviews of inmates . . . every 180
16 calendar days or less." (Ex. 1318 at 10). There was testimony explaining how these
17 periodic reviews are conducted at Eyman-Browning as well as Eyman-SMU. At both
18 locations, prisoners have their progression reviewed each month. To accomplish this,
19 officials at both locations hold weekly meetings. (Doc. 4259 at 114, 117; 4273 at 22).
20 Those meetings involve the deputy warden or the associate deputy warden, as well as other
21 correctional officers. (Doc. 4264 at 150; 4273 at 22). Those officials review each prisoner,
22 including that prisoner's "behavior, their participation in programming, their disciplinary
23 and their overall interactions with staff." (Doc. 4264 at 150; Doc. 4273 at 22-23). At
24 Eyman-Browning, each meeting lasts approximately 90 minutes, meaning approximately
25 360 minutes are spent on step reviews each month. (Doc. 4259 at 117). That means,
26 because there are 700 maximum custody prisoners at Browning, on average each prisoner
27 is reviewed for approximately thirty seconds each month. At Eyman-SMU, each meeting

28 ⁴⁶ The Court reached the same conclusion regarding the mandatory nature of the enclosure
sizes while the Stipulation was in effect. (Doc. 3861 at 10).

1 lasts between 30 and 60 minutes, meaning each month there is approximately 240 minutes
2 spent on reviews. (Doc. 4273 at 23). Again that means, on average, each prisoner is
3 reviewed for approximately 30 seconds each month.

4 Given the number of prisoners, the length of meetings, and that the relevant records
5 can be incomplete and hard to read, it is not possible officials are conducting a careful and
6 meaningful review of each prisoner each month. DO 812 contemplates step progression
7 and eventual release from maximum custody but the evidence shows actual operation
8 establishes DO 812 is not being applied in a systematic and consistent way. Prisoners
9 sometimes change step levels or are reclassified to lower custody levels but those actions
10 occur almost at random. Prisoners may remain at certain steps for lengthy periods, even
11 though they have not been subject to any disciplinary actions. Prisoners also attain Step
12 III and remain at that step for years. For an egregious example, one prisoner attained Step
13 III in October 2015 and remained in maximum custody, at Step III at least through August
14 2020. (Ex. 1220 at 33).

15 DO 812 contemplates step progression but ADCRR does not calculate how long
16 prisoners spend in maximum custody or how long prisoners spend at each step. (Doc. 4259
17 at 120). A Deputy Warden testified ADCRR does not track these figures, but ADCRR
18 does maintain an electronic database containing information on when a prisoner entered
19 maximum custody, when a prisoner had a change in his step level, and when officials
20 conducted a review of his current step level. (Ex. 1220). The evidence indicates that
21 database is used solely to record relevant dates and events, but ADCRR does not use that
22 data to calculate the amount of time spent in maximum custody or at a particular step level
23 for each prisoner. A conscientious effort to follow DO 812 would, at the very least, require
24 ADCRR have a way of ensuring prisoners progressed through the steps on a timely basis.

25 **E. DO 813**

26 DO 813 outlines ADCRR's "Close Management" process.⁴⁷ (Ex. 1319). When a
27 prisoner participates in one of five identified behaviors, such as being an active participant

28 ⁴⁷ "Close management" is different from "close custody," one of the four custody
classifications.

1 in a riot, he may be placed in “Close Management status.” That status is designed for
 2 prisoners “unable to live in general population” but who do not merit “Maximum Custody
 3 placement.” (Ex. 1319 at 3). DO 813 establishes three “phase levels” that prisoners may
 4 advance through but there was no evidence explaining how these phases work. All
 5 prisoners in close management status are eligible for six hours per week of outdoor
 6 exercise. (Ex. 1319 at 11).

7 **F. Summary of Restrictive Housing Policies**

8 Based on Defendants’ classification and housing practices proven at trial, the
 9 following prisoners qualify as subclass members:

- 10 (a) Formally classified as “maximum custody” pursuant to
 11 DO 801;
- 12 (b) Housed in a detention unit pursuant to DO 804;
- 13 (c) Placed on mental health watch pursuant to DO 807; and
- 14 (d) Placed in close management status pursuant to DO 813.

15 **III. Subclass Population**

16 In their post-trial submissions, the parties agree these four classifications cover the
 17 subclass population. Using these four classifications, and the population figures contained
 18 in Exhibit 1304, the subclass consists of the 2,667 individuals reflected in **Appendix 7**.⁴⁸
 19 That number is slightly larger than either side offers but it is important to note the exact
 20 number is not crucial. Defendants concede the subclass consists of at least 2,472 prisoners
 21 and that number undoubtedly undercounts to some extent. Moreover, the subclass size
 22 fluctuates as prisoners move in and out of particular classifications or are released from
 23 custody. Thus, the Court will establish 2,667 as the subclass population while recognizing

24
 25 ⁴⁸ While both parties rely on Exhibit 1304 to calculate the size of the subclass, they have
 26 inexplicable disputes regarding the total numbers calculated from that exhibit. According
 27 to Defendants, Exhibit 1304 establishes there were 1,636 prisoners in maximum custody,
 28 750 prisoners on detention status, 81 prisoners on mental health watch status, and 7
 prisoners on close management status. (Doc. 4309 at 346). Thus, Defendants argue there
 were a total of 2,474 subclass members as of September 30, 2021. Plaintiffs counter that
 Exhibit 1304 shows 1,801 prisoners in maximum custody, 750 in detention, and 22 in close
 management for a total of 2,573 subclass members. (Doc. 4314 at 90). Plaintiffs do not
 reference prisoners on mental health watch and do not explain the omission.

1 the exact number on any given date might be slightly higher or lower.

2 Beyond disputing the precise number of subclass members, the parties disagree on
3 the relevant total number of ADCRR prisoners to use when comparing the subclass
4 population to the entire prison population. Defendants argue the Court should consider all
5 prisoners “housed in both ADCRR-operated and contract prison complexes.” (Doc. 4315
6 at 102). Doing so would mean a total prison population of 35,410. Plaintiffs argue the
7 Court should consider only prisoners in the ten ADCRR-operated facilities, which would
8 mean a total prison population of 27,794. (Doc. 4314 at 89). Given that this lawsuit
9 challenges conditions in ADCRR-operated facilities, the population in those facilities will
10 be used. In addition, using the population in ADCRR-operated facilities allows for a
11 helpful comparison between Arizona and other states using one of Defendants’ trial
12 exhibits.

13 Defense exhibit 3530 is a report titled *Time-In-Cell 2019: A Snapshot of Restrictive*
14 *Housing based on a Nationwide Survey of U.S. Prison Systems*. The report was published
15 by The Correctional Leaders Association & The Arthur Liman Center for Public Interest
16 Law at Yale Law School. The drafters of that report aimed to provide a statistical overview
17 of the number of prisoners in each state’s prison facilities and the number of those prisoners
18 subject to “restrictive housing,” defined as “in a cell for an average of twenty-two hours or
19 more per day for fifteen days or more.” (Ex. 3530 at ADCRR00231467). The drafters
20 provided a definition for survey respondents to use that excluded individuals in privately
21 run prisons. (Ex. 3530 at ADCRR00231472). At the time of the study, the average
22 percentage of the prison population in restrictive housing across all responding states was
23 3.8%. As for Arizona, it reported a total prison population of 42,312 with 1,934 (4.6%) in
24 restrictive housing. Arkansas reported the highest percentage in restrictive housing of 11%
25 while Colorado, Delaware, North Dakota, and Vermont the lowest percentage of 0%.
26 Arizona’s percentage of 4.6% was the 14th highest. (*Id.* at ADCRR00231475).

27 Arizona’s prison population decreased significantly since the 2019 report. Now,
28 using the definitions provided by the study’s authors, Arizona has 27,794 total prisoners.

1 However, as of 2021 there are more prisoners in restrictive housing (*i.e.*, 2,667) than what
 2 Arizona reported for the 2019 study. Using the current number of prisoners in restrictive
 3 housing and the number of prisoners in ADCRR-operated facilities means Arizona now
 4 has 9.5% of its prisoners in restrictive housing which is over double the 2019 national
 5 average. Because of the high percentage of its prisoners in restrictive housing the Court
 6 agrees with Horn that “the ADCRR overuses isolation. There are more inmates held in
 7 restrictive housing than are necessary.” (Doc. 4166 at 101).

8 The number of prisoners in maximum custody (1849) and detention (746) dwarf the
 9 number of prisoners on mental health watch (50)⁴⁹ and close management status (22).
 10 Thus, the Court’s findings and analysis will focus on maximum custody and detention. For
 11 those two statuses, the manner in which activities are tracked is different and the out-of-
 12 cell offers are quite different. The Court will analyze the treatment of these two statuses
 13 separately.

14 **A. Maximum Custody⁵⁰**

15 **1. Classification Policies and Practices Lead to Overclassification**

16 Before examining the conditions in maximum custody, it is important to understand
 17 how prisoners are classified to see how classification procedures impact operations. As set
 18 forth earlier, DO 801 and its related practices and policies are designed such that large
 19 numbers of prisoners are classified as maximum custody, even when the prisoner’s
 20 characteristics would support a lower custody level. Horn provided examples of the
 21 “overclassification” produced by DO 801 and related practices. These examples show how
 22 Defendants’ policies and practices result in a large maximum custody population even
 23 when officials believe there is no penological justification that supports keeping certain
 24 prisoners at that custody level.

25
 26 ⁴⁹ Based on the evidence presented at trial, there likely are even more prisoners who should
 27 be on mental health watch.

28 ⁵⁰ Maximum custody and close management are, in effect, the same. The trial evidence
 focused on the manner in which the activities of prisoners in maximum custody were
 tracked. But it is unclear whether the activities of the prisoners in close management are
 tracked using the same form.

1 Prisoner S.C. entered Defendants' custody on April 1, 2019, to begin serving a life
2 sentence. (Doc. 4166 at 30). S.C. "scored" for placement in medium custody but,
3 employing an override, S.C. was recommended to be placed in maximum custody because
4 he had "currently served less than 2 years on a Life Sentence." (Doc. 4166 at 31; Exhibit
5 3611 at 3). S.C.'s placement was reviewed in October 2019. His classification score
6 recommended minimum custody but he remained in maximum custody because he was
7 "serving first two years in max." (Ex. 3611 at 19). S.C.'s placement was reviewed in
8 March 2020 with identical results. (Ex. 3611 at 17).

9 S.C.'s placement was reviewed again in October 2020. At that time, an official
10 erroneously stated S.C. had served two years. Based on that, and the lack of any
11 disciplinary history, the official recommended S.C. be reclassified to the lower level of
12 "close custody." (Ex. 3611 at 15). Two deputy wardens agreed S.C. could be managed at
13 close custody. The "Classification Administrator," however, disagreed and, without
14 explanation, decided S.C. was to remain in maximum custody. (Ex. 3611 at 14). For
15 unknown reasons, officials completed forms on May 3, 2021, May 17, 2021, and June 16,
16 2021, recommending S.C. be reclassified to close custody based on his custody score and
17 lack of disciplinary history. (Ex. 3611 at 8-12). All those recommendations were rejected.
18 At some unknown time past the two-year period, S.C. was eventually reclassified to a lower
19 custody level and left maximum custody. Overall, S.C. spent a significant amount of time
20 in maximum custody despite multiple prison officials repeatedly recognizing a maximum
21 custody placement was unnecessary.

22 Another prisoner, S.M., had a similar experience with the classification system.
23 S.M. entered custody on June 14, 2019, to begin serving a life term. He was placed in
24 maximum custody despite his custody scores showing he was eligible for medium custody.
25 (Doc. 4166 at 34). His maximum custody placement was reviewed over the following
26 years, with his custody score not changing, but S.M. remained in maximum custody
27 because of his "sentence structure." (Doc. 4166 at 34). In June 2021, his placement was
28 reviewed, and his scores justified minimum custody placement. But officials

1 recommended he be transferred to close custody which occurred on July 15, 2021. (Doc.
2 4166 at 35).

3 Regarding S.C. and S.M., Horn stated “there was no penological justification” for
4 keeping both in maximum custody for two or more years. (Doc. 4166 at 33, 35). Horn
5 further opined, in his “experience and [] opinion,” there was no penological justification
6 for the policy that all life-sentenced prisoners spend the first two years in maximum
7 custody. (Doc. 4267 at 26). Horn was unaware of any prison system that has a similar
8 requirement. (Doc. 4267 at 27). The only penological justification offered by Defendants
9 for this policy was from Director Shinn who testified, without elaboration, the policy was
10 “[t]o prevent harm in our facilities.” (Doc. 4274 at 69). And when Director Shinn had
11 been asked for the penological justification behind the policy at his deposition, he
12 responded “I don’t have that information with me.” (Doc. 4274 at 70). Director Shinn’s
13 attempted justification was not credible given the documented instances of other
14 correctional officials concluding individuals subject to the policy could safely be housed
15 at lower custody levels (even minimum custody). In other words, officials with actual
16 knowledge of the prisoners’ behavior and risks believed the prisoners could be housed at
17 lower custody levels without presenting a risk of harm.

18 Horn highlighted problems with other classification policies of Defendants. A
19 prisoner, V.S., entered custody in August 2018, but the records regarding him were
20 incomplete and reflected he was reclassified (maximum, close, medium) over a three-year
21 period. (Doc. 4166 at 40). In July 2020, V.S.’s custody scores reflected medium custody
22 and medium risk. But in September 2020 V.S. told officials he “did not feel safe” in the
23 housing unit where he was living. (Doc. 4166 at 40). V.S. was then “approved for
24 maximum custody because of ‘exhausting all other housing options.’” (Doc. 4166 at 41).
25 As correctly observed by Horn, “[n]ot being able to figure out how to keep a medium
26 security inmate safe is not a justification for placing that person into isolation.” (Doc. 4166
27 at 41).

28 Horn also referenced an inmate, J.J., who in 2012 committed a serious violation by

1 kidnapping an individual working at the prison for a private contractor and holding her
2 hostage for 30-40 minutes. (Doc. 4166 at 36). As a result, J.J. was placed in maximum
3 custody. His file included a note that he was “not to be removed from max custody without
4 approval from the [Offender Standards Bureau Administrator].” (Doc. 4166 at 36). Over
5 the following years, J.J.’s placement was reviewed and, while his scores reflected “medium
6 custody and medium internal risk,” he remained in maximum custody. Based on how
7 Defendants’ policies operate, despite that the 2012 kidnapping offense was included when
8 calculating J.J.’s custody scores, he still scored the lower medium custody. (Doc. 4267 at
9 39). In April 2018, a classification officer stated J.J. had remained “disciplinary free since
10 2012” and he had “shown the ability to be managed at a lower custody unit.” (Ex. 3616 at
11 64). J.J.’s custody scores at that time reflected medium custody and medium internal risk.
12 The officer recommended J.J. be transferred to close custody. That recommendation was
13 rejected, J.J. remained in maximum custody, and, at the time of trial, J.J. was still in
14 maximum custody.⁵¹

15 While acknowledging the seriousness of J.J.’s 2012 offense, Horn stated there was
16 “no rational basis for keeping [J.J.] in maximum custody” given the nine subsequent years
17 of good behavior. (Doc. 4166 at 38). Defendants offered no evidence of a penological
18 justification for keeping J.J. in maximum custody despite his custody scores and the
19 recommendation by officials to reclassify him. Instead, Defendants merely stated, without
20 record citation, that “J.J. poses a substantial risk of harm to staff and thus his classification
21 is justified” despite their own internal seemingly valid recommendation that J.J. could be
22 reclassified. (Doc. 4315 at 144).

23 Horn cited a similar situation involving inmate T.A. While in a lower custody level,
24 T.A. received six disciplinary tickets and, in June 2019, he was reclassified to maximum
25 custody. (Doc. 4166 at 38-39). In June 2020, a classification officer stated T.A. had
26 “shown great improve[ment,] he can be managed at close custody.” (Ex. 3671 at 14). T.A.

27 ⁵¹ The records indicate J.J.’s offense was sometimes noted as having occurred in 2015
28 instead of 2012. Horn noted the failure to keep accurate records could lead to
overclassification because offenses may appear more recent than the reality. (Doc. 4267
at 33-34).

1 was approved to be reclassified as close custody on July 15, 2020. (Ex. 3671 at 14).
2 Despite the reclassification, T.A. remained in maximum custody. T.A. subsequently
3 committed another violation in April 2021 that again triggered maximum custody status.
4 That violation was based on an incident where T.A. refused to return handcuffs after he
5 was in his cell. (Ex. 3671 at 30). If T.A. had been treated according to his classification
6 in “close custody,” he would not have been restrained and the disciplinary incident would
7 not have occurred.

8 Regardless of the April 2021 disciplinary charge, T.A. was meant to leave maximum
9 custody in July 2020 but, inexplicably, he remained in maximum custody for the following
10 nine months. Horn accurately described this situation as “evidence of the irrationality and
11 unfairness of maximum custody in ADCRR.” (Doc. 4166 at 39). During cross-
12 examination, defense counsel asked Horn if he was aware that, as of the time of this trial,
13 T.A. had been classified and was being housed in a close custody unit. (Doc. 4268 at 59).
14 Why defense counsel thought it helpful that T.A.’s placement as of November 2021 had
15 changed was not explained. Horn’s point was that T.A. had remained in maximum custody
16 for months after being reclassified. The reclassification of T.A. just in time for trial shows
17 consciousness of guilt.

18 A final aspect of how DO 801 is being implemented involves prisoners who are
19 classified as maximum custody, and subsequently classified to a lower level, but remain
20 housed in maximum custody. The Deputy Warden at Eyman SMU, Lori Stickley, testified
21 there are many prisoners currently housed in maximum custody at that location who have
22 already been reclassified to a lower level and were merely waiting for “beds [to] become
23 available.” (Doc. 4264 at 192). At trial, Stickley testified there were approximately 150
24 prisoners in maximum custody at Eyman SMU who had not been classified as maximum
25 custody. (Doc. 4264 at 193). Stickley did not know how long those prisoners had been
26 waiting to be moved. The Deputy Warden at Eyman Browning, Travis Scott, testified there
27 were 44 prisoners at that location “that were currently waiting to go to a close custody unit”
28 but space was unavailable. (Doc. 4264 at 148-149). Scott did not know how long those

1 prisoners had been waiting. (Doc. 4264 at 172). Added together, Eyman SMU and Eyman
2 Browning established approximately 200 prisoners being held in maximum custody despite
3 officials conceding they should not be there.

4 Overall, DO 801 and its related policies and practices provide a mechanism for the
5 classification of prisoners as maximum custody and housed in these restrictive settings
6 without penological justification and even when DO 801 is correctly implemented and
7 prisoners are reclassified to lower custody levels, they may well not leave maximum
8 custody. In short, Defendants keep hundreds of prisoners in maximum custody housing
9 despite all prison officials admitting there is no penological justification for doing so.

10 The Court does not question the wisdom or lawfulness of Defendants' policies
11 regarding classification of prisoners and where prisoners are housed. Defendants may well
12 have the authority to automatically place prisoners in maximum custody for the first two
13 years of a life sentence, regardless of that prisoner's custody score. The basic wisdom of
14 such a policy is not before the Court. However, the specific operation of the policies
15 regarding who is placed in restricted housing are crucial to assessing the conditions
16 imposed on the subclass. In particular, the policies and implementation of them regarding
17 the subclass population establish the subclass does not consist solely of uniquely dangerous
18 individuals. At trial, defense counsel suggested prisoners in maximum custody or other
19 restrictive housing units are there because they were too dangerous to house anywhere else.
20 (*See* Doc. 4263 at 41; Doc. 4268 at 54). That is simply not true for all subclass members.
21 Defendants' own policies show many subclass members do not present such dangers. In
22 fact, many subclass members are not even formally classified as "maximum custody"
23 prisoners. Yet these subclass members remain in restrictive housing.

24 **2. Subclass Custody Conditions**

25 The two maximum custody housing locations with the largest populations are
26 Eyman-SMU I ("SMU") and Eyman-Browning ("Browning"). Altogether, SMU and
27 Browning house approximately 1,300 members of the 2,667 subclass members.⁵² Plaintiffs

28 ⁵² At trial, Deputy Wardens testified Browning usually houses approximately 700
prisoners while SMU houses over 500. (Doc. 4259 at 92; 4264 at 179).

1 provided significant detail regarding these units. The descriptions of other facilities was
2 not as detailed. Thus, the most detailed factual findings regarding physical conditions and
3 general practices relate to SMU and Browning. There is sufficient evidence to make
4 limited factual findings regarding other locations.

5 **(a) SMU and Browning**

6 Plaintiffs' experts testified there may be "subtle differences" between SMU and
7 Browning but, in general, "[t]hey feel the same when you enter them." (Doc. 4306 at 43).
8 SMU and Browning are "very severe, dehumanizing units." (Doc. 4306 at 42). The units
9 were "designed to be maximally controlling" and are "maximally depriving" in practice.
10 (Doc. 4306 at 42).

11 The cells in these units are "less than 8 feet by 12 feet" and do not have windows.⁵³
12 (Doc. 4306 at 42; 4122 at 61). Inside the cells are "a bare concrete box with a metal stool,
13 shelf, toilet/sink and either a single or double slab for a bed." "The doors to the cells have
14 no windows but are made of perforated steel." (Doc. 4122 at 61). Thus, the only natural
15 light in the units comes from "gritty skylights in the ceiling outside the cells." (Doc. 4122
16 at 60). The cells "have 24-hour illumination" and prisoners often cover the light. (Doc.
17 4122 at 52). The constant illumination makes it "difficult to sleep." (Doc. 4263 at 44).
18 The lack of natural light, combined with the constant illumination, "adds to [the]
19 disorienting nature of the conditions." (Doc. 4122 at 52).

20 Evidence was not offered regarding the limitations on personal property for
21 prisoners in these units other than that, when they are brought to the Browning "intake"
22 unit, prisoners initially do not have any property. Officials "try" to get prisoners their
23 property "in the first week" of arriving. (Doc. 4264 at 139).

24 The cells in these units are "infested with insects, roaches and crickets, and infested
25 also with rodents." (Doc. 4306 at 44). During his visit, a prisoner showed Dr. Haney a
26 rodent the prisoner had captured. (Doc. 4306 at 44). There is also mold growing on the

27 ⁵³ The cells for subclass members were estimated at trial to be approximately 80 square
28 feet. (Doc. 4268 at 90). Defense counsel hinted the cells are between 88 and 89 square
feet. (Doc. 4268 at 90). It is undisputed the cells are somewhere between 80 and 90 square
feet.

1 walls throughout the SMU unit.⁵⁴ Dr. Haney encountered “a large puddle of musty-
2 smelling and moldy water outside one person’s cell that came from a leak inside.” (Doc.
3 4122 at 60). Overall, the “cells give a sense of being entombed in a small, concrete box”
4 and are “barren, stark, and . . . dehumanizing.” (Doc. 4122 at 61; Doc. 4306 at 42).

5 The cells have slots through which food trays are passed. Those food trays are
6 “worn and dirty.” (Doc. 4122 at 59). Prisoners are supposed to be fed twice per day. (Doc.
7 4273 at 55-56). This is not consistent with general industry practice, which suggests
8 prisoners should receive three meals a day, at “regular mealtimes,” including two hot
9 meals. (Doc. 4166 at 77). Around 4 or 5 in the morning, prisoners receive a “mega sack”
10 containing breakfast and lunch. (Doc. 4273 at 64-65). A mega sack is “mostly bread and
11 served cold.” (Doc. 4166 at 77). A mega sack may also contain milk, but if it is not
12 consumed immediately, the milk will likely curdle. (Doc. 4166 at 77). Prisoners are
13 supposed to receive a “hot dinner.” (Doc. 4273 at 64); (Doc. 4278 at 29). The meals are
14 “repetitive, unappetizing, and insufficient.” (Doc. 4166 at 77). Prisoners “remain hungry
15 most of the time.” (Doc. 4122 at 52); (Doc. 4263 at 65) (prisoner testified he did not receive
16 enough food while at SMU I). Prisoners often must supplement their meals by purchasing
17 food, if they have funds to do so.⁵⁵ (Doc. 4166 at 77). The Warden of one complex, who
18 had years of experience in maximum custody units, testified the “top complaint” made by
19 prisoners was about “food, commissary.” (Doc. 4278 at 36). In particular, prisoners
20 complain “they’re not getting the portions of food they’re supposed to be getting.” (Doc.
21 4278 at 36).

22 Prisoners in these units must be strip searched each time they leave their cells. (Doc.
23 4259 at 100). When out of their cells, most of the prisoners in Browning (and presumably
24 SMU as well) must be handcuffed behind their backs and escorted by one officer. (Doc.
25 4259 at 99). However, if the prisoner is housed in a cell with another prisoner, two officers
26 are required to remove the prisoner from the cell and to return him to the cell. (Doc. 4259

27 ⁵⁴ The showers at both units also have mold growing in them and are in a state of
28 “disrepair.” (Doc. 4306 at 46).

⁵⁵ One prisoner testified he was unable to buy additional food because he could not afford
to do so. (Doc. 4263 at 65-66).

1 at 99). Some prisoners must be escorted by three officers and wear leg irons and handcuffs
2 in back. (Doc. 4259 at 100).

3 Prisoners in these units have effectively no regular social contact. The only “regular
4 contact” prisoners have are “the brief, routinized ‘interactions’ that occur twice a day, when
5 they receive their meals,” assuming prisoners are fed that day. (Doc. 4165 at 53). Prisoners
6 may have some contact with mental health staff, but that contact is rare. (Doc. 4165 at 53).
7 For prisoners who are visited by mental health staff, those visits may occur through “cell-
8 front encounters.” Such encounters are not confidential and prisoners are often
9 uncomfortable talking about their issues. (Doc. 4306 at 74). If a prisoner requests a
10 “confidential, private setting,” he will be taken to a small room and placed in a “small
11 telephone booth-like cage, still in restraints.” (Doc. 4122 at 47). Maximum custody
12 prisoners are reluctant to request these individual sessions because they must be strip
13 searched before leaving their cells, placed in restraints, and placed in the cage, still in
14 restraints. The treatment cage is “obviously inhospitable” and it makes it “difficult” for a
15 prisoner to “relax and develop rapport or express their . . . deep psychological concerns or
16 fears or issues.” (Doc. 4306 at 73).

17 In these units, a housing area, also known as a “pod” or “run,” refers to an area
18 comprised of “10 cells, five stacked on top of five.”⁵⁶ (Doc. 4259 at 90-91). The term
19 “cluster” refers to a group of pods. (Doc. 4259 at 91). Browning has six pods in each
20 cluster and there are twelve clusters. (Doc. 4259 at 91). Each cluster has a “control room”
21 that is intended to be staffed by an officer. Officers in control rooms are responsible for
22 opening the doors in the cluster and documenting when certain activities occur. (Doc. 4261
23 at 120).

24 At the end of each pod is a recreation enclosure known as “the chute.” (Doc. 4259
25 at 96). Each chute is “approximately 11 feet by 24 feet, with solid concrete enclosure walls
26 approximately 15 feet high with a covering of metal mesh over the top.”⁵⁷ (Doc. 4122 at
27

28 ⁵⁶ Some pods may have eight cells “four on the lower tier, four on the top tier.” (Doc. 4273
at 95).

⁵⁷ Chutes are “probably the size of at least two cells, maybe larger.” (Doc. 4267 at 46).

1 62; Doc. 4259 at 96). A chute has “no exercise equipment in it, it’s just sort of a barren
2 area that [the prisoners] are allowed to go out in.”⁵⁸ (Doc. 4306 at 42). There is very little
3 breeze and, during warmer months, entering the chute “feels like stepping into an extremely
4 hot sauna” and the chutes have insects in them. (Doc. 4122 at 62; Doc. 4306 at 45).

5 In addition to the chutes, there are recreation areas known as the “10 by 10s,” a “20
6 by 40” enclosure, and a “50 by 90” enclosure. (Doc. 4264 at 152). The 10 by 10s are
7 approximately ten “individual recreation cages.” (Doc. 4122 at 63). Those cages are
8 roughly the same size as a cell. (Doc. 4306 at 76). The cages have shaded portions and
9 there is a misting system. (Doc. 4264 at 153). When viewed shortly before trial, the cages
10 appeared to have been unused for a lengthy period, with some doors open and “rusted in
11 place.” (Doc. 4122 at 63). During four days of touring units in 2021, Dr. Haney did not
12 observe the outdoor exercise cages being used. (Doc. 4264 at 57). Prisoners prefer the 10
13 by 10 enclosures to the chute because the 10 by 10s allow them to socialize.

14 The 20 by 40 enclosure has a basketball hoop and the 50 by 90 enclosure has a
15 basketball hoop, a table, and an area for exercises such as pull-ups and push-ups. (Doc.
16 4264 at 152). There are water jugs available at some of the enclosures. (Doc. 4264 at 153).

17 Per ADCRR policy, officers are required to conduct periodic health and welfare
18 checks, also known as “security checks” or “living, breath flesh checks” when prisoners
19 are in their cells.⁵⁹ Those checks require an officer to walk through a pod to determine if
20 there are problems with the facilities (e.g., doors working) and to ensure the safety of the
21 prisoners. (Doc. 4273 at 33). As explained by one Deputy Warden, these checks require
22 an officer “look inside of a cell” and determine if the prisoner is “alive” and “breathing.”
23 (Doc. 4265 at 29). Current policy requires these checks be performed every 30 to 59
24 minutes, at irregular intervals. (Doc. 4273 at 34). Previously, these checks were required
25 to be performed every 30 minutes, but because of low staffing it has been reduced. (Doc.
26 4273 at 34-35). The industry standard is that prisoners in housing of this sort be observed
27 twice per hour. (Doc. 4166 at 81).

28 ⁵⁸ Dr. Haney did observe “a small, blue handball” in one enclosure. (Doc. 4122 at 62).

⁵⁹ The phrase “living, breathing flesh” is used in the formal policy. (Ex. 1742 at 1).

1 In addition to ADCRR adopting a policy permitting checks far less often than
2 industry standards, records establish that when the checks do occur, they are often
3 performed in remarkably little time. For example, a security check in a pod consisting of
4 8 or 10 cells may take only one minute. (Doc. 4273 at 38). According to one Deputy
5 Warden, an officer spending only one minute on a security check was not cause for
6 concern. (Doc. 4273 at 95). However, given the need to stop at eight or ten cells to
7 determine the status of each prisoner and the need to climb the stairs to the upper tier, a
8 one-minute status check would be exceptionally cursory.

9 The staffing levels at SMU and Browning are far below what prison officials
10 acknowledge as necessary to operate the units safely. The Deputy Warden for Browning
11 stated Browning has about 60% of the staff it needs. (Doc. 4261 at 115). The Deputy
12 Warden for SMU agreed that some necessary positions and tasks are performed only
13 because existing staff are willing to work overtime. (Doc. 4273 at 33). Plaintiffs cited the
14 “Daily Post Sheet” for Browning on July 30, 2021, to illustrate staffing levels. Based on
15 the Deputy Warden for Browning’s reaction to this record, the day did not reflect an
16 unusual level of staffing.

17 The “Daily Post Sheet” identifies each “required post” where a single officer should
18 have been assigned. (Ex. 2131). The Deputy Warden for Browning described each of
19 these posts as “critical.” (Doc. 4261 at 117). On July 30, 2021, there was a total of “33
20 posts collapsed.” “Collapsed means that the post wasn’t staffed by a single person . . . or
21 there wasn’t one person assigned to that post.” (Doc. 4261 at 123). The sheet shows no
22 officer was assigned to a variety of positions. Four officers should have been assigned as
23 “Recreation Escort.” There were none. Seven officers should have been assigned as
24 “Mental Health/Medical Programs.” There was one. Four officers should have been
25 assigned to “Recreation Officer.” There was one. Six officers should have been assigned
26 to “Rover.” There was one. Finally, there was supposed to be an officer assigned to each
27 of the twelve control rooms. (Ex. 2131). There were seven officers assigned to control
28 rooms, leaving five control rooms unstaffed. But according to Defendants the control

1 rooms were not actually unstaffed because officers are assigned to multiple control rooms
2 at once. (Doc. 4264 at 162). A single officer may be assigned to two control rooms during
3 the day, and, at night, a single officer may be assigned to six control rooms at the same
4 time. (Doc. 4264 at 176). With a control room in each cluster, and each cluster including
5 six pods of 10 cells each, an officer in a control room is intended to be responsible for the
6 housing area of 60 prisoners. When a single officer is assigned to six control rooms, that
7 officer is responsible for the housing area of 360 prisoners. Inadequate staffing of control
8 rooms happens “every day.” (Doc. 4264 at 162).

9 **(b) Lewis**

10 Dr. Haney visited the Lewis complex which houses approximately five hundred
11 subclass members. While there, he toured the Rast unit (maximum custody), the Barchey
12 and Morey units (not maximum custody), the Stiner detention unit (maximum custody),
13 and the Sunrise unit (juveniles). (Doc. 4306 at 41). The cells in the Rast unit are similar
14 to those found at SMU and Browning. That is, the cells are “stark and largely barren,”
15 with no window. (Doc. 4306 at 47). Similar to SMU and Browning, being housed in the
16 Rast unit subjects prisoners “to profound levels of deprivation.” (Doc. 4122 at 65).

17 The Stiner detention unit is “a very stark, oppressive environment.” (Doc. 4306 at
18 47). Unlike many other prisons, the Stiner detention unit does not have a day room or a
19 common area where prisoners are allowed out of their cells to socialize. (Doc. 4306 at 47-
20 48). However, at least some of the cells in this unit have a window. (Doc. 4122 at 67).
21 The cells have a single or double bunk. (Doc. 4306 at 49).

22 The Sunrise unit houses juveniles. That unit consists of “windowless cells built of
23 concrete blocks, with solid doors with one small window in the door.” (Doc. 4122 at 67).
24 One cell photographed by Dr. Haney shows a bunkbed, a sink, a toilet, and a small seat
25 which is bolted to the ground. The hallway has no natural light. Instead, it is lit only by
26 fluorescent lights. (Doc. 4122 at 67).

27 **(c) Other Locations**

28 Plaintiffs’ experts toured the locations housing approximately 1800 subclass

1 members. Those experts did not tour the other locations housing the remaining subclass
2 members,⁶⁰ most of which consisted of the mental health watch or detention units at smaller
3 facilities. (Doc. 4315 at 104). Defendants argue the failure to tour, and present evidence
4 describing, every location means Plaintiffs have “provided no evidence regarding
5 conditions of confinement at” the facilities not toured. (Doc. 4315 at 104). Defendants
6 even seem to fault Plaintiffs’ experts for not touring and interviewing subclass members at
7 locations such as the Florence Globe Unit and the Winslow Apache Unit. (Doc. 4315 at
8 104). But as of September 30, 2021, those units were empty. Complaining that the experts
9 did not tour empty units is not the only problem with Defendants’ argument regarding the
10 conditions of confinement at every location.

11 Class actions often involve, to some degree, an amount of “representative
12 evidence.” *Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 455 (2016). Here, there is no
13 evidence regarding the precise physical layout of cells at some of the facilities nor is there
14 evidence regarding the exact recreation enclosures at those facilities. However, the precise
15 physical layout or exact recreation enclosures are not the core issues in this case. Rather,
16 it is the amount of out-of-cell time offered to subclass members and whether the amount
17 of isolation experienced by subclass members creates a substantial risk of harm. Resolving
18 those issues will require examining the policies and practices applied to all subclass
19 members. The evidence at trial established that, as a matter of systemwide practice,
20 subclass members are treated the same regardless of exact location. That is, the policies
21 and practices applied to subclass members are the same at the toured facilities as well as
22 the facilities not toured. To satisfy their burden of proof, Plaintiffs were not required to
23 present evidence and proof of every cell and every prisoner. Instead, Plaintiffs established
24 through testimony and corroborating evidence the same practices apply throughout the
25 system. In fact, Defendants did not even dispute this point during trial nor offer
26 countervailing evidence. For example, Defendants did not present evidence the policies
27 and practices differed across facilities. Accordingly, less evidence regarding some

28 ⁶⁰ The eight facilities that house subclass members but were not toured immediately prior to trial are Douglas, Florence, Perryville, Phoenix, Safford, Tucson, Winslow, and Yuma.

1 locations does not overcome the preponderance of evidence establishing subclass members
2 are treated the same.

3 **3. Maximum Custody Tracking**

4 The activities of prisoners in all maximum custody units are tracked using a form
5 titled “Maximum Custody Daily Out-of-Cell Time Tracking.” (Ex. 1290). That form is
6 meant to reflect a prisoner’s activities on a weekly basis. It requires officers fill in when a
7 prisoner is offered recreation, the size of the enclosure where the recreation would take
8 place, if the prisoner refused the offer, and, if the prisoner accepted the offer, the time spent
9 at recreation. The form also requires officers document if the prisoner was offered and
10 attended other out-of-cell programs or classes. Finally, if the prisoner was categorized as
11 Seriously Mentally Ill, the form requires officers track any additional hours of out-of-cell
12 time. (Ex. 1290). During the life of the Stipulation, the forms for twenty randomly selected
13 prisoners in maximum custody units were compiled monthly into what the parties refer to
14 as “maximum custody notebooks.”⁶¹ (Doc. 4264 at 126).

15 The forms purport to indicate the total amount of out-of-cell time offered to each
16 inmate. But they do not. The form requires officers track all out-of-cell time that was
17 offered, accepted, refused, or canceled. The out-of-cell time that was canceled, however,
18 was still counted when determining the total amount of time offered to inmates. For
19 example, the form found at page 112 in Exhibit 1681 identifies the prisoner as having been
20 “offered” four, three-hour recreation periods during that week. Two of those offers
21 allegedly were made but refused by the prisoner. The other two offers, however, were
22 accompanied by a “C” notation, indicating those recreation periods were canceled. A
23 separate form indicates those recreation periods were canceled “due to staff shortage.” (Ex.
24 1681 at 41). Despite those cancelations, the bottom of the form states the prisoner was
25 offered a total of 12 hours of out-of-cell time. This consciously-adopted practice of
26 counting out-of-cell time that was not offered was the result of Defendants’ inexplicable

27 ⁶¹ Those notebooks contained a variety of other documents as well, such as reports
28 explaining which activities were canceled. (Ex. 1681 at 2). Each notebook contains
hundreds of pages. For example, the June 2021 notebook for Eyman-Browning contains
302 pages. (Ex. 1681).

1 interpretation of the Stipulation.

2 The Stipulation required Defendants provide specific amounts of out-of-cell time.

3 The Stipulation also provided:

4 If out of cell time . . . is limited or cancelled for legitimate
5 operational or safety and security reasons such as an
6 unexpected staffing shortage, inclement weather or facility
7 emergency lockdown, Defendants shall make every reasonable
effort to ensure that amount of out of cell time shall be made
up for those prisoners who missed out of cell time.

8 (Doc. 1185 at 10). Defendants unilaterally, without Court authorization, interpreted this
9 provision favorably as allowing them to include out-of-cell time canceled because of
10 chronic staffing shortages when determining the total amount of out-of-cell time offered to
11 inmates. In other words, a prisoner such as that found at page 112 of Exhibit 1681 was
12 documented as being offered 12 hours of out-of-cell time, even though it is undisputed the
13 prisoner was offered, at most, 6 hours. At trial a Warden explained ADCRR interpreted
14 the Stipulation such that if a particular “cancellation was because of poor staffing that day
15 and they did not have the staff to complete that class,” it was to be included in the total
16 recorded out-of-cell time offered. (Doc. 4277 at 132). If, however, the “staff just didn’t
17 want to do [the class or activity], that’s not acceptable,” and the time could not be included
18 as out-of-cell time.⁶² (Doc. 4277 at 132).

19 In February 2021, the Court by Order made clear Defendants could not rely on
20 chronic “staff shortages” to justify cancellations of out-of-cell time. (Doc. 3861 at 9-10).
21 However, as of June 2021 just prior to the repudiation of the Stipulation, Defendants were
22 still invoking longstanding staff shortages as the reason for cancellation of some recreation
23 and still counting non-existent recreation offers when determining the total amount of out-
24 of-cell time. The fact that Defendants unilaterally decided indisputably unavailable
25 recreation time should be counted as “offered,” is a blatant illustration of how, throughout

26 _____
27 ⁶² Deputy Warden Stickley also testified about the practice of counting out-of-cell time that
28 was canceled. (Doc. 4273 at 48). She explained such time “counted” because it was not
ADCRR that decided to cancel the class. Instead, “Centurion did not have the staff
available to teach the class.” (Doc. 4273 at 94). But Centurion is ADCRR’s chosen agent
to uphold ADCRR’s commitments.

1 the ten years this case has been pending Defendants have not in good faith undertaken their
2 obligations under the Stipulation, or compliance with Court Orders.

3 Given the manner in which Defendants calculated out-of-cell time, the numbers
4 reflected on the maximum custody records for total out-of-cell time are inaccurate. To
5 correct for Defendants' obvious miscalculation regarding the amount of out-of-cell time
6 offered, Plaintiffs presented a summary document that compiled the information contained
7 in maximum custody notebooks from four locations from 2019 through 2021.⁶³ (Ex. 1980).
8 That document calculated the amount of recreation allegedly offered to prisoners, *i.e.*,
9 canceled recreation was excluded. This summary document establishes a few critical
10 points.

11 First, it establishes the total amount of weekly recreation allegedly offered to
12 prisoners at the summarized locations from 2019 through 2021 varied from zero to over
13 twelve hours.⁶⁴ For the most part, however, the total recreation allegedly offered to
14 prisoners was between five and ten hours.

15 Second, the summary establishes recreation was routinely offered only in the
16 "chute" or standard enclosure. For example, in Browning and SMU for the monitored
17 week in January 2021, the only recreation offered was in the chute. (Ex. 1980 at 4-5).
18 Thus, even before any Covid-based limitations, the chute was offered most of the time.⁶⁵

19 Third, the rate at which prisoners were recorded as refusing offers for recreation
20 was high, often so high as to render it impossible the recreation offers were legitimate. The
21 table below shows the total recreation refusal rates at four units across ten points in time
22

23
24 ⁶³ One of the locations included in the summary, Florence-Kasson, was closed in September
25 2021. (Doc. 4277 at 113). While the conditions at Florence-Kasson are no longer at issue,
the information regarding conditions in that unit are included to provide additional
evidence that practices are similar across multiple facilities.

26 ⁶⁴ Eyman-Browning shows multiple inmates were offered no recreation in the monitored
27 week for April 2020. (Ex. 1980 at 16). But the records for Eyman-Browning during the
monitored week in October 2019 show one prisoner was offered over twelve hours of
recreation. (Ex. 1980 at 24).

28 ⁶⁵ Browning and SMU in January 2019 indicate the chute was the offered location well
over 75% of the time. (Ex. 1980 at 36-37).

1 from 2019 through 2021.⁶⁶ The table shows the refusal rates were routinely above 80%
2 and often above 90%.

3 **Recreation Refusal Rate Table**

4 Month and Year	Lewis Rast	Florence Kasson	Eyman SMU	Eyman Browning
5 Jan-19	46	80	73	83
6 Apr-19	38	71	80	84
7 Jul-19	67	58	83	80
8 Oct-19	78	63	86	93
9 Jan-20	68	90	84	62
10 Apr-20	80	87	95	68
11 Jul-20	64	92	92	61
12 Oct-20	70	73	90	56
13 Jan-21	80	77	93	46
14 Apr-21	n/a	63	90	29

15 As stated by Horn, recreation refusal rates over 80% are “striking.” (Doc. 4166 ¶
16 149). Based on Horn’s expertise and pure common sense,

17 inmates like the opportunity to get out in the fresh air. They like the opportunity and there are some circumstances which they have the opportunity to at least socialize with other inmates if they use what we refer to as the 10-by-10 enclosures. And people generally need fresh air and sunshine and a change of scenery and the opportunity to get out of their cell.

18 (Doc. 4267 at 44-45). Thus, refusal rates as high as reflected in the records indicate officers
19 either did not actually make the offers or officers used “any excuse to record a refusal to
20 take advantage of outdoor exercise.” (Doc. 4166 ¶ 146). The tactic of interpreting certain
21 behavior as a refusal of a recreation offer was explained by a sign posted in a maximum
22 custody unit. It reads:

23 Beginning 06-01-2020, All inmates and their Cells shall be in
24 704 Compliance before inmates will be allowed to go to Recreation. Also, the Inmates will be awake and ready to exit

25 ⁶⁶ Allegedly due to Covid, at Browning “all programming, class group education, outside
26 recreation, SMI classes, and education were cancelled . . . from March, 2020, through June,
27 2021.” (Doc. 4261 at 115). During that time, the only recreation offered was in the chute
28 and even that recreation was canceled at times. (Doc. 4261 at 116). As of June 2021,
ADCRR started its “phase reopening” to restart some officer-led “programming and mental health programming” after Covid. (Doc. 4264 at 161). Despite reopening, the “SMI classes were canceled for July, August,” and part of September 2021 because Centurion did not have sufficient staff available. (Doc. 4264 at 161).

1 the cell when the officers arrive. Failure to be in compliance,
2 or failure to be ready to submit to the strip search or any
3 unreasonable delay once the officer arrives will be considered
a refusal of Recreation and will be documented on the DO812
forms as such.

4 (Doc. 4166 ¶ 147). The term “704 Compliance” refers to Department Order 704 which is
5 “essentially the rules of inmate behavior,” such as personal grooming and cell cleanliness.
6 (Doc. 4267 at 43-44). This policy is enforced such that a prisoner is documented as having
7 “refused” recreation if, for example, the prisoner is not fully dressed or otherwise not
8 “ready on the spot” when offered recreation. (Doc. 4267 at 43). Similarly, if a prisoner is
9 asleep, that is documented as having refused recreation. (Doc. 4267 at 41). In short,
10 “[o]fficers record things as refusals when inmates do not intend to refuse.” (Doc. 4267 at
11 44).

12 While many offers for recreation may not actually be made or a prisoner is
13 interpreted, inaccurately, as rejecting the offer, many offers are also accompanied by
14 unreasonable consequences. Prisoners who accept an offer for recreation may be left in
15 the recreation area for hours. (Doc. 4166 ¶ 148). That may happen even during hot
16 temperatures in the recreation areas where prisoners lack access to water. (Doc. 4166 ¶¶
17 148, 160). In addition, if a prisoner needs to use the restroom during the recreation time,
18 officers may not take him to the restroom. Alternatively, the prisoner may be taken back
19 to his cell, forfeiting the rest of the recreation time. (Doc. 4166 ¶¶ 148, 160).

20 Horn’s testimony that the records do not indicate legitimate offers for recreation is
21 credible and comports with common sense. Understandably at times, prisoners may have
22 idiosyncratic reasons to decline recreation offers. But refusal rates of 80 to 95%—
23 calculated based on Defendants’ own documents—make it more likely than not the
24 recreation offers were never given or offered on unacceptable terms. For example, it is not
25 plausible that in April 2020, the monitored prisoners in SMU received 42 legitimate offers
26 for recreation but only two prisoners accepted, and those prisoners accepted only one
27 recreation period each. Put in terms of a refusal rate, it is not plausible these prisoners
28 received legitimate offers for recreation but refused 95% of those offers. Equally

1 problematic is Defendants' failure to question refusal rates of 95%, strongly suggesting
2 they are aware legitimate offers are not conveyed. In short, recreation offers recorded on
3 the Maximum Custody Daily Out-of-Cell Time Tracking forms are not made, are not
4 legitimate, or are accompanied by unreasonable consequences (*i.e.*, being left outside in
5 the heat for 6 hours without water and/or restroom access).

6 **4. Detention Records**

7 Defendants do not track how long inmates remain in detention units. Some inmates
8 spend less than a month in a detention unit while others may spend six months or more in
9 a detention unit. The detention records in Exhibit 1694 establish many inmates remained
10 in detention from February 2021 through August 2021. (Doc. 4308 at 130 n.60). Detention
11 is not necessarily a short-term placement.

12 ADCRR uses a form titled "Individual Inmate Detention Record" to "document out-
13 of-cell time and activities for people in detention." (Doc. 4273 at 56). Officers are
14 expected to document when inmates in detention receive meals, are allowed to shower, or
15 are offered recreation. (Doc. 4273 at 57). The form is the only way ADCRR tracks
16 recreation offers to inmates in detention. (Doc. 4273 at 58). During trial, the Deputy
17 Warden at SMU was asked about the contents of particular detention records. She
18 conceded that "according to the sheet," one prisoner did not receive dinner on four nights
19 from February 15, 2021, through February 22, 2021. (Doc. 4273 at 66; Exhibit 1694 at
20 539). During that same week, the record shows the prisoner was not offered any showers
21 or any recreation time. (Doc. 4273 at 66-67). The records for two other prisoners, in the
22 same cluster of cells for the same week, also showed no dinner for four nights, no showers,
23 and no recreation offers. (Ex. 1694 at 541, 545). The record for yet another prisoner in
24 the same cluster for the same week indicates no dinner on four nights but he was offered
25 one shower and one recreation period. (Ex. 1694 at 547). Records for even more prisoners
26 indicate a similar pattern of missed meals and, at most, one offer for shower and one offer
27 for recreation. (Ex. 1694 at 551-570).

28 Another record for a prisoner in that cluster of cells contained a notation that the

1 prisoner “moved out,” presumably meaning he left the detention unit in the middle of that
2 week. However, the record also indicates this prisoner received meals in the detention unit,
3 and also exchanged his laundry and linens, for two days after he left the unit. (Ex. 1694 at
4 583). Another form does not have a prisoner name or any other identifying information
5 filled in but that form indicates two meals were delivered on all seven days, dinner was
6 delivered on two days, and the inmate had laundry and linen exchanges multiple times.
7 When asked if this particular record “could have just been filled out for no one,” Stickley
8 responded “I don’t know.” (Doc. 4273 at 79). Overall, the evidence establishes the
9 detention forms often are pre-filled for the entire week and do not indicate what truly
10 happened. (Ex. 1694 at 593).

11 In an attempt to summarize the conditions recorded by the forms at various
12 locations, Horn analyzed 125 detention records at SMU detention unit for a week in
13 February 2021. (Doc. 4166 ¶¶ 190-191). Based on his expert review, “fewer than half
14 reflect 2 offers of recreation, about half reflect a single offer of recreation, and about a tenth
15 reflect no offers of recreation.” (Doc. 4166 ¶ 191). Those records do not “reflect[] any
16 person actually went to recreation” at this location during this week. (Doc. 4166 ¶ 191).
17 The records regarding showers were similar, with the majority of prisoners offered showers
18 one or two times but a few prisoners were not offered any showers. While there was a high
19 rate of purported refusal of showers, the records indicate that if prisoners accepted, they
20 would be left in the shower for approximately an hour. (Doc. 4166 ¶ 192).

21 After the Stipulation was repudiated and during preparation for trial, the September
22 2021 records for SMU showed some improvement but still “not a single person went to
23 recreation.” (Doc. 4166 ¶ 196). In addition, the records again had entries for a prisoner
24 who left the unit midweek, indicating the records are pre-filled. (Doc. 4166 ¶ 197).

25 The records for the Yuma Cheyenne detention unit for a week in February 2021
26 show prisoners were given three offers to shower and either two or three offers for
27 recreation. However, not a single prisoner went to recreation that week. (Doc. 4166 ¶ 199).
28 The records for this location in July 2021 indicate about half of the prisoners were offered

1 two recreation periods, but not a single prisoner went to recreation. (Ex. 1700-2 at 2234-
2 2283).

3 The records for the Lewis Morey detention unit in July 2021 show approximately
4 half of the prisoners received either no or one offer for recreation, and about half received
5 two offers, with a few prisoners receiving three offers. (Doc. 4166 ¶ 204). Three prisoners
6 went to recreation during this week and the recreation time is listed as less than one hour.
7 (Doc. 4166 ¶¶ 207-208). The prisoners were offered two or three showers. (Doc. 4166
8 ¶ 204). And the records show some prisoners did not receive three meals every day,
9 including one prisoner who was documented as receiving no meals on one day, one meal
10 on one day, and two meals on two days. (Doc. 4166 ¶ 205). The September 2021 records
11 for this location show most prisoners received two shower offers and most prisoners were
12 offered recreation twice but almost all offers were recorded as refused. The two prisoners
13 who accepted recreation offers received 45 minutes of recreation. (Ex. 1697 at 1773,
14 1775).

15 The records for the Lewis Bachman detention unit for July 2021 are, as
16 characterized by Horn, “alarming.” (Doc. 4166 ¶ 215). The records document profoundly
17 cruel treatment of prisoners this week. The weekly record for one prisoner indicates he
18 was offered a shower once, which he accepted, as well as recreation once, which he refused.
19 But for the seven-day period, this prisoner allegedly received only nine meals. (Ex. 1697
20 at 1275). But that prisoner was one of the lucky ones. A different prisoner that week was
21 not offered a shower, not offered recreation, and received only seven meals. (Ex. 1697 at
22 1277). Other prisoners received no offers for out-of-cell time and only received one or two
23 meals for the entire week. (Ex. 1697 at 1315-1319). Thus, officials at this unit
24 affirmatively documented they confined many prisoners in their cells for 168 straight hours
25 and provided them with only a few meals for the entire week. That affirmative
26 acknowledgment is shocking enough. But the fact that no supervisory official took any
27 action in response to this level of inhumane disregard for even feeding the prisoners
28 indicates a profound disinterest in caring for the prisoners.

1 The records for the Lewis Bachman detention unit for August 2021, which was
2 during trial preparation, are mildly better than for July 2021. Again, many prisoners were
3 not offered any out-of-cell time. (Doc. 4166 ¶ 219). The records also indicate the prisoners
4 routinely did not receive three meals per day. Many records show days prisoners had no
5 meals. (Doc. 4166 ¶ 220). It is incomprehensible that prison officials were not concerned
6 when their own records admitted at trial established blatant violations of policy regarding
7 recreation and nutrition.⁶⁷

8 Based on the evidence presented at trial, the treatment of prisoners in detention units
9 is shocking. According to Defendants' own records, prisoners in detention units are
10 routinely offered no out-of-cell time and are routinely denied meals. In their post-trial
11 briefing, Defendants argue the detention records simply reflect "deficient documentation,"
12 and the prisoners must have at least been fed.⁶⁸ (Doc. 4315 at 130). Defendants even
13 steadfastly claim if officials had "determined that inmates actually were not fed or that
14 there was a pattern of deficient completion of paperwork by a particular officer, corrective
15 action would be taken." (Doc. 4315 at 129-130). Defendants offered no explanation,
16 however, how the records recounted above do not reflect either a pattern of not feeding
17 prisoners or a "pattern of deficient completion of paperwork." Defendants did not present
18 any evidence they took corrective action in response to their own unrefuted documentation,
19 which reflected weeks of denying prisoners in detention units any out-of-cell time and
20 adequate nutrition.

21 **5. Mental Health Watch**

22 When a prisoner is placed on mental health watch, all his or her activities are tracked
23 on a form known as an "Observation Record." When Plaintiffs' expert reviewed the
24

25 ⁶⁷ The records for other locations and other time periods establish it was commonplace for
26 prisoners to not receive three meals per day. (Exhibits 1696, 1697, 1699, 1700). Plaintiffs
accurately summarize this information. (Doc. 4308, pages 85-87).

27 ⁶⁸ Defendants blithely also argue "Plaintiffs' reliance on cherry picked detention records
28 for only seven out of seventeen detention units across the state proves nothing." (Doc.
4315 at 123). Records showing Defendants, across multiple locations, deprive prisoners
of recreation and food certainly prove more than "nothing." It establishes their
constitutional rights are being violated.

1 Observation Records for the mental health watch unit at SMU, he noted none of the forms
2 reflected the prisoners were receiving recreation. (Doc. 4166 at 51). The Deputy Warden
3 at Browning testified that individuals on mental health watch at that location are supposed
4 to be provided recreation opportunities but there are no facilities at Browning that would
5 allow for recreation. (Doc. 4261 at 114).

6 **6. Expert Opinion Regarding Subclass Conditions**

7 Plaintiffs offered the expert opinions of Horn and Dr. Haney that the conditions
8 imposed on the subclass members lack a penological purpose and present a substantial risk
9 of serious harm. Defendants did not offer their own experts. Nor did they offer any
10 remotely credible lay opinions contradicting Plaintiffs' expert opinions. Thus, the Court
11 did not have the opportunity to critically examine competing views from qualified experts
12 and then determine which view is more credible. Rather, the Court was left with either
13 crediting Plaintiffs' experts who have spent their entire careers studying these issues, or
14 rejecting those experts based solely on the unsubstantiated arguments presented by defense
15 counsel. Based on careful review of written testimony, as well as in-court observation of
16 direct and cross-examination, the opinions offered by Horn and Dr. Haney are credible.

17 **(a) Horn**

18 Horn credibly testified ADCRR "overuses isolation." (Doc. 4166 at 101). ADCRR
19 keeps more prisoners in isolation than almost any other state and often there is no rational
20 basis supporting placement of a particular prisoner in isolation. For example, ADCRR
21 places numerous prisoners in isolation who, according to ADCRR's own policies, merit a
22 lower level of custody placement. ADCRR has promulgated policies that purport to
23 provide a path for prisoners to earn their way out of isolation. However, those policies are
24 "unusually and unnecessarily complicated," leaving prisoners and officials confused
25 regarding their implementation. (Doc. 4166 at 102). Indeed, the evidence reflects that
26 ADCRR houses prisoners in isolation because it lacks lower custody cells and staff as
27 evidenced by the hundreds of prisoners awaiting transfer out of maximum custody.

28 ADCRR keeps prisoners in isolation for years, including prisoners who have "been

1 free of any discipline for years.” (Doc. 4166 at 103). ADCRR claims to review the
2 isolation placement for many prisoners on a monthly basis but those “reviews are brief to
3 the point of perfunctory.” (Doc. 4166 at 104). Prisoners are not involved in the review
4 process and do not receive information regarding what he should do in the future to merit
5 a lower classification. (Doc. 4166 at 104). The step-progression system contained in DO
6 812 “offers inmates the promise of advancement if they maintain a good disciplinary record
7 and participate in prescribed programs, and [officials] do not meet that promise. [Officials]
8 do not fulfill that promise” because prisoners have no way of knowing when, or if, they
9 will be able to advance. (Doc. 4268 at 68).

10 The units housing subclass members do not have sufficient staff to operate in a safe
11 manner. Staff are not available to conduct sufficient security checks “to properly determine
12 whether an inmate is in distress or not.” (Doc. 4166 at 104). The staffing shortage is
13 exacerbated by the physical layout of the many units which preclude staff from having
14 adequate “sight lines” or the “ability to hear inmates.” (Doc. 4166 at 104). On cross-
15 examination, defense counsel asked Horn whether New York and Pennsylvania had “the
16 staffing luxury” such that sufficient staff could respond to an emergency without leaving
17 critical posts vacant. (Doc. 4268 at 104). No doubt to defense counsel’s surprise, Horn
18 responded he “wouldn’t call it a luxury” for the prison to have adequate staff to handle
19 emergencies without leaving critical posts abandoned. (Doc. 4268 at 104). When pressed
20 on this point by defense counsel, Horn explained other systems ensure sufficient staffing
21 so any emergency response will not require staff involved in “direct supervision of
22 inmates” abandon their posts. (Doc. 4268 at 105).

23 The lack of staff is also the obvious explanation for why prisoners do not receive
24 the out-of-cell time promised by ADCRR policy. Based on the “actual practices,” prisoners
25 “do not get to leave their cells for the one hour per day five days a week recommended by
26 the profession” nor do they get the hours promised by ADCRR policy. (Doc. 4166 at 105).
27 Staff use “a variety of means to obscure the reality of what is happening.” (Doc. 4166 at
28 105). Despite what may be indicated on the forms, prisoners “are often recorded as

1 refusing recreation when they have not” and, in any event, out-of-cell time is “often
2 cancelled.” (Doc. 4166 at 105). On cross-examination, Horn explained prisoners should
3 be allowed outside recreation even if they “are not following the rules and don’t have their
4 cells in compliance.” (Doc. 4268 at 109). When asked whether staff should accommodate
5 any prisoner who is not immediately ready to accept an offer for recreation, Horn stated
6 “outside exercise, the ability to get fresh air when you’re confined in these conditions, is
7 so important that it is worth some level of effort” by the staff. (Doc. 4268 at 111).

8 In contrast, Defendants did not present any meaningful evidence or testimony
9 casting doubt on Horn’s conclusions. Defendants did not justify why they keep prisoners
10 in isolation who, by their own policy and their own admission, should be housed elsewhere.
11 Defendants did not explain why the policy regarding step-progression is implemented in a
12 random and chaotic way nor did Defendants explain why individuals may remain at
13 particular steps for years on end. In addition, Defendants concede they lack sufficient staff
14 to operate the facilities as contemplated by ADCRR’s own policies. Defendants’ own
15 deputy wardens acknowledged they lack sufficient staff to have officers posted at all
16 “critical” locations and rely on existing staff who agree to volunteer to work overtime shifts
17 even to meet the present staffing levels. (Doc. 4261 at 117). And Defendants did not
18 dispute that out-of-cell time is routinely canceled because of staffing shortages nor did
19 Defendants offer evidence that the out-of-cell offers are, in fact, legitimate ones that
20 prisoners in isolation can accept. Horn’s testimony and opinions were credible and
21 incontestable.

22 **(b) Dr. Haney**

23 Based on his training and experience, Dr. Haney explained “we now know that
24 isolated confinement is painful. People who are exposed to it suffer when they experience
25 it.” (Doc. 4306 at 18). The amount of suffering, however, “[d]epends upon the conditions
26 and the length of time that people are [in isolated confinement].” (Doc. 4306 at 18). And
27 while some people experience harm that appears “to be reversible,” others experience “very
28 severe” harm that “can be life threatening.” (Doc. 4306 at 18).

1 In Dr. Haney's view, the most "widespread" reaction to isolated confinement is
2 "depression. People become despondent." (Doc. 4306 at 21). This is especially
3 pronounced when prisoners are placed in isolated confinement for an indeterminate amount
4 of time. (Doc. 4306 at 21). In addition to depression, prisoners placed in isolated
5 confinement may become "unpredictably and inexplicably anxious, nervous, on edge."⁶⁹
6 (Doc. 4306 at 21). Alternatively, prisoners may get "angry and irritable," sometimes
7 leading to "explosive behavior." (Doc. 4306 at 22). Isolated confinement may lead "to
8 self-harm and it can lead to suicide." (Doc. 4306 at 23).

9 "Social contact and social interaction are essential components in the creation and
10 maintenance of normal social identity and social reality." (Doc. 4122 at 26). Deprivation
11 of social contact "is psychologically destabilizing" and "[i]t undermines a person's sense
12 of self or social identity and erodes his connection to a shared social reality." (Doc. 4122
13 at 26). Individuals deprived of social contact "are apt to confuse reality with their
14 idiosyncratic beliefs and fantasies and likely to act upon such fantasies, including violent
15 ones." (Doc. 4122 at 26).

16 While Dr. Haney believes isolated confinement presents a substantial risk of harm
17 to all prisoners, those prisoners with mental illness "are more vulnerable to the pains and
18 stresses of solitary confinement." (Doc. 4306 at 25). Dr. Haney further opined prisoners
19 under the age of 18 are especially susceptible to harm from being placed in isolated
20 confinement. (Doc. 4306 at 25). Dr. Haney believes that even during the time the present
21 litigation has been pending, there has developed a "broader and deeper consensus,
22 scientific consensus," that isolated confinement is harmful. (Doc. 4306 at 26).

23 The American Psychiatric Association believes "[p]rolonged segregation of adult
24 inmates with serious mental illness, with rare exceptions, should be avoided due to the

25 _____
26 ⁶⁹ Travis Scott, a Deputy Warden with twenty years' experience, was asked whether out-
27 of-cell time was important. He responded "Yes. Very important." (Doc. 4264 at 151).
28 The Deputy Warden then went on to explain "When inmates are occupied or have out-of-
cell time or classroom, it helps decrease tension amongst the inmates. It makes the unit a
safer place to work. The inmates are less agitated. It makes it safer for the staff for when
they're interacting with those inmates. We want them to be able to get out to do their
exercises or to go to class. Keeps them occupied." (Doc. 4264 at 151).

1 potential for harm to such inmates.” (Doc. 4306 at 28). The American Psychiatric
2 Association takes a similar position regarding solitary confinement of juveniles. (Doc.
3 4306 at 31). The National Commission on Correctional Health Care takes the position:

- 4 (i) Prolonged, greater than 15 consecutive days, solitary
5 confinement is cruel, inhuman, and degrading treatment
6 and harmful to an individual’s health.
7 (ii) Juveniles, mentally ill individuals, and pregnant women
8 should be excluded from solitary confinement of any
9 duration.

8 (Doc. 4306 at 36).

9 Based on his experience studying approximately 29 state prison systems, Dr. Haney
10 credibly testified Arizona’s system is “among the most severe and the most depriving
11 solitary confinement units that [he has] encountered.” (Doc. 4306 at 56; Doc. 4264 at 65).
12 The conditions in Arizona “place[] the mental health of even psychologically strong
13 incarcerated persons in jeopardy and creates especially high risks of harm for those whose
14 mental illness makes them especially vulnerable.” (Doc. 4122 at 67). He stressed this
15 opinion was taking “into account not what the regulations provide for, but what [he] learned
16 is actually being delivered” in Arizona. (Doc. 4306 at 56). Dr. Haney found the
17 requirements of DO 812, in particular the amount of out-of-cell time set out in that policy,
18 were not being followed. (Doc. 4263 at 31).

19 The physical attributes of the units combine with the “deprivation of social contact”
20 to impose “severe” limitations. And “[t]he amount of out-of-cell time the prisoners are
21 getting is severe by any measure.” (Doc. 4306 at 56). While there were a few
22 improvements shortly after the parties entered into the Stipulation, those improvements
23 began to disappear “within a year or two.” (Doc. 4122 at 91). The conditions are now the
24 same, or worse, than the conditions present at the outset of this litigation in 2013. (Doc.
25 4122 at 91). The only exception is that prisoners now have tablets, which they still have
26 to pay to send emails from. (Doc. 4306 at 78). Even then, not every prisoner is entitled to
27 a tablet and use of the tablets is not free. (Doc. 4264 at 51-52).

28 On cross, Dr. Haney noted the better state systems provide “at least two hours a

1 day” out-of-cell time. (Doc. 4306 at 99). When pressed on how long would be “too long”
2 to spend in maximum custody, Dr. Haney noted the United Nations believes 15 days is the
3 limit. He did not agree with that specific limit, but he noted a “month or years” is “too
4 long.” (Doc. 4263 at 16). Defense counsel asked if keeping someone in isolation longer
5 than 15 days would mean “there is going to be psychological harm to that person.” (Doc.
6 4263 at 17). Dr. Haney explained that causation is not that simple. Rather, when keeping
7 individuals in isolation, “[t]here’s risk of harm. There is risk of harm. So all of this is
8 about risk of harm. And the longer somebody’s exposed to these kind of conditions, the
9 greater the risk of harm.” (Doc. 4263 at 17).

10 Of particular concern to Dr. Haney is the Sunrise unit which houses “juveniles who
11 have been committed to the adult prison system.” (Doc. 4306 at 50). On the day of his
12 visit, the unit contained one girl and approximately twelve boys. (Doc. 4306 at 50). Dr.
13 Haney opined, in extremely strong terms, that the conditions in this unit were intolerable
14 for juveniles. Dr. Haney was “shocked” that Defendants would house juveniles “in such
15 gratuitously harsh” and “abominable” conditions. (Doc. 4122 at 67). Doing so “is
16 singularly inappropriate and highly dangerous.” (Doc. 4122 at 67). Dr. Haney noted
17 Defendants had “learned nothing” from a previous tragic suicide with which he was
18 personally involved.⁷⁰ (Doc. 4122 at 68). Dr. Haney opined that continuing to subject
19 juveniles to harsh isolation practices is “playing with fire.” (Doc. 4122 at 69). And the
20 conditions in the Sunrise unit “create[] a very substantial risk of harm.” (Doc. 4306 at 81).

21 Defendants offered no contrary opinions or testimony. Defendants did not offer an
22 expert stating isolated confinement creates no concerns. Nor did Defendants even proffer
23 a penological purpose for keeping many prisoners in isolated conditions. Thus, for
24 purposes of this case, it is undisputed isolated confinement is harmful for all subclass

25 _____
26 ⁷⁰ During a visit in 2016, Dr. Haney noted a 17-year-old girl had been held in solitary
27 confinement for more than two months. (Doc. 4122 at 68). Dr. Haney requested defense
28 counsel be informed that this girl was at “serious risk of self-harm due to the prolonged
period of time she was held in solitary.” (Doc. 4122 at 68). Shortly after his visit, the girl
turned 18 and was transferred to a different maximum custody unit. The girl committed
suicide a few weeks later. (Doc. 4122 at 68). Dr. Haney believes Defendants’ “learned
nothing from that young woman’s tragic and preventable death.” (Doc. 4122 at 68).

1 members. The conditions specific to this case, both the physical layout of the cells and the
2 amount of out-of-cell time actually available to subclass members, present a substantial
3 risk of serious harm to the mental health of every subclass member.

4 If ADCRR were following its own policies, including the amount of out-of-cell time
5 promised and required by DO 812 and the chance to leave isolated confinement, the
6 situation might be different. Dr. Haney's testimony cannot be read as prohibiting isolated
7 confinement regardless of the circumstances. And the Court recognizes the need and value
8 of isolated confinement in some circumstances. However, the actual practices imposed on
9 the subclass and analyzed by Dr. Haney present a substantial risk of harm. That risk of
10 harm is elevated for prisoners with a mental illness. And the risk of harm is extremely high
11 for juveniles.

12 **IV. Legal Standard for Subclass**

13 The legal standard and inquiry applicable to subclass members is somewhat
14 different from that applicable to the class. "The Eighth Amendment's prohibition against
15 cruel and unusual punishment protects prisoners not only from inhumane methods of
16 punishment but also from inhumane conditions of confinement." *Morgan v. Morgensen*,
17 465 F.3d 1041, 1045 (9th Cir. 2006). *See also Farmer v. Brennan*, 511 U.S. 825, 832
18 (1994) (noting "[t]he Constitution does not mandate comfortable prisons, but neither does
19 it permit inhumane ones"). "[W]hile conditions of confinement may be, and often are,
20 restrictive and harsh, they 'must not involve the wanton and unnecessary infliction of
21 pain.'" *Morgan*, 465 F.3d at 1045 (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347
22 (1981)). Under this standard, the conditions of confinement "must not be devoid of
23 legitimate penological purpose, or contrary to evolving standards of decency that mark the
24 progress of a maturing society." *Id.* (citation and quotation marks omitted).

25 "Where the conditions of confinement are challenged rather than the confinement
26 itself, a plaintiff must make two showings. First, the plaintiff must make an objective
27 showing that the deprivation was sufficiently serious to form the basis for an Eighth
28 Amendment violation. Second, the plaintiff must make a subjective showing that the

1 prison official acted with a sufficiently culpable state of mind.” *Johnson v. Lewis*, 217
2 F.3d 726, 731 (9th Cir. 2000).

3 **A. Objective Prong**

4 Restrictions or deprivations “inherent in the prison setting” cannot “satisfy the
5 objective prong of an Eighth Amendment inquiry.” *Johnson*, 217 F.3d at 731. Only
6 restrictions or deprivations of “the minimal civilized measure of life’s necessities are
7 sufficiently grave to form the basis of an Eighth Amendment violation.” *Id.* (quotation
8 marks and citation omitted). The “life’s necessities” include, among others, “adequate
9 shelter, food, clothing, sanitation, medical care, and personal safety.” *Id.* When a prisoner
10 is denied a necessity, “[t]he circumstances, nature, and duration of [the] deprivation . . .
11 must be considered in determining whether a constitutional violation has occurred.” *Id.* In
12 general, “[t]he more basic the particular need, the shorter the time it can be withheld.” *Id.*
13 (quoting *Hoptowit v. Ray*, 682 F.2d 1237, 1259 (9th Cir. 1982), *overruled on other grounds*
14 *by Sandin v. Connor*, 515 U.S. 472 (1995)). For example, forcing prisoners to lie
15 “motionless in the dirt in subfreezing temperatures for five to nine hours” could be
16 sufficient to establish a deprivation of the “basic human need[.]” for shelter. *Johnson*, 217
17 F.3d at 732. But housing prisoners for “short periods of time” in a padded cell that was
18 “dark, scary, and smelled bad” containing a “pit toilet encrusted with excrement and urine”
19 will not qualify as deprivation of the basic human need for shelter or sanitation. *Anderson*
20 *v. Cty. of Kern*, 45 F.3d 1310, 1313 (9th Cir. 1995). *See also Hutto v. Finney*, 437 U.S.
21 678, 686–87 (1978) (“[T]he length of confinement cannot be ignored in deciding whether
22 the confinement meets constitutional standards. A filthy, overcrowded cell and a diet of
23 ‘grue’⁷¹ might be tolerable for a few days and intolerably cruel for weeks or months.”).

24 **B. Subjective Prong**

25 Conditions of confinement such as those challenged here require Plaintiffs establish
26 the deprivations “occurred with deliberate indifference to [their] health or safety.” *Foster*

27
28 ⁷¹ “Grue” was described as “a substance created by mashing meat, potatoes, oleo, syrup,
vegetables, eggs, and seasoning into a paste and baking the mixture in a pan.” *Hutto*, 437
U.S. at 683.

1 *v. Runnels*, 554 F.3d 807, 812 (9th Cir. 2009). This “involves a two part inquiry.” The
2 first part requires Plaintiffs show Defendants “were aware of a substantial risk of serious
3 harm to [their] health or safety.” *Thomas v. Ponder*, 611 F.3d 1144, 1150 (9th Cir. 2010).
4 Whether Defendants “had the requisite knowledge of a substantial risk is a question of fact
5 subject to demonstration in the usual ways, including inference from circumstantial
6 evidence.” *Farmer*, 511 U.S. at 842. And Defendants’ knowledge of a substantial risk
7 may be established “from the very fact that the risk was obvious.” *Id.*

8 **V. Conditions Imposed on the Subclass**

9 In the class certification order, the Court identified the seven practices subclass
10 members were allegedly being subjected to contrary to constitutional requirements. Those
11 seven practices were:

- 12 (i) Inadequate psychiatric monitoring because of chronic
- 13 understaffing;
- 14 (ii) Use of chemical agents against inmates on psychotropic
- 15 medications;
- 16 (iii) Lack of recreation;
- 17 (iv) Extreme social isolation;
- 18 (v) Constant cell illumination;
- 19 (vi) Limited property; and
- 20 (vii) Insufficient nutrition.

21 When assessing whether Plaintiffs have carried their burden of proof regarding these
22 practices, the Court cannot combine various practices to conclude the “overall conditions”
23 violate the Eighth Amendment. *Wilson v. Seiter*, 501 U.S. 294, 305 (1991). As explained
24 by the Supreme Court, “[s]ome conditions of confinement may establish an Eighth
25 Amendment violation in combination when each would not do so alone, but only when
26 they have a mutually enforcing effect that produces the deprivation of a single, identifiable
27 human need such as food, warmth, or exercise—for example, a low cell temperature at
28 night combined with a failure to issue blankets.” *Id.* at 304. Thus, the Court can only
combine various conditions when, together, they deprive prisoners of a “single, identifiable
human need.” *Id.* The challenged practices involve some well-established “human needs”

1 such as the need for exercise, ability to sleep, and sufficient food. But the subclass also
2 challenges practices involving matters that have not yet been widely recognized as “human
3 needs,” such as extreme limitations on social contact or limited property.

4 It is important to note Defendants admit keeping all subclass members in the
5 restrictive environments at issue is not justified. There are approximately 200 subclass
6 members who Defendants’ employees admitted at trial should no longer be held in
7 maximum custody units. In other words, there simply is no penological justification for
8 holding those subclass members under harsh and restrictive conditions. Defendants’
9 concession they house prisoners in these restrictive conditions without penological
10 justification means Defendants should have remedied it long ago. *See Wood v. Beauclair*,
11 692 F.3d 1041, 1050 (9th Cir. 2012) (finding conduct “totally without penological
12 justification” satisfies the objective prong of the Eighth Amendment analysis).

13 Further, policies allow prisoners to be placed in isolated confinement without
14 penological justification. As recounted earlier, the policy requiring prisoners start serving
15 life sentences in maximum custody is not supported by a valid penological interest. In
16 addition, Defendants’ policies that some prisoners must remain in maximum custody
17 because of misconduct years ago is not supported by a legitimate penological interest.

18 Despite the subclass including many prisoners who obviously should not be housed
19 in isolated confinement, the Court will conduct the practice-by-practice analysis on the
20 subclass as a whole. Thus, the Court will not analyze separately the practices and policies
21 as applied to prisoners who everyone agree do not merit isolated confinement. The Court
22 will assess whether Plaintiffs have carried their burden of proving certain policies or
23 practices, as applied to members of the subclass Defendants believe should be in isolated
24 confinement, violate the Eighth Amendment.

25 **1. Defendants do not have a policy or practice of using chemical**
26 **agents against inmates on psychotropic medications.**

27 Neither at trial nor in their post-trial submissions did Plaintiffs identify the exact
28 contours of the practice they were attempting to prove. While the class certification order

1 described the practice as use of chemical agents against prisoners on particular medication,
2 Plaintiffs' response to Defendants' proposed findings of fact describes the challenged
3 practice as "widespread and indiscriminate use of force on people who engage in self-
4 harm." (Doc. 4314 at 109). That was not the practice certified. Plaintiffs have not proven
5 Defendants have a policy or practice of using chemical agents against inmates on
6 psychotropic medications that violates the Eighth Amendment.

7 In reaching this conclusion, the Court notes Plaintiffs presented disturbing evidence
8 of the use, and overuse, of chemical agents against prisoners with obvious mental health
9 needs. For example, the February 12, 2020, email between medical providers quoted
10 earlier involved I.C., a "mental health patient" at the Phoenix facility, who had been "self
11 harming by banging his head for the past several days resulting in . . . the use of OC
12 [pepper] spray." (Doc. 4109 at 79). The "Regional Director of Mental Health"
13 recommended officials "continue using OC spray as needed while the on site mental health
14 team comes up with a treatment plan." (Doc. 4109 at 79). Using pepper spray in lieu of
15 immediate psychiatric treatment was obviously inappropriate. And this was not the only
16 evidence of such practices.

17 During trial, as discussed above, Plaintiffs presented multiple videos and other
18 evidence that Rahim Muhammed was repeatedly subjected to OC spray when he was
19 experiencing mental health crises. The evidence established prison officers did not know
20 how to handle Muhammed and they were unable to convince him to stop his self-harming
21 behaviors. Given Muhammed's behavior, it was obvious prison officials should have
22 arranged for much more attention from mental health providers.⁷² Once Muhammed

23 ⁷² During trial, the Court asked the Deputy Warden about the failure to obtain additional
24 mental health care for Muhammad. (Doc. 4279 33-36). The Deputy Warden claimed
25 "mental health" personnel were involved with Muhammad "every single time" Muhammad
26 was subjected to OC spray. (Doc. 4279 at 33). But there was no evidence establishing
27 such interventions. The Deputy Warden stated Muhammad first had an "issue"
28 approximately "three or four weeks" after he arrived. (Doc. 4279 at 36). After repeated
instances of self-harm and OC spray, the Deputy Warden reported to the "mental health
lead" that Muhammad needed "more care than what" was available at his location. (Doc.
4279 at 34). Muhammad was transferred "shortly thereafter." (Doc. 4279 at 34).
Muhammad was at that location for approximately seven months. (Doc. 4279 at 37). Thus,

1 received additional mental health care, and was transferred to a more suitable location, he
2 was able to function at a much higher level as shown by his trial testimony being coherent
3 and convincing. The treatment of Muhammed might have violated the Eighth Amendment,
4 but that treatment does not prove the existence of a general policy regarding using OC
5 spray against prisoners on medication.

6 The evidence regarding I.C. and Muhammed make it more likely than not that prison
7 officers overuse chemical agents. Those chemical agents are used because adequate mental
8 health care is not available. With appropriate mental health care, the need for chemical
9 agents would be significantly reduced. Accordingly, remedying the patently insufficient
10 mental health resources will reduce the need for interventions by officers involving
11 chemical agents and likely provide the relief Plaintiffs sought regarding the use of chemical
12 agents.

13 **2. Subclass members do not receive adequate recreation and**
14 **exercise opportunities.**

15 The Ninth Circuit has recognized, repeatedly, “exercise is one of the basic human
16 necessities protected by the Eighth Amendment.” *Norbert v. City & Cty. of San Francisco*,
17 10 F.4th 918, 929 (9th Cir. 2021). The amount of exercise that must be offered to prisoners,
18 as well as whether that exercise may be indoors or outside, “must be evaluated on the full
19 extent of the available recreational opportunities.” *Id.* at 930. In other words,
20 “[d]etermining what constitutes adequate exercise requires consideration of the physical
21 characteristics of the cell and [prison] and the average length of stay of the inmates.”
22 *Pierce v. Cty. of Orange*, 526 F.3d 1190, 1212 (9th Cir. 2008) (quotation marks and citation
23 omitted). For example, in a case where prisoners were held in “continuous segregation,
24 spending virtually 24 hours every day in their cells with only meager out-of-cell
25 movements and corridor exercise,” they were entitled to “one hour per day, five days a
26 week” of outdoor exercise. *Spain v. Proconier*, 600 F.2d 189, 199 (9th Cir. 1979). By

27 _____
28 the Deputy Warden knew of Muhammad’s difficulties after approximately one month, but
waited five or six months to speak to the “mental health lead” about arranging additional
services.

1 contrast, prisoners were not entitled to outdoor exercise when they were held in a far less
2 restrictive setting that allowed out-of-cell “recreation time” of at least one hour every day.
3 *Norbert v. City and County of San Francisco*, 10 F.4th 918, 934 (9th Cir. 2021).

4 In general, prisoners must be provided sufficient time and access to locations such
5 that they enjoy “meaningful” recreation opportunities. *Shorter v. Baca*, 895 F.3d 1176,
6 1185 (9th Cir. 2018). The Ninth Circuit has noted offers for recreation in a room with
7 “space constraints” that lacks “appropriate equipment” may not “constitute an exercise
8 opportunity.” *Pierce v. Cty. of Orange*, 526 F.3d 1190, 1212 n.22 (9th Cir. 2008).

9 The Court is not assessing the constitutionality of the amounts of recreation set forth
10 in DO 812. If subclass members were receiving legitimate offers for recreation in the
11 amount and locations set forth in DO 812, and prisoners were able to progress through the
12 step program set forth in DO 812, it is unlikely prisoners would have a viable claim based
13 on inadequate recreation. A minimum of 7.5 hours of recreation per week, with the promise
14 that additional and better recreation offers could be earned, would present a very different
15 situation from what is presented here. Instead, the actual practice is that DO 812 is not
16 followed. Subclass members are routinely denied recreation of even 7.5 hours per week
17 and, even when prisoners should be provided recreation in different enclosures, recreation
18 is routinely offered in the chute which is only marginally better than their cells.

19 The tracking forms for individuals in maximum custody establish it is more
20 probable than not the subclass members are routinely receiving legitimate offers for five
21 hours or less of recreation per week. Even five hours is an overstatement based on the
22 implausibly high refusal rates and the practice to interpret, whenever possible, responses
23 to offers as denials. The detention forms establish it is more probable than not that
24 prisoners in detention units routinely receive no recreation offers. While the forms
25 sometimes indicate recreation offers, every single prisoner is often recorded as refusing
26 recreation. That indicates it is more probable than not the offers for recreation, even if
27 documented on the form, are overstating the offers actually made.

28 Beyond the insufficient amount of recreation time actually offered to subclass

1 members, the offered location is insufficient under the particular facts of this case. Here,
2 maximum custody units are “barren, stark, and . . . dehumanizing.” (Doc. 4122 at 61; 4306
3 at 42). When allegedly given the opportunity to leave their cells, the offer is merely to be
4 placed in one of the chutes for a potentially extended period. The chutes are only
5 marginally larger than the cells, contain no exercise equipment, and have no toilet. The
6 chutes are open to the sky, meaning they are stifling in the summer and attract insects. And
7 prisoners are taken to the chute one at a time, precluding any socialization. Accordingly,
8 the chutes are a better location for prisoners to obtain some amount of exercise, but exercise
9 in the chute is not sufficiently “meaningful” on a long-term basis.

10 Prisoners often spend years or decades in maximum custody. Prisoners may spend
11 months in detention units. Given the length of time prisoners remain in isolated
12 confinement, the physical conditions of the cells (*i.e.*, cell size and pest infestations), and
13 the stark conditions of the chute, the amount of recreation offered to subclass members
14 deprives them of the essential human need to exercise. *See Pierce v. Cty. of Orange*, 526
15 F.3d 1190, 1212 (9th Cir. 2008) (noting courts have held prisoners “are ordinarily entitled
16 to daily exercise, or five to seven hours of exercise per week, outside their cells”). The
17 objective prong of the Eighth Amendment test is met.

18 The subjective prong is easily met. It is undisputed the records for maximum
19 custody as well as detention establish subclass members routinely receive few, if any,
20 recreation offers. Even if accurate, the records show prisoners refusing recreation at
21 implausibly high rates. Officials must have known prisoners were not being offered
22 legitimate opportunities to exercise. And because it has been established for decades that
23 prisoners in long-term housing must be provided some meaningful amount of recreation,
24 the failure to provide that exercise must have been done with deliberate indifference to the
25 subclass members’ rights. *Shorter v. Baca*, 895 F.3d 1176, 1185 (9th Cir. 2018).

26 **3. Subclass members are subject to unconstitutional amounts of**
27 **social isolation.**

28 Plaintiffs claim that subclass members are subject to profound levels of social

1 isolation. The evidence established prisoners are subject to “extreme social isolation”
2 creating a substantial risk of serious harm. (Doc. 4165 at 93). No other conclusion is
3 possible.

4 Subclass members may be celled individually or with one other person.⁷³ Beyond
5 a cellmate, subclass members often have effectively zero social contact. For many, the
6 only interactions that might be described as social contacts are when meals are delivered.
7 (Doc. 4165 at 53). Beyond meal delivery, subclass members may remain in their cells with
8 absolutely no interaction with another human for days at a time. Some additional
9 interaction may occur on the days when subclass members are offered showers or
10 recreation. But even if those offers are accepted, there likely will be no opportunity for
11 meaningful social interaction.

12 Individuals who accept an offer to shower or to go to recreation will have brief
13 interactions with one officer while the prisoner is searched, handcuffed, and escorted to
14 and from the shower or recreation enclosure.⁷⁴ Both showers and recreation, if offered in
15 the chute, are done alone. The amount of social isolation that may be enforced on subclass
16 members is illustrated by a Detention Record covering the week beginning July 11, 2021.
17 (Doc. 1697 at 1277). During that seven-day period, prisoner M.H. received only seven
18 meals. Thus, M.H. interacted with prison staff for a few seconds, seven times, when
19 receiving his meals. That was the entirety of M.H.’s social contact that week. M.H. did
20 not receive a single offer to shower nor did he receive a single offer for recreation. M.H.
21 was kept in his cell for at least the seven straight days reflected in the record, receiving
22 minimal food, and experiencing no contact with another person.

23 The record for M.H. is on the extreme end of the conditions experienced by subclass

24 _____
25 ⁷³ As noted by Dr. Haney, having a cellmate “does not mitigate, and indeed may exacerbate,
26 the psychological impact of” living in a maximum custody unit. (Doc. 4165 at 54). Living
27 in such close proximity to a single other individual is not “meaningful social contact” and
28 “may become an additional stressor” because those relationships may create “tension and
even conflict” between prisoners. (Doc. 4165 at 54). “[C]onstant, forced, inescapable, and
unremitting contact with another person in such a small and enclosed space” can become
“intolerable.” (Doc. 4165 at 55).

⁷⁴ Some prisoners might require more than one officer be present during this process. But,
at most, there will be three officers.

1 members. But all subclass members are subjected to profound deprivations of social
2 interaction. Subclass members have interactions when they receive meals and when they
3 receive offers for showers or recreation. But those interactions are with one or two staff
4 members. And because recreation is often offered in the chute, no social interactions will
5 occur during the recreation beyond the interaction with the staff member while being
6 transported to and from the chute.

7 The deprivation of social contact imposed on subclass members places all subclass
8 members “at significant risk of serious psychological harm.” (Doc. 4165 at 50).
9 Defendants did not present any evidence, expert or otherwise, questioning this conclusion.
10 Presumably because it has been established for decades that profound levels of social
11 isolation are harmful. As one court noted almost thirty-five years ago, it “seems pretty
12 obvious . . . that isolating a human being from other human beings year after year or even
13 month after month can cause substantial psychological damage, even if the isolation is not
14 total.” *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir. 1988). Another court noted
15 in 1995 that “conditions of extreme social isolation and reduced environmental stimulation
16 . . . will likely inflict some degree of psychological trauma upon most inmates confined
17 there for more than brief periods.”⁷⁵ *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal.
18 1995). And yet another court noted, in 2020, “the substantial risks of prolonged solitary
19 confinement are obvious, longstanding, pervasive, well-documented, [and] expressly noted
20 by prison officials in the past.” *Porter v. Pennsylvania Dep’t of Corr.*, 974 F.3d 431, 445
21 (3d Cir. 2020) (quotation marks and citation omitted). In reaching that conclusion, the
22 Third Circuit quoted approvingly from an earlier case that had concluded prolonged
23 deprivation of social contact creates a situation where a prisoner’s “very identity is at risk
24 of disintegration.” *Id.* (quoting *Williams v. Sec’y Pennsylvania Dep’t of Corr.*, 848 F.3d
25 549, 566 (3d Cir. 2017).

26 ⁷⁵ The *Madrid* court found the lack of social isolation and environmental stimulation were
27 not “per se violative of the Eighth Amendment.” *Id.* Instead, those conditions violated the
28 Eighth Amendment rights of only those prisoners with existing mental illness or similar
conditions. The conditions in *Madrid*, however, differed from those here. For example,
prisoners in *Madrid* were entitled to “an exercise period five times each week” and were
generally out of their cells for 90 minutes every day. 889 F. Supp. at 1156, 1230.

1 Social contact is a need protected by the Eighth Amendment. That does not mean
2 the same amount of social contact is required for all prisoners or that, in some
3 circumstances, it cannot be denied for periods of time. For purposes of the subclass, the
4 only issue is whether all prisoners in isolated confinement can be deprived of effectively
5 all social contact for an indeterminate amount of time, up to years and decades. Requiring
6 subclass members go decades without meaningful social contact presents a substantial risk
7 of serious psychological harm. The objective prong is satisfied.

8 The subjective prong is also satisfied given the decades-long recognition by
9 academics, prison administrators, and courts that social isolation of the sort imposed on the
10 subclass creates a significant risk of serious harm. The risk is so obvious that Defendants
11 must have known their practices were creating a risk of harm.

12 **4. Subclass members are not subjected to unconstitutional cell**
13 **illumination practices.**

14 “Adequate lighting is one of the fundamental attributes of ‘adequate shelter’
15 required by the Eighth Amendment.” *Keenan v. Hall*, 83 F.3d 1083, 1090 (9th Cir. 1996)
16 (quotation marks and citation omitted). Requiring prisoners live “in constant illumination”
17 can be unconstitutional. *Id.* Existing caselaw links excessive lighting to sleep deprivation.
18 *See, e.g., id.* at 1091 (holding excessive cell lighting allegedly caused “grave sleeping
19 problem”). The Court will assume Plaintiffs challenge the cell illumination practices as a
20 deprivation of their right to adequate shelter or sleep.⁷⁶

21 Plaintiffs presented very little evidence regarding the cell illumination experienced
22 by subclass members. Dr. Haney stated there was constant illumination in certain cells.
23 (Doc. 4122 at 52). And one prisoner testified that, while on mental health watch, his cell
24 was illuminated “24/7” that made him feel “insane.” (Doc. 4263 at 89). But Dr. Haney
25 noted prisoners often cover the lights in their cells, presumably reducing the amount of
26 light to at least some degree. (Doc. 4122 at 52).

27 ⁷⁶ Plaintiffs repeatedly reference that subclass members do not experience “natural light.”
28 (Doc. 4308 at 38). If Plaintiffs’ theory was the deprivation of natural light, that theory fails
because Plaintiffs did not prove deprivation of “natural light” violates the objective prong
of the Eighth Amendment.

1 Plaintiffs presented no evidence regarding how bright the lighting in the cells
2 actually is nor did they present evidence establishing subclass members, in general,
3 experience negative effects such as sleeping problems because of the lighting. *See*
4 *Grenning v. Miller-Stout*, 739 F.3d 1235, 1240 (9th Cir. 2014) (reversing grant of summary
5 judgment because record did not indicate how bright the lighting in cells was). In addition,
6 it is undisputed Defendants have a legitimate penological interest in lighting the subclass
7 members' cells so officers "can actually look in the cell and make sure that the inmate is
8 alive and okay." (Doc. 4263 at 46).

9 Without evidence regarding how bright each cell is, the impact of lighting on
10 subclass members, and the existence of a penological purpose for some amount of lighting,
11 Plaintiffs have not carried their burden of providing the current cell illumination practices
12 violate the objective prong of the Eighth Amendment. *See Chappell v. Mandeville*, 706
13 F.3d 1052, 1058 (9th Cir. 2013) (holding cell illumination claim failed because there was
14 undisputed penological purpose).

15 **5. Subclass members are not subjected to unconstitutional**
16 **limitations on their property.**

17 Plaintiffs did not present evidence regarding the exact limitations on property they
18 are challenging. At trial, there was evidence that entitlement to property varies
19 significantly across the subclass. For example, subclass members in detention, close
20 management, and in an intake facility are permitted very little, if any, property. (Doc. 4264
21 at 139; Doc. 4165 at 52). Similarly, subclass members in a mental health watch unit are
22 not entitled to any "personal property." (Doc. 4122 at 72). But there is no evidence
23 regarding deprivation of property in the general maximum custody units. Plaintiffs have
24 not established, on a subclass-wide basis, any practice or policy regarding property that
25 violates a basic human need.

26 **6. Subclass members are subjected to practices resulting in**
27 **inadequate nutrition.**

28 "Adequate food is a basic human need protected by the Eighth Amendment," but

1 that “food need not be tasty or aesthetically pleasing.” *Keenan v. Hall*, 83 F.3d 1083, 1091
2 (9th Cir. 1996) (quotation marks and citations omitted). In one case, the Ninth Circuit
3 addressed an Eighth Amendment claim by an inmate who alleged he had been “denied 16
4 meals in 23 days.” *Foster v. Runnels*, 554 F.3d 807, 812 (9th Cir. 2009). The Ninth Circuit
5 concluded that, if true, that was a sufficiently serious deprivation of a life necessity. *Id.* at
6 813. Moreover, the knowing denial of food easily meets the subjective prong because
7 “[t]he risk that an inmate might suffer harm as a result of the repeated denial of meals is
8 obvious.” *Id.* at 814.

9 As with other aspects of the subclass’s claims, the issue is not whether Defendants’
10 policies require prisoners receive nutritionally adequate food. It is undisputed the menus
11 and policies contemplate the delivery of meals that would be nutritionally adequate. (Ex.
12 4406). In other words, if Defendants implemented their own policies, there would likely
13 be no plausible claim for relief. But the evidence establishes Defendants’ actual practices
14 differ dramatically from its policies.

15 Subclass members routinely receive less food than policy requires and less food
16 than appropriate. Subclass members routinely report they are receiving insufficient food.
17 The “top complaint” by prisoners regarding their conditions of confinement is that they do
18 not receive the portions of food outlined in Defendants’ policies and menus. (Doc. 4278
19 at 36). In addition, the detention records show prisoners are routinely denied meals. Some
20 of those records establish prisoners were denied far more than the “16 meals in 23 days”
21 the Ninth Circuit found to be an obvious constitutional violation. *Foster v. Runnels*, 554
22 F.3d 807, 812 (9th Cir. 2009). For example, one prisoner received nine meals over a seven-
23 day period. (Ex. 1697 at 1275). Another prisoner received only seven meals over a seven-
24 day period. (Ex. 1697 at 1277).

25 Defendants claim the records are inaccurate. Defendants argue they are not correct
26 because prisoners would “report if they were not being fed.” (Doc. 4315 at 129). But they
27 do and the “top complaint” from prisoners regarding their conditions of confinement was
28 insufficient food. Next, Defendants argue Plaintiffs merely “cherry picked examples of

1 deficient documentation” of meals. (Doc. 4315 at 130). According to Defendants, there
2 are “thousands of pages” showing prisoners received their meals and only some records
3 establish prisoners were fed the appropriate number of meals. (Doc. 4315 at 130).
4 However, the records across locations proved subclass members, as a matter of practice,
5 routinely do not receive adequate meals. At the very least, the records show every subclass
6 member is subject to food practices that create a substantial risk of harm. And because the
7 failure to deliver adequate food is so obvious in the records, Defendants are deliberately
8 indifferent in denying prisoners a basic human need.

9 **INJUNCTIVE RELIEF UNDER THE PRISON LITIGATION REFORM**
10 **ACT**

11 Because the Court has determined by a preponderance of the evidence that
12 Defendants are deliberately indifferent to a substantial risk of serious harm, it must fashion
13 an appropriate remedy. As noted at the beginning of its decision, the Court is mindful of
14 its responsibilities in light of the PLRA’s requirements, namely that “[t]he court shall not
15 grant or approve any prospective relief unless the court finds that such relief is narrowly
16 drawn, extends no further than necessary to correct the violation of the Federal right, and
17 is the least intrusive means necessary to correct the violation of the Federal right.” 18
18 U.S.C. § 3626(a)(1)(A).

19 In this case, there is no question remedial measures are necessary to correct
20 constitutional deficiencies and the Court will meet its constitutional obligations. Thus, the
21 Court will employ an expert to assist with crafting an injunction that remedies the
22 constitutional violations—no more and no less.

23 **IT IS THEREFORE ORDERED** that the Court finds in favor of Plaintiffs and
24 against Defendants as to their claims in Counts One, Count Two, Count Four, and Count
25 Five. Count Three is dismissed.

26 **IT IS FURTHER ORDERED** that the Court finds in favor of Plaintiffs and against
27 Defendants as to the following certified class practices:

- 28
- Failure to provide timely access to health care;

- 1 • Failure to provide timely emergency treatment;
- 2 • Failure to (timely) provide necessary medication;
- 3 • Insufficient health care staffing;
- 4 • Failure to provide care for chronic diseases;
- 5 • Failure to provide timely access to medically necessary specialty care;
- 6 • Failure to provide mentally ill prisoners medically necessary mental health
- 7 treatment (i.e., psychotropic medication, therapy, and inpatient treatment); and
- 8 • Failure to provide suicidal and self-harming prisoners basic mental health care.

9 **IT IS FURTHER ORDERED** that the Court finds in favor of Plaintiffs and against
10 Defendants as to the following certified subclass practices:

- 11 • Inadequate psychiatric monitoring because of chronic understaffing;
- 12 • Lack of recreation;
- 13 • Extreme social isolation; and
- 14 • Insufficient nutrition.


15 **IT IS FURTHER ORDERED** within 14 days of this Order the parties are invited
16 to nominate proposed experts to assist the Court with crafting an injunction that complies
17 with 18 U.S.C. § 3626(a)(1)(A). The Court will consider the proposals and will appoint a
18 qualified expert on or before **August 15, 2022**.

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IT IS FURTHER ORDERED Plaintiffs’ Motion to Exclude Evidence Due to Rule 30(b)(6) Designee’s Lack of Knowledge (Doc. 4163) is **denied as moot**; Plaintiffs’ Motion in Limine Re: Admission of Exhibits (Doc. 4215) is **denied** except as explained herein; Defendants’ Motion to Strike Portions of Plaintiffs’ Experts’ Declarations (Doc. 4219) is **denied**; the parties’ Joint Motion to Admit Exhibits (Doc. 4224) is **granted**; and Plaintiffs’ Motion in Limine to Admit Exhibits 556 and 941 (Doc. 4225) is **denied** except as explained herein.

Dated this 30th day of June, 2022.



Honorable Roslyn O. Silver
Senior United States District Judge

1 **Appendix 1**

2 **Medical Staffing**

3

4 **Douglas Complex⁷⁷**

5 **Population: 1,524**

6 POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
7 Assistant Director of Nursing	1.00	1.00	
8 Director of Nursing	1.00	1.00	
9 Licensed Practical Nurse/Medical Assistant	4.00	4.00	
10 Medical Assistant	-	0.00	
11 Medical Director	1.00	1.00	
12 Midlevel Practitioner	1.50	2.00	0.50
13 Nursing Assistant/Patient Care Technician	4.00	4.00	
14 Registered Nurse	8.00	7.30	(0.70)
15 Staff Physician	N/A	N/A	
16 TOTAL	20.50	20.30	(0.20)

17

18 **Eyman Complex**

19 **Population: 5,219**

20 POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
21 Assistant Director of Nursing	6.00	3.00	(3.00)
22 Director of Nursing	1.00	1.00	
23 Licensed Practical Nurse/Medical Assistant	30.00	19.70	(10.30)
24 Medical Assistant	-	3.00	3.00
25 Medical Director	1.00	1.00	
26 Midlevel Practitioner	5.50	5.00	(0.50)
27 Nursing Assistant/Patient Care Technician	9.00	9.35	0.35
28 Registered Nurse	20.00	9.90	(10.10)
Staff Physician	1.00	1.00	
TOTAL	73.50	52.95	(20.55)

77 Does not include Administrative Assistant, Assistant Facility Health Administrator, Clinical Coordinator, Facility Health Administrator, Healthcare Delivery Facilitator, Inventory Coordinator, Lab Technician, Lead Inventory Coordinator, Medical Records Clerk and Supervisor, Physical Therapist, Release/Discharge Planner, Scheduler, X-Ray Technician, Mental Health care staff (addressed in Part Two), or Dental staff. "N/A" means the position does not exist at the facility. Medical Assistant, Education Coordinator, Physical Therapist, Clinical Coordinator, and Recreation Therapist positions exist in excess of the staffing allocation, even though they may not be filled.

Florence Complex			
Population: 2,534			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	6.00	4.00	(2.00)
Director of Nursing	1.00	0.00	(1.00)
Licensed Practical Nurse/Medical Assistant	30.00	15.90	(14.10)
Medical Assistant	-	0.00	
Medical Director	1.00	1.00	
Midlevel Practitioner	6.00	6.75	0.75
Nursing Assistant/Patient Care Technician	20.00	14.90	(5.10)
Registered Nurse	36.00	20.25	(15.75)
Staff Physician	2.00	1.25	(0.75)
TOTAL	102.00	64.05	(37.95)

Lewis Complex			
Population: 4,220			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	6.00	2.00	(4.00)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	34.00	17.30	(16.70)
Medical Assistant	-	0.90	0.90
Medical Director	1.00	1.00	
Midlevel Practitioner	6.00	5.50	(0.50)
Nursing Assistant/Patient Care Technician	14.00	12.70	(1.30)
Registered Nurse	30.00	24.35	(5.65)
Staff Physician	2.00	0.00	(2.00)
TOTAL	94.00	64.75	(29.25)

Perryville Complex			
Population: 3,318			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	6.00	2.00	(4.00)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	24.00	18.50	(5.50)
Medical Assistant	-	0.00	
Medical Director	0.80	1.00	0.20

Midlevel Practitioner	5.00	6.00	1.00
Nursing Assistant/Patient Care Technician	14.00	12.60	(1.40)
Registered Nurse	30.00	15.10	(14.90)
Staff Physician	1.20	1.50	0.30
TOTAL	82.00	57.70	(24.30)

Phoenix Complex			
Population: 468			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	3.00	0.00	(3.00)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	3.00	4.80	1.80
Medical Assistant	-	0.00	
Medical Director	1.00	1.00	
Midlevel Practitioner	4.00	5.00	1.00
Nursing Assistant/Patient Care Technician	5.75	1.90	(3.85)
Registered Nurse	12.00	9.65	(2.35)
Staff Physician	1.00	0.00	(1.00)
TOTAL	30.75	23.35	(7.40)

Safford Complex			
Population: 1,035			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	2.00	2.00	
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	6.00	2.80	(3.20)
Medical Assistant	-	0.00	
Medical Director	1.00	1.00	
Midlevel Practitioner	1.00	2.00	1.00
Nursing Assistant/Patient Care Technician	4.00	4.00	
Registered Nurse	8.00	12.80	4.80
Staff Physician	N/A	N/A	
TOTAL	23.00	25.60	2.60

Tucson Complex			
Population: 4,420			

POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	8.00	4.00	(4.00)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	40.00	24.30	(15.70)
Medical Assistant	-	0.00	
Medical Director	1.00	1.00	
Midlevel Practitioner	8.00	7.00	(1.00)
Nursing Assistant/Patient Care Technician	19.00	16.80	(2.20)
Registered Nurse	36.00	18.30	(17.70)
Staff Physician	2.00	0.75	(1.25)
TOTAL	115.00	73.15	(41.85)

Winslow Complex			
Population: 1,481			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	2.00	1.00	(1.00)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	4.00	1.90	(2.10)
Medical Assistant	-	1.00	1.00
Medical Director	1.00	1.00	
Midlevel Practitioner	2.00	2.00	
Nursing Assistant/Patient Care Technician	3.00	5.60	2.60
Registered Nurse	6.00	11.10	5.10
Staff Physician	N/A	N/A	
TOTAL	19.00	24.60	5.40

Yuma Complex			
Population: 3,374			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Assistant Director of Nursing	5.00	4.80	(0.20)
Director of Nursing	1.00	1.00	
Licensed Practical Nurse/Medical Assistant	10.00	12.00	2.00
Medical Assistant	-	2.00	2.00
Medical Director	1.00	1.00	
Midlevel Practitioner	4.00	5.90	1.90

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Nursing Assistant/Patient Care Technician	6.00	14.75	8.75
Registered Nurse	14.00	16.55	2.55
Staff Physician	1.00	1.00	
TOTAL	42.00	59.00	17.00

Appendix 2

Dr. Murray's Scale

A rating of **5—Excellent** was assigned to care that was timely and reflected good decision-making. The care may not have been perfect in all instances, but the imperfections found did not affect the outcomes. This rating may allow for a lack of preventive health care. Regarding documentation, this rating was used if the notes were clear and comprehensive (usually free-typed instead of utilizing the template).

A rating of **4—Very Good** may represent care that was mostly solid, but there may be some important care that was delayed slightly or a decision that should have been made a bit earlier eventually got made and there was no harm to the patient by the delay.

A rating of **3—Good** may represent a mix of care that was sometimes poor and sometimes great. However, if there was a problem with care that markedly increased risk to a patient, a lower score was assigned, since it does not help to provide excellent care for some problems and to not address a problem that had a significant risk of causing an adverse outcome.

A rating of **2—Fair** would be assigned if the decision-making represented a lack of basic practice rules or put the patient at some risk. It may represent good decision-making regarding referrals, with delay in the referral. Often this rating reflected that there was some good care, but it was overshadowed by the presence of care that put the patient at risk and could not be overlooked. Using this rating for documentation would represent incomplete notes where the reader cannot follow the care very easily at all.

A rating of **1—Poor** represents care that cannot be excused or overlooked. It represents risk to patients, lack of basic knowledge or follow through, or a timeline that does not realistically apply to the patient's problem. In documentation, this rating might be used when the patient's care was fragmented, to a point where one cannot follow what should happen. This may be due to the shortcomings of eOMIS or may be due to a lack of comprehensive documentation by the provider.

(Doc. 4206 ¶¶ 209-213).

Appendix 3

Mental Health Staffing

Douglas Complex⁷⁸			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	N/A	N/A	
Behavioral Specialist	N/A	N/A	
Mental Health Lead	N/A	N/A	
Mental Health Clerk	N/A	N/A	
Mental Health Midlevel (NP/PA)	N/A	N/A	
Mental Health Registered Nurse	N/A	N/A	
Psychiatrist	N/A	N/A	
Psychologist	N/A	N/A	
Psychology Associate	1.00	0.00	(1.00)
TOTAL	1.00	0.00	(1.00)

Eyman Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	4.00	7.00	3.00
Behavioral Specialist	N/A	N/A	
Mental Health Lead	1.00	1.00	
Mental Health Clerk	1.00	0.00	(1.00)
Mental Health Midlevel (NP/PA)	3.50	4.00	0.50
Mental Health Registered Nurse	2.00	0.90	(1.10)
Psychiatrist	1.00	1.00	
Psychologist	3.00	2.00	(1.00)
Psychology Associate	13.00	8.00	(5.00)
TOTAL	28.5	23.9	(4.60)

Florence Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	4.00	0.00	(4.00)

⁷⁸ Does not include Administrative staff, Health Care staff, or Dental staff. "N/A" means the position does not exist at the facility. Behavioral Specialist positions exist in excess of the staffing allocation, even though they may not be filled.

Behavioral Specialist	0.00	0.00	
Mental Health Lead	1.00	0.00	(1.00)
Mental Health Clerk	1.00	1.00	
Mental Health Midlevel (NP/PA)	3.50	3.00	(0.50)
Mental Health Registered Nurse	1.00	0.00	(1.00)
Psychiatrist	1.00	1.00	
Psychologist	3.00	0.90	(2.10)
Psychology Associate	8.00	2.00	(6.00)
TOTAL	22.50	7.90	(14.60)

Lewis Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	4.00	3.00	(1.00)
Behavioral Specialist	N/A	N/A	
Mental Health Lead	1.00	0.00	(1.00)
Mental Health Clerk	1.00	1.00	
Mental Health Midlevel (NP/PA)	3.50	3.00	(0.50)
Mental Health Registered Nurse	2.00	1.00	(1.00)
Psychiatrist	1.00	1.00	
Psychologist	3.00	2.00	(1.00)
Psychology Associate	12.00	10.25	(1.75)
TOTAL	27.50	21.25	(6.25)

Perryville Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	3.00	2.00	(1.00)
Behavioral Specialist	N/A	N/A	
Mental Health Lead	1.00	1.00	
Mental Health Clerk	1.00	0.00	(1.00)
Mental Health Midlevel (NP/PA)	3.50	3.20	(0.30)
Mental Health Registered Nurse	5.20	4.70	(0.50)
Psychiatrist	1.00	1.00	
Psychologist	2.00	1.75	(0.25)
Psychology Associate	10.00	9.00	(1.00)
TOTAL	26.70	22.65	(4.05)

Phoenix Complex			
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POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	5.00	2.00	(3.00)
Behavioral Specialist	N/A	N/A	
Mental Health Lead	N/A	N/A	
Mental Health Clerk	N/A	N/A	
Mental Health Midlevel (NP/PA)	3.50	3.50	
Mental Health Registered Nurse	15.80	8.80	(7.00)
Mental Health Registered Nurse Charge	1.00	0.90	(0.10)
Psychiatrist	1.00	1.00	
Psychologist	4.00	2.50	(1.50)
Psychology Associate	11.00	9.00	(2.00)
TOTAL	41.30	27.70	(13.60)

Safford Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	N/A	N/A	
Behavioral Specialist	N/A	N/A	
Mental Health Lead	N/A	N/A	
Mental Health Clerk	N/A	N/A	
Mental Health Midlevel (NP/PA)	N/A	N/A	
Mental Health Registered Nurse	N/A	N/A	
Psychiatrist	N/A	N/A	
Psychologist	N/A	N/A	
Psychology Associate	1.00	1.00	
TOTAL	1.00	1.00	0.00

Tucson Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	6.00	4.00	(2.00)
Behavioral Specialist	0.00	0.00	
Mental Health Lead	1.00	1.00	
Mental Health Clerk	1.00	1.00	
Mental Health Midlevel (NP/PA)	3.50	4.50	1.00
Mental Health Registered Nurse	2.00	2.00	
Psychiatrist	1.00	0.00	(1.00)
Psychologist	4.00	3.90	(0.10)

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Psychology Associate	14.00	11.00	(3.00)
TOTAL	32.50	27.40	(5.10)

Winslow Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	N/A	N/A	
Behavioral Specialist	N/A	N/A	
Mental Health Lead	N/A	N/A	
Mental Health Clerk	N/A	N/A	
Mental Health Midlevel (NP/PA)	N/A	N/A	
Mental Health Registered Nurse	N/A	N/A	
Psychiatrist	N/A	N/A	
Psychologist	N/A	N/A	
Psychology Associate	1.00	1.00	
TOTAL	1.00	1.00	0.00

Yuma Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Behavioral Health Technician	3.00	3.00	
Behavioral Specialist	N/A	N/A	
Mental Health Lead	1.00	1.00	
Mental Health Clerk	1.00	1.00	
Mental Health Midlevel (NP/PA)	3.00	3.00	
Mental Health Registered Nurse	1.00	1.00	
Psychiatrist	1.00	1.00	
Psychologist	1.00	0.00	(1.00)
Psychology Associate	9.00	6.75	(2.25)
TOTAL	17.00	16.75	(3.25)

Appendix 4
Pennington-Stallcup's Email

Eyman Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychology Associate	13.00	7.5	(5.50)
Florence Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	3.00	0.90	(2.10)
Psychology Associate	8.00	3.00	(6.00)
Lewis Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	3.00	2.00	(1.00)
Psychology Associate	12.00	9.0	(3.00)
Perryville Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	2.00	1.75	(0.25)
Psychology Associate	10.00	8.00	(2.00)
Phoenix Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	4.00	1.50	(2.50)
Psychology Associate	11.00	10.00	(1.00)
Tucson Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	4.00	2.0	(2.00)
Psychology Associate	14.00	11.00	(3.00)

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Yuma Complex			
POSITION	CONTRACT FTE	HIRED FTE	FTE VARIANCE
Psychologist	1.00	0.00	(1.00)
Psychology Associate	9.00	7.50	(1.50)

(Ex. 2141).

Appendix 5

Dr. Penn's Chart Reviews

Patient No.	Access to Care?	Notes	Trial Tr. Page
1	No		3102
6	No		3102
11	No		3103
12	Yes	“death by probable suicide, possible problems with medical access to care”; ⁷⁹ patient submitted HSRs on 9/2 and 9/12 but was not seen until 9/16	3103
13	Yes	patient died by hanging while in segregation; “many late entries but seen regularly by mental health for . . . health and welfare rounds”; “possible medical access to care problem”	3103
14	No		3104
16	No		3104
17	No		3104
21/22 ⁸⁰	No		3104
27	No		3104
28	No		3105
29	No		3105
30	No		3105
34	No		3105
38	No		3106
49	No		3106
52	Yes	died by suicide by hanging; “ambulance team refused to go to the patient’s location due to their policy and he was brought to medical on a gurney”	3106-07
55	No		3106
56	No		3107-08

⁷⁹ Direct citations to Exhibit 3 to the Penn Report appear in quotation marks.

⁸⁰ “Patient 21” and “Patient 22” referred to the same individual.

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61	No		3108
62	No		3108
72	No		3108
80	No		3108
81	No		3109-10
82	No		3109-10
86	Yes	“two weeks on [suicide] watch but didn’t see psychiatric clinician”	3110
87	No		3109-10
90	No		3110
92	No		3110
95	No	patient waited almost three weeks to have psychotic complaints addressed	3111
97	No		3110
98	Yes	““on [suicide] watch 6-21-19 through 7-8-19 but saw no psychiatric provider under 7-18-19””; patient was on olanzapine, an anti-psychotic medication	3111, 3114
100	No		3111
114	Yes	“Depakote prescribed at too low a dose as revealed by disturbed behavior in lab.”	3116
115	Yes	patient committed suicide on a date early in 2021; “[patient] might have benefited from a prison inpatient unit”	3116
118	No		3116
120	Yes	patient had died by suicide before the relevant time for this review; “answered yes only so I could submit the review”	3117
129	Yes	“lithium continued at low 600 milligram daily dose despite low level of .3 and a suicide attempt on this dose”	3122-23

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131	Yes	“health care request written in Spanish, yet most mental health meetings say no interpreter was used and do not state whether interview was conducted in Spanish”	3123
136	Yes	“has inexplicably been prescribed clonidine for depression[/]anxiety”	3123
140	No		3122
145	Yes	“low dose of Risperdal consta 12.5 mg [every two] weeks despite chronic auditory hallucinations”	3126
146	Yes	“patient was taken off of Risperdal but had to be returned due to resurgent psychosis”; “decision to stop Risperdal was probably a mistake, but the reasoning was documented”	3126
147	No		3122
148	No		
151	No		3128
152	Yes	“low dose haloperidol, 1 milligram [twice daily] by psych APN is inadequate as evidenced by symptoms. May have catatonia, which would benefit from benzo or [electro-convulsive therapy].”	3128
153	No		3128
155	Yes	“lithium was increased prescribed once daily at night, which is not optimal”; diagnosis of bipolar I was not well substantiated	3129
156	Yes	“marginally adequate care”	3129
158	No		3130
159	Yes	“marginal adequate [sic]	3130

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		access to care”	
160	Yes	“concerns about polypharmacy and combining Cogentin with Zyprexa”	3130
167	Yes	“access to care adequate but concerns about medication decisions”	3132
168	Yes	“access to care adequate but concerns about decision-making”	3132
169	No		3135
179	Yes	AIMS examination (a physical examination for possible neurological side effects of psychotropic medications) is performed only once a year	3135
228	No	patient died by suicide	3137
235	Yes	“It is concerning that patient is not on meds and carries a diagnosis of schizophrenia or bipolar DO”; patient has been on involuntary medication in the past; “unmedicated, [patient] is likely going to have difficulties functioning”	3137
252	Yes	“documentation is poor”	3141-42
258	No		3142
259	No		3142
271	Yes	“admission in 2006 but encounters only go back to January 2020, limited documentation available”	3143
272	Yes	“no scheduled visit with the psychiatric midlevel since August 2020”	3143

Appendix 6

Recreation per Step/Location

	Step I	Step II	Step III
Browning	Three, 2.5-hour blocks per week in the standard ⁸¹ enclosure	Three, 2.5-hour blocks per week, one of which can be in the 10x10 enclosure	<p>For GP – One, 2.5-hour block per month in 20x40 basketball enclosure (up to eight inmates)</p> <p>For GP and STG - Three, 2.5-hour blocks per week, to include one-time per week, in the 10x10 enclosures</p> <p>For Condemned Row – Four, 2.5-hour blocks per week of outdoor recreation - All can be in the 10x10 interactive enclosures</p> <p>For all inmates: In pod recreation;⁸² Recreation with another inmate in accordance with Department Order #704, Inmate Regulations</p>
SMU I / Rast	Three, 2.5-hour blocks per week to include 10x10 enclosure (two inmates)	<p>Three, 2.5-hour blocks per week 10x10 enclosure (two inmates), and;</p> <p>One, 2.5-hour block per month in 20x40 basketball enclosure (up to eight inmates)</p>	<p>Three, 2.5-hour blocks per week to include one-time per month in 10x10 enclosure (two inmates), and;</p> <p>One, 2.5-hour block per month in 20x40 basketball enclosure (up to eight inmates), and;</p> <p>One, 2.5-hour block per month in 50x90 (up to 32 inmates)</p>

⁸¹ The “standard enclosure” is also referred to as the “chute.” (Doc. 4259 at 104).

⁸² “In pod recreation” refers to time when prisoners may be out of their cells in their pods without restraints. (Doc. 4259 at 105-106).

1 **Appendix 7**

2 **Maximum Custody Population**

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Location	Max	Detention	M/H Watch	Close Management
Douglas				
Complex Detention		31		
Eyman				
Rynning Detention		25		
Rynning Close Mgt.				15
SMU I	350			
SMU I SO	130			
SMU I P.C.	16			
SMU I Detention		153		
SMU I M/H Watch			13	
Browning Intake	31			
Browning Unit	435			
Browning STG	144			
Browning D/Row	15			
Browning M/H Watch			3	
Browning BMU	11			
Browning Enhanced	31			
Browning RSHP	6			
Browning Close Management				0
Florence				
Housing Unit 8	36			
Health Unit	12			
Globe Detention		0		
Perryville				
Perryville Watch Cells			7	
Santa Maria Detention		9		
Phoenix				
Reception	212			
B-Ward	32			
Flamenco Ida Watch M			0	
Lewis				
Morey Detention		73		
Rast PC	311			

1	Rast Close				7
2	Management				
3	Stiner Detention		64		
4	Bachman Detention		67		
5	Safford				
6	Miles Detention		18		
7	Tonto Detention		0		
8	Tucson				
9	Cimarron Detention		77		
10	Rincon MH Watch			27	
11	Rincon MH Program II	77			
12	Rincon MH Watch II			0	
13	Manzanita Detention		3		
14	Winchester Detention		22		
15	Complex Detention		69		
16	Winslow				
17	Complex Detention		23		
18	Apache Detention		0		
19	Yuma				
20	Cheyenne Detention		52		
21	Dakota Detention		60		
22	TOTALS	1849	746	50	22
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