Appendix A

Review of Florence and Lewis May and June CGARs – Mental Health Measures

Florence

Measure 8

This Measure requires that "MH-3A prisoners shall be seen a minimum of every 30 days by a mental health clinician." The following records were listed in the CGAR as compliant, but the prisoner was not in fact seen every 30 days:

June 2015 [ADCM120799]:

1. [redacted] (seen 5/21/15 and 6/21/15);
2. [redacted] (seen 4/20/15 and 6/1/15);
3. [redacted] (seen 5/21/15 and 6/21/15);
4. [redacted] (seen 2/18/15 and 5/12/15).

May 2015 [ADCM071832]:

1. [redacted] (seen 3/4/15 and 5/7/15);
2. [redacted] (seen 2/18/15 and 5/28/15).

Measure 11

This Measure requires, in part, that "MH-3B prisoners who are prescribed psychotropic medications for psychotic disorders, bipolar disorder, or major depression [hereinafter "a qualifying diagnosis"] shall be seen by a mental health provider a minimum of every 90 days." In the following cases, the monitor erroneously concluded that the prisoner does not have a qualifying diagnosis.

June 2015 [ADCM120800]:

1. [redacted] (prisoner's diagnoses include psychotic disorder and depressive psychosis);
2. [redacted] (schizoaffective disorder NOS);
3. [redacted] (psychotic disorder NOS).

The monitor lists prisoner [redacted] as compliant, stating he was seen on 5/29/15, but there is no provider note on or near that date. Finally, the monitor lists prisoner [redacted]6 as compliant; this appears to be an error, as this prisoner is housed at Lewis and his record indicates that he has "no history of MH services." This prisoner is also listed as compliant under Mental Health Measure 10.

Measure 20

This Measure requires that "MH-3 and above prisoners who are housed in maximum custody shall be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days." In the June 2015 CGAR (ADCM120802), prisoner [redacted] is listed as compliant, allegedly receiving a 1:1 or group session on June 11, 2015. His record, however, lists no individual or group session on that date. Similarly, prisoner [redacted] is listed as compliant, allegedly receiving a 1:1 or group session on "6/1/34." Assuming this is meant to be 6/1/15, no record of a 1:1 or group session was found on that date.

Lewis

Measure 8

Prisoner [redacted] is listed as compliant, purportedly receiving a clinician contact on 6/23/15. However, his file indicates that he was actually not seen that date due to a security staff shortage. He was not seen until 7/2/15, more than 30 days after the previous contact on 5/26/15. Accordingly, this file should have been listed as noncompliant.

Prisoner [redacted] is also listed as compliant, allegedly receiving a clinician contact on 6/24/15. However, there is no note in his file corresponding to that date. He did receive a 1:1 on 6/1/15, but his previous appointment on 5/21/15 was canceled due to a lockdown, and there is no other contact within 30 days of 6/1/15. This file is noncompliant.

Measure 9

This Measure requires that "MH-3A prisoners who are prescribed psychotropic medications shall be seen a minimum of every 90 days by a mental health provider." The following files were listed as compliant with this Measure; in fact, they are not:
June 2015 [ADCM120856-57]:

1. [redacted] (seen 5/21/15 and 1/21/15);
2. [redacted] (seen 4/23/15; no other provider contact in 2015);
3. [redacted] (seen 4/15/15; no other provider contact in 2015);
4. [redacted] (seen 4/8/15; no other provider contact in 2015);
5. [redacted] (seen 5/13/15; no other provider contact in 2015).

In addition, prisoner [redacted] is listed as compliant, purportedly receiving a provider contact on 5/27/15. But this prisoner's record lists no encounters, and he was apparently discharged from ADC in 1989. This appears to be an error.

Measure 11

The following files listed as compliant in the June CGAR are not:

1. [redacted] (qualifying diagnosis; telepsychiatry contact 5/27/15; no other provider contact in 2015);
2. [redacted] (qualifying diagnosis; seen 6/11/15; no other provider contact in file).

In the case of prisoner [redacted] three other provider appointments in May and June of 2015 were canceled (6/10/15, cell searches; 5/27/15, told patient refused but couldn't confirm; 5/11/15, unable to meet with patient due to time constraints/record unavailable).[1]

[1] Cancellation of mental health appointments due to security staff shortages and for other non-clinical reasons appears to be a common occurrence. *See* Prisoner [redacted] 6/25/15 ("Attempted to meet w/pt for scheduled appt. Pt. not brought to appt. by security"), listed as compliant for Mental Health # 5 (timely update of mental health treatment plan), ADCM120853;

Prisoner File Review – Mental Health Treatment Not in Accord With Stipulation

The following are additional examples of prisoners whose mental health care was noncompliant with the Stipulation and/or deficient in other significant respects.

[redacted]
Mr. [redacted] is classified as MH3-A and SMI. As of 9/4/15, he had not been seen by the provider since 6/4/15 (MH Measure 9). His treatment plan was not updated between 2/16/15 and 8/11/15; the latter encounter lasted 51 seconds (MH Measures 5, 6). A 9/9/15 advocacy letter from David Fathi to Daniel Struck, attached hereto and to which we have received no response, sets forth additional serious deficiencies in the mental health care provided to this prisoner.

[redacted]
Mr. [redacted] is diagnosed with major depressive disorder and classified as MH3-B. He was on suicide watch from 6/26/15 to 7/2/15 after he cut his arm. He was not seen by mental health staff for four days after being put on watch, and was only seen twice, 6/30 and 7/1. (MH Measure 22). There also is no documentation of any encounters with mental health staff between 3/19/15 and 5/20/15, even though he was housed at the MDU. (MH Measure 20). Despite the placement on suicide watch, and the fact that he is on psychotropic medication for depression, Mr. [redacted] last psychiatrist appointment was 3/19/15, when his Paxil was increased because he reported worsening symptoms of depression. (MH Measure 11). A 9/21/15 advocacy letter from Corene Kendrick to Daniel Struck, attached hereto and to which we have received no response, sets forth additional serious deficiencies in the mental health care provided to this prisoner.

[redacted]
Mr. [redacted] is classified as MH3-A and SMI. He was seen by the clinician on 4/7/15, 5/21/15, 6/18/15, and 8/13/15 (MH Measure 8). He was seen by the provider on 4/8/15; as of 9/4/15, he had not been seen again (MH Measure 9). On 4/8/15, Dr. Rawa noted, "took for [sic] a couple months not getting the Celexa after transfer from Barchey to Rast." As of 9/4/15 his treatment plan had not been updated since 1/27/15 (MH Measure 5). He reported to us in an interview that the he suffers from dizziness and exhaustion in the heat, and does not go outside because

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Prisoner [redacted] 7/14/15 ("Pt. scheduled for appt. Unable to meet with pt due to staff/security shortage per Lt. Whiting"); Prisoner [redacted] 7/14/15 ("Pt scheduled for appt. Unable to meet with pt due to staff/security shortage per Lt. Whiting"). (The last two prisoners were on the master list of all MH-3 and above prisoners provided prior to the tour).

It also appears that the patient's records are frequently unavailable to mental health staff. *See, e.g.,* Prisoner [redacted] 8/19/15 ("med hist, chart, eomis, and scale unavailable. No previous documentation available"); Prisoner [redacted] 6/3/15 ("Eomis unavailable" "Pt presents for HNR, currently unavailable"); Prisoner [redacted] 8/11/15 ("chart, eomis, and scale unavailable"); Prisoner [redacted] 8/11/15 ("Met w/pt at SDU, eomis and scale unavailable"); Prisoner [redacted] 7/21/15 ("Met w/pt at SDU, eomis and scale unavailable"); Prisoner [redacted] 3/4/15 ("no chart").

prisoners are sent outside for three hours and are not allowed to come in sooner. His post at Rast MDU (2-A) does not have a list of prisoners on heat medications who should be allowed to return to the unit sooner. He said that officers regularly test the heat in his cell and it is often over 90 degrees.

[redacted] is classified as MH3-A and SMI. She was not seen by the provider between 2/25/15 and 6/3/15, and as of 9/4/15 had not been seen since 6/3/15 (MH Measure 9). On that date, the SOAPE notes' sections for O and A are empty, which calls into question whether she was seen that day. Her treatment plan was not updated between 11/7/14 and 7/30/15 (MH Measure 5). She reported that she is on Zoloft and she suffers from exhaustion and dizziness from the heat in her cell.

[redacted] is classified as SMI and MH3-A. He has not received a clinician contact every 30 days as required (seen 6/4/15 and 7/6/15) (MH Measure 8). In addition, a 4/8/15 note by Moonjelly states "Lithium level ordered in Jan. 2015, not done yet."

[redacted] is classified as SMI and MH3-A. He has not received a clinician contact every 30 days as required (seen 7/27/15 and 8/27/15) (MH Measure 8).

[redacted] is classified as SMI and MH 4. He is not receiving the monthly 1:1 sessions with a clinician required by MH Measure 15 (seen on 6/29/15 and 8/22/15).

[redacted]' diagnoses include depressive psychosis. He was classified MH3-C, and has not been seen by the provider since 1/21/15 (MH Measure 12). On 7/14/15 the mental health clerk changed his diagnosis to MH3-D, but he was not seen by the provider within 30 days of discontinuing medication (MH Measure 13).

On 5/20/15, Mr. [redacted] submitted an HNR that said the following:

> I was taken off my medication and since then I have been experiencing some personal issues. I have requested to speak to the psych associate well over two months now and I still haven't seen him. I would like to speak to the psych associate as soon as possible.

On 5/27/15, a response to Mr. [redacted] HNR stated "you will be scheduled for the next available appointment." As of 9/3/15, no appointment had occurred.

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[2] [redacted] is a transgendered female who identifies as a woman, and prefers the use of female pronouns and her chosen name.

[redacted] is classified as SMI and MH3-A. He was last seen by the provider on 4/30/15 (MH Measure 9).

[redacted] is classified as SMI and MH3-A. He was seen by a clinician on 5/21/15 and 8/12/15 (MH Measure 8).

[redacted] is classified as SMI and MH3-A. His diagnoses include psychotic disorder NOS.

On 8/20/15, Dr. Shaw wrote the following note:

> Patient seen at cell as he appeared somewhat agitated and behaviorally unstable. His speech was coherent, but seemed rambling and unfocused. Had smeared butter on the lexan windows in the cell door, and staff reported that he had tied a sheet around his neck like a cape and that he had been running and jumping around his cell.

Dr. Shaw further noted, "Appeared at times to be responding to internal stimuli."

On 8/28/15, RN Bojaj wrote the following note:

> IM's mood was congruent with his affect: fearful/paranoid; disorganized. IM presented delusional as usual; and paranoid.

Despite these repeated staff observations of Mr. [redacted] decompensated state, as of 9/3/15 there had been no follow-up by a psychiatrist.

[redacted] is classified as SMI and MH3-A. His diagnoses include schizoaffective disorder. Mr. [redacted] was last seen by the provider on 5/20/15 (MH Measure 9).

[redacted] is classified as SMI and MH3-A. His diagnoses include major depressive disorder, recurrent, severe with psychotic features. Mr. [redacted] was last seen by the provider on 5/20/15 (MH Measure 9).

[redacted] is classified as SMI and MH3-A. His diagnoses include bipolar disorder. He was not seen by the provider between 3/5/15 and 6/17/15 (MH Measure 9). His treatment plan was not updated between 4/8/15 and 7/8/15 (MH Measure 5). In addition, the 4/8/15 review states that

he was "seen in recreation and socialization group," rather than in a "face to face clinical encounter" as required by MH Measure 6.

[redacted]
The CQI minutes (ADCM121116) state that Mr. [redacted] "attempted suicide 7/22/15." However, the only mental health note in his file for 7/22/15, by an unlicensed staff person, states that Mr. [redacted] reported that he was attacked and almost raped; there is no mention of a suicide attempt and no placement on suicide watch – indeed, Mr. [redacted] is assessed as "stable."

The next mental health note is 7/24/15, stating that Mr. [redacted] is on continuous suicide watch and "tried to hang himself." Either there is an error in the date of Mr. [redacted] attempted suicide in the CQI minutes, or there was a two-day delay before this suicide attempt came to the attention of mental health staff.

[redacted]
Mr. [redacted] is classified as SMI and MH3-A. His diagnoses include schizoaffective disorder. His 6/2/15 treatment plan update provides no indication that it was done after a face-to-face clinical encounter (MH Measure 6).

In addition, the CQI minutes state that Mr. [redacted] "attempted suicide 7/9/15" (ADCM 121116). But the only mental health note in his file on that date is by psych tech Phillips, stating "IM housed in watch pod; not seen by PT." As with Mr. [redacted] either there is an error in the date of Mr. [redacted] suicide attempt in the CQI minutes, or it was not promptly brought to the attention of mental health staff.

[redacted] is classified as SMI and MH3-A. He was not seen by the provider between 3/4/15 (when Dr. Rawa noted "no chart") and 8/6/15 (MH Measure 9). His 7/3/15 treatment plan review by Dr. Shaw indicates "see clinical note dated 7/3/15," but there is no note by Dr. Shaw on that date, and no indication that Dr. Shaw completed the treatment plan review after a face-to-face clinical encounter with Mr. [redacted] (MH Measure 6).

[redacted] is classified as SMI and MH3-A. His diagnoses include schizoaffective disorder. He was not seen by the provider between 3/20/15 and 8/19/15 (MH Measure 9). In addition, on 3/20/15, Dr. Rawa noted "doing alright but not getting rx post transfer from Bachman to Barchey." On 8/19/15, Ms. Nadeau noted "Med hist, chart, eomis, and scale unavailable. No previous documentation available." In addition, Mr. [redacted] treatment plan was not updated between 4/21/15 and 8/6/15 (MH Measure 5).

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[redacted] is classified as SMI and MH3-A. His diagnoses include psychotic disorder NOS. Mr. [redacted] was not seen by the provider between 3/18/15 and 7/24/15 (MH Measure 9). His treatment plan was not updated between 2/23/15 and 6/10/15 (MH Measure 5).

[redacted] is classified as MH3-B; his diagnoses include psychotic disorder NOS. He was not seen by the clinician between 4/3/15 and 7/16/15 (MH Measure 10). As of 9/4/15 he had not been seen by the provider since 5/27/15 (MH Measure 11).

[redacted] has been diagnosed as bipolar and determined to be SMI. He takes medications to control his symptoms, but he does not remember what the medications are. He has run out of his pysch medications and reports that it took psych two months to reorder them. (Pharmacy # 2, MH # 1, 7). These medications make him susceptible to heat and he will skip pill pass on hot days because he has to wait for too long in the heat. (¶ 15).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 4/21/15 and 5/22/15, or between 7/16/15 and 8/25/15 (MH Measure 8).

[redacted] is classified as MH3-A and SMI. His treatment plan was not updated between 12/30/14 and 7/30/15 (MH Measure 5).

[redacted] is classified as MH3-B; his diagnoses include paranoid schizophrenia, and he is prescribed Haldol. As of 9/4/15 he had not seen the provider since 5/20/15 (MH Measure 11).

[redacted] is classified as MH3-A and SMI. His treatment plan was not updated between 12/16/14 and 7/30/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 7/23/15 and 8/26/16 (MH Measure 8). His treatment plan was not updated between 3/25/15 and 6/25/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 4/2/15, 5/7/15, and 6/25/15 (MH Measure 8). Although he is prescribed medication, as of 9/4/15 he had not been seen by provider since 5/20/15 (MH Measure 9). His treatment plan was not updated between 3/13/15 and 6/25/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 3/11/15 and 5/7/15, or between 6/4/15 and 7/29/15 (MH Measure 8).

[redacted] is classified as MH3-A and SMI. His treatment plan was not updated between 2/13/15 and 6/10/15 (MH Measure 5). He was seen by the clinician on 2/13/15, 4/22/15, 6/9/15, 7/7/15, and 8/26/15 (MH Measure 8).

[redacted] is classified as MH3-A and SMI. His treatment plan was not updated between 2/2/15 and 6/25/15 (MH Measure 5). He was not seen by the clinician between 4/14/15 and 6/25/15 (MH Measure 8).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 4/2/15 and 5/7/15, or between 6/4/15 and 7/29/15 (MH Measure 8).

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 1/16/15, 4/2/15, 5/7/15, and 7/29/15 (MH Measure 8). He was not seen by the provider between 2/19/15 and 6/3/15, and as of 9/4/15 had not been seen since 6/3/15 (MH Measure 9). His treatment plan was not updated between 4/2/15 and 7/29/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 6/16/15 and 7/30/15 (MH Measure 8). His treatment plan was not updated between 4/22/15 and 7/30/15 (MH Measure 5). As of 9/4/15 he had not seen the provider since 5/8/15 (MH Measure 9). On 5/8/15, the provider noted, "there is no treatment plan in his chart for my review" (MH Measure 7).

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 4/2/15, 5/7/15, 6/4/15, and 7/29/15 (MH Measure 8). He was not seen by the provider between 5/13/15 and 8/26/15 (MH Measure 9). His treatment plan was not updated between 4/2/15 and 7/29/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 3/6/15, 4/7/15, and 6/18/15 (MH Measure 8). He was not seen by the provider between 12/17/14 and 5/27/15 (MH Measure 9).

[redacted] is classified as MH3-A and SMI. He was not seen by the provider between 4/15/15 and 8/19/15 (MH Measure 9). His treatment plan was not updated between 11/7/14 and 7/30/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 4/7/15 and 7/2/15 (MH Measure 8). His treatment plan was not updated between 11/7/14 and 7/30/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 5/5/15 and 6/24/15, and as of 9/4/15 had not been seen since 6/24/15 (MH Measure 8). When he was seen by the provider on 8/6/15, she noted that "after meeting w/pt was informed that medication has not been delivered for injection due today." While the record purports to show that his treatment plan was updated on 6/24/15 and 8/20/15, these encounters lasted 28 seconds and 56 seconds, respectively. Such brief and perfunctory encounters do not satisfy the requirement that the treatment plan be updated after a "face-to-face clinical encounter between the prisoner and the mental health provider or mental health clinician" (MH Measure 6).

[redacted] is classified as MH3-A and SMI. He was not seen by the clinician between 7/15/15 and 9/1/15 (MH Measure 8). In addition, the 9/1/15 encounter lasted approximately 90 seconds. As we have previously pointed out (see 7/14/15 Eidenbach letter at 22), such brief encounters do not satisfy the definition of "seen" set forth in Appendix A to the Stipulation.

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 3/27/15, 7/27/15, and 9/2/15; in addition, the 9/2/15 encounter lasted less than two minutes (MH Measure 8). The only treatment plan in his record is dated 9/2/15 (MH Measure 5).

[redacted] is classified as SMI and MH3-A. He was seen by the clinician on 5/13/15, 6/25/15, and 8/12/15 (MH Measure 8). He was not seen by the provider between 3/26/15 and 7/21/15 (on 7/14/15, the provider noted, "Pt. scheduled for appt. Unable to meet with pt. due to staff/security shortage per Lt. Whiting") (MH Measure 9).

[redacted] is classified as MH-3A and SMI. He was not seen by the clinician between 4/2/15 and 7/17/15 (MH Measure 8). As of 9/4/15, he had not been seen by the provider since 5/8/15 (MH Measure 9), and his treatment plan had not been updated since 4/2/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was seen by the clinician on 3/30/15, 5/8/15, 6/30/15, 7/10/15, and 8/12/15 (MH Measure 8). He was not seen by the provider between 3/6/15 and 8/11/15 (MH Measure 9). As of 9/4/15, his treatment plan had not been updated since 5/8/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. He was not seen by the provider between 3/17/15 and 7/21/15 (MH Measure 9). As of 9/4/15, his treatment plan had not been updated since 5/8/15 (MH Measure 5).

[redacted] is classified as MH3-A and SMI. On 4/9/15, the provider noted, "been w/o meds for a month. Unsure why not receiving." The provider reordered his medications, but as of 9/4/15 he had not been seen again by the provider since 4/9/15 (MH Measure 9). As of the same date, his treatment plan had not been updated since 5/19/15 (MH Measure 5).

[redacted]
On 9/2/15, we saw Mr. [redacted] on watch in Rast Max. Although he was on a 10-minute watch, the checks were not consistently being done every 10 minutes (for example, there were no checks between 6:43 and 7:00 a.m.). In addition, although we reviewed his watch log at 11:00 a.m., it purported to show that a check had been done at 11:05 a.m., casting serious doubt on the veracity of the logs.

Mortality Reviews Identifying Deficiencies in Care – Florence and Lewis

Florence

[redacted] died on [redacted] from complications of metastatic colon cancer. Co-existing conditions were the cancer had metastasized to his liver and lungs, he had severe malnutrition and deconditioning, anemia, malignant pleural effusion and respiratory failure, and coccygeal decubitus ulcer. Dr. Johnson (Florence Medical Director) concluded that his death could have been prevented or delayed by more timely intervention, noting that Mr. [redacted] "repeatedly and consistently complained of bowel issues for 2 months. He was not seen by GI until 2 months after his initial complaints." Deficiencies identified were (1) failure to recognize symptoms or signs; (2) failure to follow clinical guidelines; (3) diagnosis inaccurate; (4) diagnosis and treatment not timely, and (5) inappropriate treatment. ADCM0328221-24.

According to the mortality review, Mr. [redacted] reported he had been experiencing bowel problems for two months, but it took another two months to be seen by a provider. The provider put him on antibiotics and steroids because they thought he had Crohn's Disease or ulcerative colitis. Three months later, he "was discovered to have poorly differentiated colon adenocarcinoma with multiple metastatic lesions in his liver, lungs, and bones." Dr. Johnson notes there was also a one month delay between a referral for a colonoscopy and the actual colonoscopy. According to Dr. Johnson, Mr. [redacted] received a chemo port within 3 days of the cancer diagnosis, and then oncology and surgery were consulted and he began chemotherapy (no dates given). Mr. [redacted] developed a pleural effusion in his lung, was hospitalized and declined all future care. "He was made DNR/DNI and was transferred to Promise facility" for hospice care and he died three days later.

Lewis

[redacted] died on [redacted] of heroin toxicity. The Mortality Report notes that he had co-existing conditions of diabetes, hyperlipidemia, and HCV, and ADC Medical Program Administrator Dr. Rowe wrote in his 7/28/15 review that "Chronic care for patients with diabetes should be more timely and frequent especially when not controlled." ADCM120633-36.

Lewis – Analysis of "To Be Scheduled and Scheduled Specialty Care Appointments"
ADCM120999-121010

Urgent Specialty Referrals Requested Prior to May 30, 2015 and Still Listed as "Scheduled" as of August 18, 2015 (All Entries Not in Compliance With Specialty #3)
3/3/15 – [redacted], Health– urgent hematology/oncology consultation requested, status listed is "Scheduled"

4/7/15 – [redacted], Barchey– urgent pulmonology consultation requested, status listed is "Scheduled"

4/20/15 – [redacted] Morey– urgent abdominal ultrasound requested, status listed is "Scheduled"

5/21/15 - [redacted], Rast– urgent oral surgery consult requested, status listed is "Scheduled"

Referrals for Rheumatology Still Listed as "Pending" and not "Scheduled" as of August 18, 2015 (Highlighted Entries Not in Compliance With Specialty # 4)
2/25/15 – [redacted] Barchey

3/6/15 – [redacted], Buckley

4/9/15 – [redacted], Buckley

5/26/15 – [redacted] Stiner

5/29/15 – [redacted] Rast

6/3/15 – [redacted], Stiner

6/5/15 – [redacted] Morey

6/25/15 – [redacted] Stiner

7/12/15 – [redacted] Health Unit

8/13/15 – [redacted] Rast Max[3]

[3] Plaintiffs' counsel interviewed Mr. [redacted] and reviewed his medical record and notified Defendants of his urgent medical and mental health needs in a 9/21/15 advocacy letter, attached hereto, to which we have received no response.

Referrals for Infectious Disease Still Listed as "Pending" and not "Scheduled" as of August 18, 2015 (Highlighted Entries Not in Compliance With Specialty # 4)

No request date listed – [redacted] Barchey

3/17/15 – [redacted], Bachman

4/27/15 – [redacted] Barchey

5/6/15 – [redacted] Stiner

5/28/15 – [redacted] Stiner

6/3/15 – [redacted], Eagle Point

6/16/15 – [redacted] Buckley[4]

6/17/15 – [redacted] Stiner

7/2/15 – [redacted], Barchey

7/10/15 – [redacted] Bachman

7/12/15 – [redacted] Bachman

8/10/15 – [redacted], Barchey

8/12/15 – [redacted] Stiner (see also 6/17/15 request)

8/13/15 – [redacted], Rast Max
[redacted] Stiner

[4] Counsel for Plaintiffs have notified ADC multiple times (two expert reports, six advocacy letters) about delays in infectious disease consults and delivery of HIV medication for Mr. [redacted]

Spot-Check of June 2015 Lewis CGAR Access to Care # 5

Are urgent provider referrals being seen by the Medical Provider within 24 hours of the referral?

CGAR finding: (ADCM120825)
Worksheets: (Rast – ADCM122143, Stiner - ADCM122153, Eagle Point - ADCM122155)

Rast Unit
Seven of seven files found compliant, but for six of them there were no referrals or encounters in eOmis that corresponded with the dates for referrals and medical provider encounters stated on the monitor's worksheet. For the seventh, the prisoner saw a nurse on the day listed for an emergency response, but there is no provider encounter.

- [redacted] the auditor found compliance based on a 6/22 referral and a 6/22 Medical Provider encounter. The eOmis records shows that on 6/22 a Registered Nurse saw the patient as a result of an ICS (emergency) response, but made no referral to a provider (the nurse got a verbal order).
- [redacted] the auditor found compliance based on a 6/6 referral and 6/6 Medical Provider encounter. No records of any such referral or encounter found in eOmis.
- [redacted] the auditor found compliance based on a 6/24 referral and 6/24 encounter. No records of any such referral or encounter found in eOmis.
- [redacted] the auditor found compliance based on a 6/24 referral and 6/24 encounter. No records of any such referral or encounter found in eOmis.
- [redacted] the auditor found compliance based on a 6/24 referral and 6/24 encounter. No records of any such referral or encounter found in eOmis.
- [redacted] the auditor found compliance based on a 6/10 referral and 6/10 encounter. No records of any such referral or encounter found in eOmis.
- [redacted] the auditor found compliance based on a 6/10 referral and 6/10 encounter. No records of any such referral or encounter found in eOmis.

Stiner Unit
Nine of ten files found compliant, but none of the ten were relevant to the performance measure:

- [redacted] – no provider appointments documented in eOmis for June (listed as noncompliant on CGAR).
- [redacted] – 6/4 provider appointment was follow up from rheumatology appointment, no nursing referral documented, not relevant to performance measure
- [redacted] – 6/4 provider appointment was follow up from telemed, no nursing referral documented, not relevant to performance measure
- [redacted] – 6/4 provider appointment was follow up from telemed, no nursing referral documented, not relevant to performance measure
- [redacted] – 6/5 provider appointment was chronic care appointment, no nursing referral documented, not relevant to performance measure

- [redacted] – no 6/10 provider appointment as listed in monitor's notes; there was a 6/11 provider's line appointment but no nursing referral documented, not relevant to performance measure
- [redacted] – no 6/30 provider appointment as listed in the monitor's notes, prisoner had a dental appointment
- [redacted] – no 6/30 provider appointment as listed in the monitor's notes, prisoner had a dental appointment
- [redacted] - no 6/30 provider appointment as listed in the monitor's notes, prisoner had a dental appointment
- [redacted] - no 6/30 provider appointment as listed in the monitor's notes, prisoner had a dental appointment

Eagle Point/Sunrise Unit

One file marked as compliant, but is not relevant to this measure

- [redacted] – 6/25 no provider appointment as listed in the monitor's notes, prisoner had a dental appointment

Spot-Check of June 2015 Lewis CGAR Access to Care # 6 (Emergency Referrals)

Prisoner #[redacted] not relevant to performance measure as the nurse had marked the referral as urgent, not emergent.

Language Interpretation: Prisoner File Review Notes

[redacted] **(no interpreter at 3 out of 6 encounters)**

He is listed on the interpreter phone logs as having a 31 minute encounter on 3/26/15 at 18:49, but there are no health care encounters included in eOmis for that date other than "system generated conversion."

1. 4/9/15 – NP McGarry provider line. No interpreter documented, encounter not on phone log.
2. 4/22/15 – routine dental appt. with Dr. Weekly in response to 2/11/15 HNR. No interpreter documented, encounter not on phone log.
3. 5/22/15 – nurse intake after arriving 5/18/15 at North Unit. No interpreter documented, encounter not on phone log.
4. 7/17/15 – nurse intake exam with RN Madrid.
5. 8/18/15 – NL with RN Madrid.
6. 8/19/15 – telemedicine appt w/ provider re: injury – provider Christina Boryczka, she documents in record that the nurse (Madrid?) provided interpretation.

[redacted] **(no interpreter at 2 out of 4 encounters)**

He is listed on the phone logs as having encounters with interpreter on 3/5, 3/10, 3/20, and 4/24/15. However, there are no health care encounters listed in eOmis as occurring on 3/5, 3/10, or 3/20. On 3/5/15 a lab test was ordered, 3/10 and 3/20 are listed as "system-generated pharmacy order"

1. 4/2/15 – provider Johnson requested an off-site specialty referral for a testicular ultrasound. There are no notes of any kind showing an encounter occurred with Johnson on that date, so it's unclear whether an interpreter was used. No interpreter documented, encounter not on phone log.
2. 4/14/15 – return from off-site hospital, seen by RN Palmer. No interpreter documented, encounter not on phone log.
3. 4/24/15 – follow up re: ultrasound with provider. Used phone interpreter, documented in phone logs.
4. 5/28/15 – apparently in the interim moved to North Unit. Seen on NL by RN Madrid.

[redacted] **(no interpreter at 4 out of 8 encounters)**

1. 2/22/15 – dental follow up to tooth extraction. No interpreter documented, encounter not on phone log.
2. 2/23/15 – dental follow up to tooth extraction. No interpreter documented, encounter not on phone log.
3. 2/26/15 – CC appointment w/ NP McGarry. Used phone interpreter (don't have the phone log for February, but she made a note of that in her SOAPE notes) to discuss his HGB-A1C levels being too high, not a candidate for surgery.
4. 3/11/15 – NL with RN Madrid re hernia pain.
5. 3/30/15 – Provider appt w/ NP McGarry. Used phone interpreter, on phone log.
6. 4/8/15 – saw nurse re SNO. No interpreter documented, encounter not on phone log.

7. 4/19/15 – NL re SNO request. No interpreter documented, encounter not on phone log.
8. 4/21/15 – NL w/ RN Madrid re: knee pain.

[redacted] **(no interpreter at 4 out of 5 encounters).**

He is listed on the phone logs as having an encounters with interpreter on 3/5. However, there are no health care encounters including in eOmis as occurring that date, only "conversion"

1. 4/13/15 – return from offsite, seen by RN Palmer. No interpreter documented, encounter not on phone log.
2. 4/22/15 –dental appt w/ Dr. Weekly. No interpreter documented, encounter not on phone log.
3. 4/24/15 – follow up with NP Maranzano re: ultrasound result. No interpreter documented, encounter not on phone log.
4. 5/1/15 – saw RN Palmer re: lab results. No interpreter documented, encounter not on phone log.
5. 7/8/15 – dental appt w/ Dr. Weekly. No interpreter documented, encounter not on phone log.

[redacted] **(no interpreter at 3 out of 6 encounters)**

1. 3/5/15 – saw NP McGarry with use of phone interpreter – documented in medical record and on language log.
2. 3/13/15 – NL, saw RN Tiernan, no interpreter documented, encounter not on phone log
3. 3/16/15 – NL w/ Nurse Backous, no interpreter documented, encounter not on phone log
4. 5/8/15 – NL sick call with RN Madrid.
5. 5/12/15 – NL – saw RN Madrid re: injury.
6. 5/28/15 – provider appt w/ NP McGarry, no interpreter documented, encounter not on phone log. NOTE: unclear if he was actually seen, because there are no vitals, no documentation or SOAPE notes of an encounter/exam with him.

[redacted] **(two encounters, both with interpreter)**

CC patient: diabetic

1. 3/4/15 – CC appt w/ NP McGarry with use of phone interpreter – documented in medical record and in phone log.
2. 5/19/15 – CC appt w/ NP McGarry who documented that she used RN Madrid as the interpreter.

[redacted] **(no interpreter at 8 out of 8 encounters).**

He is listed in interpreter phone logs as having interpreter at encounters on 3/6/15 and 3/26/15, but there are no appointments or other health care encounters in eOmis for those dates.

1. 6/5/15 – NL seen by RN Palmer re: head contusions. No interpreter documented, encounter not on phone log.

2. 6/15/15 – saw NP Armenta. She states in the SOAPE notes that Mr. [redacted] is Spanish speaking, but it's unclear if she speaks Spanish. No interpreter documented, encounter not on phone log.
3. 6/22/15 – isolation mental health check by RN Delgado. Unknown if RN Delgado speaks Spanish. No interpreter documented, encounter not on phone log.
4. 6/29/15 –isolation MH check by RN Delgado. No interpreter documented, encounter not on phone log.
5. 7/8/15 –isolation MH check by clerk Anthony Lynn. No interpreter documented, encounter not on phone log.
6. 7/17/15 – isolation MH check by Behrend. No interpreter documented, encounter not on phone log.
7. 7/20/15 – isolation MH check by CNA Amber Wilson. No interpreter documented, encounter not on phone log.
8. 8/3/15 – isolation MH check by CNA Wilson. No interpreter documented, encounter not on phone log.

[redacted] **(no interpreter at 19 out of 23 encounters).**

1. 3/12/15 – saw NP McGarry with use of phone interpreter – documented in medical record and on language log.
2. 3/30/15 – saw NP McGarry, no interpreter documented, encounter not on phone log
3. 4/2/15 – saw NP McGarry with use of phone interpreter – documented in medical record and on language log.
4. 4/12/15 – NL call w/ Nurse Brinton. No interpreter documented, encounter not on phone log.
5. 4/15/15 – dental appt w/ Dr. Weekly. No interpreter documented, encounter not on phone log.
6. 4/28/15 – saw NP McGarry. No interpreter documented, encounter not on phone log.
7. 5/7/15 – NL w/ RN Madrid.
8. 5/11/15 – NP McGarry. No interpreter documented, encounter not on phone log.
9. 6/10/15 – dental appt. No interpreter documented, encounter not on phone log.
10. 7/13/15 – dental appt. No interpreter documented, encounter not on phone log.
11. 7/24/15 – NL sick call. No interpreter documented, encounter not on phone log.
12. 7/26/15 – ICS response vomiting for three days. Seen by mental health RN Bainbridge. No interpreter documented, encounter not on phone log.
13. 7/27/15 – sick call. No interpreter documented, encounter not on phone log.
14. 7/28/15 – isolation MH check by Behrand. No interpreter documented, encounter not on phone log.
15. 7/29/15 – isolation MH check by Behrand. No interpreter documented, encounter not on phone log.
16. 7/29/15 – NL sick call. No interpreter documented, encounter not on phone log.
17. 7/30/15 – seen by NP Maranzano. No interpreter documented, encounter not on phone log.

18. 8/3/15 – isolation MH check by Behrand. No interpreter documented, encounter not on phone log.
19. 8/4/15 - – isolation MH check by Behrand. No interpreter documented, encounter not on phone log.
20. 8/6/15 - – isolation MH check by Behrand. No interpreter documented, encounter not on phone log.
21. 8/9/15 – NL sick call w/ Nurse Baller. No interpreter documented, encounter not on phone log.
22. 8/13/15 – dental appt. w/ Weekly. No interpreter documented, encounter not on phone log.
23. 8/13/15 – was transferred back to North Unit. Saw RN Madrid, who took his vitals.

[redacted] **(no interpreter for 4 out of 7 encounters)**

1. 3/11/15 –intake dental exam by Dr. Weekly. No interpreter documented, encounter not on phone log.
2. 3/24/15 – provider encounter with use of phone interpreter. Documented in medical record and on language line.
3. 5/18/15 – nursing intake exam with LPN Garcia.
4. 5/24/15 – ICS by RN Brinton re: low blood sugar. No interpreter documented, encounter not on phone log.
5. 6/25/15 –dental appt. No interpreter documented, encounter not on phone log.
6. 8/14/15 – saw Dr. Sharp for CC appointment. No interpreter documented, encounter not on phone log.
7. 8/22/15 – NL sick call w/ RN Madrid in response to HNR filed 8/20.

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Our review of prisoners' records at Lewis and Florence revealed additional instances in which language interpretation required by paragraph 14 of the Stipulation was not provided:

[redacted] is listed on the June language log (ADC121250) as having Spanish interpretation for three minutes at 7:45 am on April 1. (It is unclear why the April encounter is listed on the June logs). We reviewed his file and he had two encounters with health care staff (6/17/15 provider, 6/20/15 nursing), with no indication that an interpreter was used. Neither of these encounters are listed on the June 2015 language log.

[redacted] is a Mexican national and does not speak English fluently. See 6/18/15 note by Moonjelly ("Inmate is Spanish speaking with few broken words of English"). However, he was seen by Pedretti on 6/29/15, with no indication that an interpreter was provided. Neither of these encounters appear on the June 2015 language log. (ADCM121250)

[redacted] is a Mexican national and does not speak English fluently. He has not been provided the required interpretation for health care encounters. See notes dated 8/22/15 ("I/M has language barrier which affected assessment"); 8/25/15 ("IM seen on 30" MHW. Interpretation provided by CO to facilitate accurate assessment"); 9/4/15 ("I/M was tearful. Mostly Spanish speaker").

[redacted]
We interviewed Mr. [redacted] and confirmed that he does not speak English. He has not had interpretation for medical, dental, or mental health encounters.

- 8/14/15 – saw nurse McConkey on NL. No documentation of Spanish interpreter.
- 7/29/15 – dental refusal. No documentation of Spanish interpreter.
- 7/23/15 – CC appt with Dr. Malacheski. No documentation of Spanish interpreter.
- 7/10/15 – refused MH individual counseling with Angela Scott at Stiner CDU. No documentation of Spanish interpreter.
- 6/15/15 – MH individual counseling with Angela Scott at Stiner CDU. Says that his speech was WNL and logical thought process, but no other information in the SOAPE notes. No documentation of Spanish interpreter.
- 6/1/15 – nurse Barrow MH cell check: "no complaints" - No documentation of Spanish interpreter.
- 5/29/15 - nurse Barrow MH cell check: "no complaints" - No documentation of Spanish interpreter.
- 5/27/15 - nurse Barrow MH cell check: "no complaints" - No documentation of Spanish interpreter.
- 5/22/15 - nurse Barrow MH cell check: "no complaints" - No documentation of Spanish interpreter.
- 5/20/15 – nurse Charmaine Rhodes MH cell check: "no complaints" - No documentation of Spanish interpreter.

[redacted]
We interviewed Mr. [redacted] and ascertained that he does not speak English, a fact that is confirmed by his record. See 9/22/14 entry by Newman ("due to the language barrier (and without a translator) this visit did not last very long"); 10/23/14 note by Roun ("due to language barrier, and no translator, the interview was short"). However, Mr. [redacted] was seen by Dr. Riaz on 5/5/15 and 8/11/15, with no mention of an interpreter. The May 5 encounter does not appear on the May 2015 language log. (ADCM121249)

[redacted]
An 8/24/15 note by Boryczka reads as follows:
"57 yo male (primarily Spanish speaking) here for f/u LTBI …. It was attempted to see the patient without an interpreter. Pt did not understand the questions and what I was saying without an interpreter present."

Prisoners Whose Documented Medical Care Does Not Comply With Stipulation Requirements

Advocacy Letters

We have previously notified you of prisoners whose medical records we reviewed at Lewis and Florence who are in need of immediate medical attention. The letters, attached hereto as Appendix C, detail their problems at length and the relevant stipulation requirements:

[redacted] Florence Central, 9/17/15 letter

- Delays in referral to urology and in chemotherapy for treatment of testicular cancer
- Specialty Care # 1, 3, 5; Chronic Care # 1

[redacted] Lewis Buckley, 9/25/15 letter

- Delays in being seen by nurse or provider despite numerous HNRs re: broken clavicle
- Access to Care # 1, 2, 6; Specialty Care # 5

[redacted], Lewis Rast MDU, 9/21/15 letter

- Inadequate treatment of psoriatic arthritis, osteomyelitis, anemia, large open wounds, unexplained weight loss of almost 90 pounds
- Chronic Care # 2, 4; Specialty Care # 1, 4, Access to Care # 7, Medical Diets # 1; Pharmacy # 2

[redacted], Florence South, 3/9/15 and 9/16/15 letters

- Delays in being seen by oncology for prostate cancer recurrence; inadequate post-surgery wound management; multiple delays or cancellation of provider's urgent requests for specialty care
- Chronic Care # 1, 3; Specialty Care # 1, 2, 3, 4, 6

[redacted] Florence Central, 9/17/15 letter

- Delay in referral to oculoplastic surgeon for broken bones in his face
- Specialty Care # 4

[redacted], Florence Central, 9/23/15 letter

- Inadequate management of diabetes and post-amputation medical care
- Access to Care # 9, Specialty Care # 3, 4, Chronic Care # 1

[redacted], Lewis Rast, 9/22/15

- Failure to monitor chronic condition of cancer, delay in access to nurse or provider lines, delay/cancellation of specialty referral for alarming symptoms
- Chronic Care # 1, 2; Specialty Care # 1, 3, 4; Access to Care # 2, 4, 5

[redacted] Florence Central, 9/17/15 letter

- Delay in treatment of throat cancer; delay in referral for PT scan and diagnostic tests
- Chronic Care # 1, Specialty Care # 1, 2, 5, 7

[redacted] Lewis Buckley, 9/23/15 letter

- Delay in treatment of prostate cancer that has now metastasized; failure to provide wasting diet; no response to HNRs
- Access to Care # 1, 2, 4; Specialty Care # 1, 3; Medical Diets # 1

[redacted] Lewis Rast MDU, 9/23/15 letter

- Delay in emergency specialty care, failure to follow discharging hospital recommendations
- Access to Care # 6, 8, 9

[redacted] Florence East, 9/17/15 letter

- Failure to provide monthly blood test to monitor lymphocyte levels or refer to oncology for possible relapse of leukemia.
- Chronic Care # 2, Specialty Care # 5, 6, 7

[redacted], Florence East, 9/18/15 letter

- Failure to provide diagnostic procedures and specialty treatment for ulcerative colitis
- Specialty Care # 3

[redacted], Florence South, 9/17/15 letter

- Failure to provide post-stroke medication, physical therapy, occupational therapy; failure to provide medical devices; no response to HNRs; failure to provide interpretation at health care encounters
- Stipulation ¶ 14; Access to Care # 1, 2; Specialty Care # 3, 5

[redacted] Florence South, 9/18/15 letter

- Failure to be seen by nurse or provider despite numerous HNRs re: broken hand.
- Access to Care # 1, 2, 6; Specialty Care # 4, 6

[redacted], Lewis Buckley, 10/12/15 letter

- Failure to install dialysis port per nephrologist instruction, delay in urgent consults
- Specialty Care # 1, 4, 5; Chronic Care # 1

[redacted] Florence North, 9/17/15 letter

- Delay in treatment of Stage 3 colorectal cancer; delay in diagnostic procedure and specialty referrals for metastasized cancer; failure to provide all chemotherapy / medication
- Specialty Care # 3, 4, 5; Chronic Care # 1; Pharmacy # 2

[redacted] Florence North, 9/18/15

- Failure to provide specialist's recommended treatment and medication for Buerger's disease
- Specialty Care # 3, 5; Pharmacy # 3, 7

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Additionally, we identified the following prisoners at Lewis and Florence with medical or dental care not in compliance with the Stipulation performance measures:

[redacted] Lewis Rast MDU
He has Hepatitis C. He saw NP Taylor for chronic care appointment on 8/13/15, previous CC appointment was 12/22/14. (Chronic Care # 2)

[redacted] has diabetes and seizure condition. He turned in a HNR in August, complaining of symptoms he says is related to diabetes. The Plan of Action, written on HNR, "seen 8/17/15 PL." (Access to Care # 1, 2). But he was not seen on the provider line; on that date he only had a urine sample collected. (Chronic Care # 2). He has not seen the results of that test. Two months ago, he had a blood draw, but hasn't gotten results of test. (Specialty # 8).

[redacted] has cancer of his sinuses. It appears there were delays in evaluating and diagnosing his condition, based on his interview and his med record. Until two months ago he had been housed on East Yard, where he complained for many months that he was experiencing bilateral pain and blockage in his ears, as well as nose bleeds. In his record, we found many HNRs re ear pain, including on 7/14/14, 8/21/14 and 10/30/14. He was told he had allergies and given decongestants. (Access to Care # 1, 2, 4). He was finally sent to an ENT on 2/20/15, who identified a mass in his sinuses. The ENT recommended a CT scan with contrast, which was not done until 5/7/15, and was done without contrast. (Specialty Care # 1, 3, 7) He underwent surgery in an attempt to remove the mass on about 7/13/15 and was finally diagnosed with cancer on 7/23/15. He just started receiving chemo, once a week. Mr. [redacted] is supposed to receive Morphine 4x/day. He reported that, on his first chemo day, he was awakened at 4 am and placed in a cage, where he waited 3 hours before he was taken to the cancer center in Phoenix. His drip chemo treatment took about five hours, and he returned to the prison around 4 pm. He was not provided his Morphine that morning, and was in considerable pain.

[redacted] was diagnosed with cancer while in county jail. In October 2014, ADC sent his for a biopsy. He reports he was scheduled to see oncology, but he says he was tricked into signing a refusal. He was told his appointment was with pysch, which he doesn't need to see, so he refused. His mass is currently causing headaches, numbness in his left arm, and pain in his back.

[redacted] had all of his top teeth pulled 6-7 months ago. After the extractions, he was informed that he was not eligible for dentures or a partial. (Dental # 3). Mr. [redacted] has been diagnosed with a mass in his lung. ADC radiographed his chest approximately 6 months ago. He has not been informed of the results and has not been seen for a follow-up appointment. (Specialty Care # 8). He saw the provider approximately 2 months ago for back and radiating pain. He was referred to a pain management specialist by NP Ende. When a new nurse practitioner took over, she cancelled the appointment without an exam. (Specialty Care # 1, 2). NP Ende never discussed Mr. [redacted] radiographs or lung mass.

[redacted] has had a growth on his testicle for more than a year, and has not had a requested ultrasound. (Specialty # 1, 4).

[redacted]
He had a back injury more than nine months ago that was so severe that he now has to rely upon a wheelchair. On 3/18/15 the Yuma provider requested lumbar spine MRI. The request was denied on 3/24/15 with alternate treatment plan of trying physical therapy first. There is no documentation that this denial was conveyed to Mr. [redacted] (Specialty # 2). There is no documentation of implementation of the alternate treatment plan either through a PT referral or actually seeing the PT. (Specialty # 2). On 6/25/15 the Lewis provider requested MRI of back injury. Listed as scheduled for 8/7/15, but no notes from the appointment or updated to show what happened at the appointment. (Specialty # 5). Mr. [redacted] reported that the MRI did not occur in August, because he was too tall for the machine. There was no record of a request for a referral to a facility with a larger MRI machine.

[redacted]
He has long QT syndrome, dysrhythmia, HCV, and a pacemaker. He has not had an echocardiogram since 5/20/14. He has two chronic care appointments listed as occurring on 6/8/15 and 7/20/15, but in both cases there are no SOAPE notes or any documentation of an encounter actually occurring other than the notation of vital signs taken by the nurse. (Chronic Care # 2)

[redacted]
He has lost 50 pounds in past year for unknown reasons, he has HCV and kidney problems. His medical record shows that he supposedly had three chronic appointments (1/29/15, 4/21/15, 7/27/15) with provider, in each one the only thing documented is his vital signs were taken; there are no SOAPE notes or any other individualized information showing an encounter occurred with the provider. (Chronic Care # 2) Medical records confirm a 50 lb weight loss – listed as 5'6" and 111 pounds. Has filed six HNRs, the responses to all of them say he will be seen. 8/18/15 – reaction to medication; 8/17/15 – blood in urine; 7/9/15 - requesting CC appt; 6/13/15

– requesting CC appt; 4/28/15 – status of blood and stool tests. (Chronic Care # 1, 2; Access to Care # 1, 2; Specialty Care # 8).

[redacted]
Mr. [redacted] is being treated for brain cancer. He also has a seizure condition, for which he takes Keppra. The night before our visit, several inmates in the Florence infirmary said, and Mr. [redacted] confirmed, that he had had a seizure. According to the prisoners, there was no nurse in the building when he started seizing, and the c/o called an ICS. There is supposed to be an RN stationed in the HU-8 at night. (Staffing # 1, 4; Infirmary Care # 5). Mr. [redacted] latest blood draw testing of Keppra levels was dated 3/19/15. (Chronic Care # 1, 2).

[redacted] has a history of brain cancer, and has experienced delays in receiving specialty treatment for a possible recurrence. According to his medical records, he saw specialists on 5/28/15 and 6/9/15, with a diagnosis of astrocytoma. He reports that he was not told the results of these tests (Specialty Care # 7, 8; Chronic Care # 4). He did not see the provider until 8/27/15, who ordered a follow up appointment in three months, but it is unclear if any requests were made for treatment of the astrocytoma. (Chronic Care # 1, 3).

[redacted] receives dialysis onsite at Central. His fistula clogged, and he received a temporary port several weeks ago. He needs to have a permanent port placed. Per his record, his 8/11/15 referral to the vascular surgeon was forwarded to UM on 8/16, and as of 9/1/15, was still pending approval. (Specialty Care # 1)

[redacted] He is listed as 5' 8" and 140 lbs on the Inmate Datasearch page, but he clearly weighs less than that now. He was standing in his underwear, and appeared very thin. He said that he had submitted two HNR's requesting a "wasting diet." He said that he eats all his food, and does not know why he is losing weight. His medical record contained one HNR dated 8/17/15, on which Mr. [redacted] wrote "want wasting diet." The nurse wrote in response, "you do not meet requirements." There was no documented nurse encounter. (Access to Care # 1, 2; Medical Diets # 1). His weight has not been taken since 3/19/15, when he weighed 137 lbs. (Access to Care # 3).

[redacted] has been diagnosed with multiple myeloma, stage II. His initial diagnosis was made in June 2011. His medical record indicates that "treatment [was] switched to velcade in 2013 and was lost to follow-up." (Specialty Care # 1, 5). Dr. Sharp submitted a plan to "accelerate onco referral" on June 16, 2015, noting that he'd "finally received the full oncology report from 2/4/2015." Mr. [redacted] was not seen until August 21, 2015. (Specialty Care # 3).

[redacted] takes medication to control his blood pressure. He went without these medications for 3 months. (Pharmacy # 2). He submitted multiple HNRs asking for refills. (Access to Care # 1, 2). Then, without telling him or scheduling an appointment with a nurse or provider, they changed his medication. (Chronic Care # 1, 2).

[redacted] has numerous medical conditions, including kidney disease, HCV, HBV, and hypertension. He also has a prosthetic eye, and glaucoma in his remaining eye. He has had problems getting his numerous medications renewed. For example, his prescription for Lisinopril was prescribed on 8/6/15. He did not receive it until 8/15. (Pharmacy # 1). He requires a lubricant (lubrifresh) for his prosthetic eye. Under his prescription, it was dispensed to him on 6/15/15, with 6 refills. As of 7/28/15, he had run out. (Pharmacy # 2). His medical record shows that he submitted HNRs for refills on 7/23, 8/7 and 8/13. (Access to Care # 1). As of 9/1, he had not received any refills. He says that he was referred to the orthopedist more than a year ago for DJD. He says that he has asked his PCP repeatedly about when he will be seen, and has been told that he is scheduled for an appointment. However, in his medical record, a referral to the orthopedist dated 6/4/15 had been denied, with an "alternative treatment plan" to monitor his knees annually. Mr. [redacted] saw his PCP on 7/2/15, but the PCP did not advise him of this denial. (Specialty Care # 1, 2). He reports that he is supposed to see an ophthalmologist at least once a year to monitor his cataract in his remaining eye. He says the last time he went was 18 months ago. His record contains a referral to the ophthalmologist for cataracts on 3/31/15. It was referred to the UM on 4/1/15, and is apparently still pending approval. (Specialty Care # 4).

[redacted] has diabetes. He takes insulin and metformin to control his diabetes. He also takes medication to control his blood pressure. He has been out of his metformin and blood pressure medication for a month now. (Pharmacy # 2). Two weeks ago, he was seen by the provider and told his medications were on order. He had submitted one HNR and was planning to submit another. (Access to Care # 1, 2).

[redacted] has lupus, he saw a rheumatologist via tele-med in mid-July but the specialist had limited knowledge of lupus. His treatment plan has not changed. (Chronic # 1) He discovered lumps on his penis in early July, and has submitted three HNRs about this but has not been seen. (Access to Care # 1, 2, 4).

[redacted] is housed in HU-8 due to recurrence of rectal cancer. He had been housed in HU-8 for 16 months during his original treatment for rectal cancer and returned to East unit in or around May 2015 when the cancer was determined to be in remission. Mr. [redacted] states that shortly after his return to East unit, his symptoms rapidly deteriorated, including experiencing intense fatigue and pain. After three months of submitting HNRs reporting the symptoms he was

sent out for emergency surgery to remove a cancerous mass from his rectum and returned to housing in HU-8. (Access to Care # 1, 4; Specialty Care # 1, 3). He is currently receiving chemotherapy, has a wound vac, and is pending an MRI for determination of if the cancer has spread from his rectum. He states that during the last change of his wound vac, which happens every three days, it appeared that a mass had started to regrow in the wound.

[redacted] has psoriatic arthritis and HCV. There is no treatment plan for his HCV. (Chronic Care # 1). A rheumatology consult was requested on 6/5/15, and as of 9/3/15, the request was still listed as pending. (Specialty Care # 1, 4).

[redacted] reports that he has a tumor in his lung that has displaced his heart. Despite putting in multiple HNRs, he wasn't seen until he waited for NP Ende to walk past and begged for care. (Access to Care # 1, 2, 4). That evening he was called to medical to have radiographs and was informed he had cancer. He didn't start his chemotherapy for 4 weeks after his oncology appointment. (Specialty # 5, Chronic Care # 1). During his chemotherapy, his lungs filled with fluid, which then became infected. He was sent to the hospital, where he nearly died from the infection. Since his return, he continues to hack white phlegm but had restarted his chemotherapy.

[redacted]
He has chronic HCV and weight loss (40+ lbs in 6 months - now 125 lbs, 5'10"). States he always feels sick, fatigued, with stomach pain. He has submitted multiple HNRs describing his symptoms, but is not seen by nurses or doctors. He also has filed countless HNRs re: drops in blood sugar level, to no avail. (Access to Care # 1, 2, 4; Chronic Care # 2).

- 8/10/15 – requesting glutose gel to manage blood sugar. Response says to buy candy from the canteen.
- 7/15/15 – requesting follow up re: thyroid – response says on provider line.
- 6/15/15 – requesting glutose. Response says to buy peanut butter at the store.
- 5/18/15 – requesting glutose. Not stamped with a receipt day, no response.
- 4/10/15 – requesting glutose

[redacted] has a seizure disorder but according to his medical records is not receiving his Dilantin. He claims that he was told on 7/23/15 at his intake exam that he is too close to release to be given medication. (Chronic Care # 3; Pharmacy # 2; Medical Records # 11). He was scheduled for a chronic care appointment on 8/3/15, but the appointment did not appear to have actually happened. (Access to Care # 4; Chronic Care # 2).

[redacted]
He reported that he was diagnosed with terminal cancer on 7/23/15 after long delays in diagnosis despite a recent history of kidney cancer. He stated that his treatment plan for the kidney cancer

(that was in remission) included CAT scans with contrast every six months. His record did not show these scans occurred with the necessary frequency. (Chronic Care # 1) Through review of his records, it appears that while at Eyman, Mr. [redacted] had a CT scan without contrast in August 2014 that found at least two nodules in his lungs and recommended follow-up testing for "more sensitive evaluation and further characterization." However, it was unclear from the EMR that the results had ever been reviewed by a provider. (Specialty Care # 5). It does not appear that Mr. [redacted] received any additional testing until 6/8/15 when he had another chest CT without contrast that found additional nodules in his lungs.

[redacted]
He has had sharp abdominal pains since the beginning of the summer. He filed HNRs, would get response saying he was on the list to be seen. (Access to Care # 1, 2). When he saw the nurses, they thought it was indigestion, and there were delays in seeing the provider. (Access to Care # 5). He saw the provider on 8/4/15 and the provider said it was most likely his liver. His blood was tested, but he had not been told the results yet. (Specialty Care # 8). The blood panel found him positive for Hep B and Hep C, but there is no documentation of a treatment plan or a chronic care appointment being scheduled. (Chronic Care # 1, 2, 3, 4).

[redacted] had all of his top teeth extracted in 2013 by ADC. Since then, he has only been seen by dental once and has never been fitted for dentures. (Dental # 3).

[redacted]
He has asthma and COPD. He was not seen for 18 months for a chronic care visit – seen on 6/11/15, w/ prior encounter on 10/1/13. (Chronic Care # 2).

[redacted] has cirrhosis, and has undergone numerous banding procedures. He says that in the last three weeks, they have been without electricity about half the time. The temperature in his cell gets quite hot. He says that his lactulose, which according to manufacturer specifications must be kept at room temp between 68 and 77 degrees, frequently goes bad in his room. His latest bottle had gone bad about four days earlier. He had regularly requested more from the pill call nurses who pass his cell daily, but he had not received it.

Analysis of Florence-Central August Information Reports (ADCM122196 - 122213)

8/5/15 - The report shows that telemed, psych, and x-ray lines are completed and that dental was not. The report includes an attached list of prisoners and the reasons for their appointments. It appears that only two non-emergent nursing encounters occurred on that day.

8/6/15 - The report shows that multiple telemed and psych appointments did not occur because medical did not notify custody of all of the scheduled appointments until too late in the day, and custody staff had been redirected to other tasks and could not transport the prisoners to the clinic.

8/12/15 - The report shows that only three provider encounters and one nursing encounter occurred on that day.

8/13/15 - The report shows that not all prisoners were seen due to late notification of custody staff by medical of the needed transports.

8/14/15 – No report is included, just a list of prisoners, indicating that only a nursing line was held on that day, and that nine prisoners were seen.

8/17/15 – The report states that policy/practice is for Corizon to give custody staff 24 hours' notice of appointments. However, this did not happen. Instead, Nurse Scott delivered a one page telemed appointment list at 7:05 am indicating that the line was supposed to have started at 7 am. The report states that prisoners arrived to the medical clinic around 8 am and Nurse Scott was notified multiple times by custody staff that prisoners were there waiting. The report also indicates that the telemed line was started and stopped multiple times that morning and at 11 am was put on hold during the telemed provider's lunch break. The custody staff reported to Nurse Scott that prisoners could not be held in the cages for more than two hours at a time and they were already beyond that timeframe. According to the report, Nurse Scott then asked custody if the prisoners could be let out of the holding cages for a few minutes and then returned to the cages to continue waiting to be seen. The report states that some of the prisoners originally called up for appointments were returned to their housing units because of the extended waiting period. At 1 pm, Nurse Scott provided a second page of the telemed appointments list. Custody attempted to identify these additional prisoners. It is unclear, from the report, if they were seen on that day.

8/20/15 – The report shows that nursing, dental, and psych lines were run without issue. However, it does not appear that a provider's line occurred on that day.

8/23/15 – The report shows that only a dressing changes line was held on that day.

8/26/15 – The report states that x-ray, dental, nursing, and provider lines were held and completed. However, only five nursing encounters and two provider encounters were scheduled.

Access to Care # 1 – HNR Screened by LPN/RN Within 24 Hours of Receipt

		March	April	May	June	July		5 Month Average
Douglas		100	93	95	97	100		**97**
Eyman		74	54	54	80	80		**68**
Florence		87	95	83	87	85		**87**
Lewis		29	20	40	27	24		**28**
Perryville		96	98	100	100	98		**98**
Phoenix		85	88	84	97	100		**91**
Safford		100	95	95	100	100		**98**
Tucson		100	100	100	100	100		**100**
Winslow		100	100	100	100	95		**99**
Yuma		100	72	98	98	90		**92**
Monthly Statewide Average		**87**	**82**	**85**	**89**	**87**		**86**

Access to Care # 2 – Seen by RN Within 24 Hours of HNR

		March	April	May	June	July		5 Month Average
Douglas		85	100	75	70	90		**84**
Eyman		22	32	46	62	58		**44**
Florence		55	63	48	47	50		**53**
Lewis		29	30	24	42	46		**34**
Perryville		66	82	82	86	64		**76**
Phoenix		83	87	54	82	95		**80**
Safford		100	100	95	90	100		**97**
Tucson		45	78	78	75	61		**67**
Winslow		45	80	85	85	70		**73**
Yuma		40	24	28	54	28		**35**
Monthly Statewide Average		**57**	**68**	**61**	**69**	**66**		**64**

Access to Care # 4 – Routine Provider Referral Within 14 Days

		March	April	May	June	July		5 Month Average
Douglas		95	90	89	94	83		**90**
Eyman		52	56	62	42	66		**56**
Florence		63	61	60	43	73		**60**
Lewis		16	88	86	55	57		**60**
Perryville		50	66	58	66	40		**56**
Phoenix		98	100	89	64	90		**88**
Safford		100	100	100	100	100		**100**
Tucson		57	59	57	47	47		**53**
Winslow		65	70	90	100	95		**84**
Yuma		74	70	72	78	86		**76**
Monthly Statewide Average		**67**	**76**	**76**	**69**	**74**		**72**

June 2014 Lewis CGAR Spot-Check (Monitor found 33/60 = 55% compliance) [5]
CGAR: 120824-25
Worksheet: ADCM122145, 122153; 122155

We looked in the prisoners' health care records used the date the nursing encounter occurred and then looked for a specific referral to a provider, either through a check box/ button/or in written notes, and found the following.

Stiner
The monitor found 4 out of 10 compliant. ADCM122153. We reviewed the four records that the monitor had listed as compliant, and found that all four were actually noncompliant, and three of the four were not relevant to the measure and shouldn't have been counted in the first place.

- [redacted] – 6/4 NL referral to a provider, and then a 6/5 chronic care encounter regarding an unrelated issue – no subsequent provider appointments in response to 6/4/15 referral.
- [redacted] – 5/30 NL – was not referred to a provider and shouldn't have been considered under this measure
- [redacted] – 6/4 NL – was not referred to a provider and shouldn't have been considered under this measure

[5] The total number files listed by institution as compliant on the CGAR adds up to 27 of 53 (51%), not 33 out of 60. ADCM120824-25. The total number of files listed as compliant on the monitor's worksheets is 43 out of 75 (57%). ADCM122143-58.

- [redacted] – 6/4 NL - was not referred to a provider and shouldn't have been considered under this measure

Eagle Point/ Sunrise

The monitor found five out of 10 compliant. We reviewed the five records that the monitor had listed as compliant, and found that all were not relevant to the measure and shouldn't have been counted in the first place.

- [redacted] – 6/5 provider appointment, there was no referral from nurse and thus shouldn't have been considered under this measure
- [redacted] – 6/18 f/u re lab results, there was no referral from nurse and shouldn't have been considered under this measure
- [redacted] – 6/18 f/u from 5/8 surgical consult, there was no referral from nurse and thus shouldn't have been considered under this measure
- [redacted] – he had no provider appointments in the month of June
- [redacted] – he had a 6/18 chronic care appointment, no 6/25 provider appointment as the monitor indicates on worksheet.

Bachman

The monitor found five out of 10 compliant on his worksheet. ADCM122145. However, on the CGAR, Bachman is listed as having 1 of 3 compliant. ADCM120824. We reviewed the five that were marked as compliant, and found that there were no referrals or encounters on the dates listed.

- [redacted] – no referral to provider documented on listed date of 6/1 and shouldn't have been considered under this measure
- [redacted] – no referral to provider documented on listed date of 6/1 and shouldn't have been considered under this measure
- [redacted] – no referral to provider documented on listed date of 6/4 and shouldn't have been considered under this measure
- [redacted] – no encounter or referral documented on listed date of 6/9 and therefore shouldn't have been considered.

The highest possible compliance rate for Lewis for June, assuming every file we did not review was (a) relevant, and (b) accurately recorded would be 30 out of 65 files (or 46%).

Access to Care # 7 (Follow-up Sick Call Within Ordered Timeframes)

		March	April	May	June	July		5 Month Average
Douglas		85	83	0	100	96		**73**
Eyman		50	39	28	45	44		**41**
Florence		63	20	25	29	100		**47**
Lewis		84	100	100	100	73		**91**
Perryville		54	56	58	58	44		**54**
Phoenix		100	100	0	93	71		**73**
Safford		100	100	50	100	100		**90**
Tucson		47	34	46	67	60		**51**
Winslow		58	82	100	95	95		**86**
Yuma		76	76	79	29	86		**69**
Monthly Statewide Average		**72**	**69**	**49**	**72**	**77**		**68**

Spot-Check of June 2015 Lewis CGAR Access to Care # 7

CGAR finding: ADCM120825
Worksheets: ADCM122144, 122146, 122154

Bachman
Ten files were marked as compliant, we spot-checked the first four files listed in the worksheet. None of the four are relevant to the outcome measure.

- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 provider f/up re: results of CT scan

Rast
Ten files were marked as compliant, we spot-checked first six files listed in the worksheet. None of the six are relevant to this outcome measure.

- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 CC – no initiating sick call order
- [redacted] – 6/30 follow up on nursing referral – was not ordered by a provider
- [redacted] 6/30 follow up on nursing referral – was not ordered by a provider
- [redacted] – 6/30 follow up on nursing referral – was not ordered by a provider

Stiner

Ten files were marked as compliant, none are relevant to this outcome measure

- [redacted] – follow up on nursing referral – was not ordered by a provider
- [redacted] – 5/26 intake evaluation, enrolled in chronic care, first CC appointment scheduled but no timeframe for f/u indicated
- [redacted] – 6/25 provider ordered patient to continue in CC for HCV, no f/u date ordered – CC appointment 6/29
- [redacted] – 12/1/14 CC – f/u 6/29/15
- [redacted] – 6/29/15 CC – no initiating order
- [redacted] – 6/29/15 CC – no initiating order
- [redacted] – 6/29/15 CC – no initiating order
- [redacted] – 6/29/15 CC – no initiating order
- [redacted] – 6/29/15 CC – 4/29/15 CC
- [redacted] – 6/29/15 CC – no initiating order

Infirmary Care # 4 – IPC Provider Encounters Every 72 Hours

		March	April	May	June	July		5 Month Average
Florence		0	0	0	0	0		**0**
Lewis		80	100	100	20	70		**74**
Perryville		100	90	78	100	100		**94**
Tucson		44	40	20	27	20		**30**
Monthly Statewide Average		**56**	**58**	**50**	**37**	**48**		**49**

Dental # 3 – Routine Dental Within 90 Days

		March	April	May	June	July		5 Month Average
Douglas		25	2	100	100	62		**58**
Eyman		76	78	80	100	92		**85**
Florence		95	83	88	96	100		**92**
Lewis		39	26	36	93	60		**51**
Perryville		24	18	41	67	54		**41**
Phoenix		97	100	100	98	100		**99**
Safford		100	100	N/A	100	100		**100**
Tucson		79	67	96	100	94		**87**
Winslow		100	100	100	95	100		**99**
Yuma		66	56	100	94	97		**83**
Monthly Statewide Average		**70**	**63**	**82**	**94**	**86**		**79**

Dental # 4 – Urgent Dental Within 72 Hours

		March	April	May	June	July		5 Month Average
Douglas		78	76	100	100	100		**91**
Eyman		81	82	77	96	98		**87**
Florence		84	77	92	100	100		**91**
Lewis		37	40	52	85	75		**58**
Perryville		74	86	74	97	100		**86**
Phoenix		98	40	98	98	40		**75**
Safford		75	75	N/A	92	100		**86**
Tucson		60	68	73	98	100		**80**
Winslow		80	92	60	78	69		**76**
Yuma		76	86	97	95	100		**91**
Monthly Statewide Average		**74**	**72**	**80**	**94**	**88**		**82**

Staffing # 3 – Statewide Dental Staffing at Contract Levels

		March	April	May	June	July		5 Month Average
Statewide		71	72	70	75	74		**72**

Mental Health # 13 – MH-3D Prisoners Seen Within 30 Days of Discontinuing Meds

		March	April	May	June	July		5 Month Average
Douglas		N/A	N/A	N/A	N/A	N/A		
Eyman		0	14	0	20	25		**12**
Florence		17	22	17	8	17		**16**
Lewis		0	9	0	0	0		**2**
Perryville		43	69	24	55	33		**45**
Phoenix		N/A	N/A	N/A	N/A	N/A		
Safford		N/A	N/A	N/A	N/A	N/A		
Tucson		0	35	12	13	0		**12**
Winslow		0	N/A	N/A	N/A	N/A		
Yuma		43	0	0	18	29		**18**
Monthly Statewide Average		**15**	**25**	**9**	**19**	**17**		**17**

Mental Health # 20 – MH-3 & Above Prisoners in Max Custody Seen 1:1 or Group Every 30 Days

		March	April	May	June	July		5 Month Average
Douglas		N/A	N/A	N/A	N/A	N/A		
Eyman		45	85	57	50	65		**60**
Florence		85	85	25	65	70		**66**
Lewis		50	100	40	70	70		**66**
Perryville		100	90	60	70	50		**74**
Phoenix		N/A	N/A	N/A	N/A	N/A		
Safford		N/A	N/A	N/A	N/A	N/A		
Tucson		29	N/A	71	17	67		**46**
Winslow		N/A	N/A	N/A	N/A	N/A		
Yuma		N/A	N/A	N/A	N/A	N/A		
Monthly Statewide Average		**62**	**90**	**51**	**54**	**64**		**64**

Mental Health # 21 – MH-3 & Above Prisoners in Max Custody Seen by MH Staff on Weekly Rounds

		March	April	May	June	July		5 Month Average
Douglas		N/A	N/A	N/A	N/A	N/A		
Eyman		0	5	48	100	95		**50**
Florence		5	40	70	85	95		**59**
Lewis		0	0	100	10	100		**42**
Perryville		30	100	80	70	100		**76**
Phoenix		N/A	N/A	N/A	N/A	N/A		
Safford		N/A	N/A	N/A	N/A	100		
Tucson		0	N/A	86	100	67		**63**
Winslow		N/A	N/A	N/A	N/A	N/A		
Yuma		N/A	N/A	N/A	N/A	N/A		
Monthly Statewide Average		**7**	**36**	**77**	**73**	**93**		**57**

Mental Health # 26 (Mental HNRs responded to within MHTM timeframes)

		March	April	May	June	July		5 Month Average
Douglas		100	100	100	100	100		**100**
Eyman		14	36	42	40	36		**34**
Florence		63	50	18	29	52		**42**
Lewis		21	4	71	81	70		**49**
Perryville		98	100	91	100	88		**95**
Phoenix		50	100	0	100	100		**70**
Safford		100	100	100	100	100		**100**
Tucson		89	62	79	69	88		**77**
Winslow		50	50	100	60	75		**67**
Yuma		67	91	94	95	100		**89**
Monthly Statewide Average		**65**	**69**	**69**	**77**	**81**		**72**

Pharmacy # 1 – Timely Provision of New Formulary Prescriptions

		March	April	May	June	July		**5 Month Average**
Douglas		60	97	85	78	79		**80**
Eyman		32	34	48	50	64		**46**
Florence		54	54	58	59	71		**59**
Lewis		63	71	74	57	70		**67**
Perryville		76	78	84	88	92		**84**
Phoenix		86	96	98	90	92		**92**
Safford		100	100	100	100	85		**97**
Tucson		54	58	54	53	58		**56**
Winslow		75	65	50	50	80		**64**
Yuma		76	78	60	78	74		**73**
Monthly Statewide Average		**68**	**73**	**71**	**70**	**77**		**72**

Pharmacy # 2 – Medication Renewal Without Interruptions

		March	April	May	June	July		**5 Month Average**
Douglas		78	100	78	58	52		**73**
Eyman		72	54	44	52	70		**58**
Florence		58	66	60	64	67		**63**
Lewis		60	65	61	73	64		**65**
Perryville		77	77	67	69	64		**71**
Phoenix		84	93	87	92	100		**91**
Safford		100	93	80	100	100		**95**
Tucson		77	76	76	76	53		**71**
Winslow		65	90	95	96	100		**89**
Yuma		62	40	50	70	60		**56**
Monthly Statewide Average		**73**	**75**	**70**	**75**	**73**		**73**

Pharmacy # 3 - Medication Refill Without Interruption

		March	April	May	June	July		**5 Month Average**
Douglas		0	0	100	80	60		**48**
Eyman		0	0	6	10	0		**3**
Florence		0	0	20	2	14		**7**
Lewis		0	0	0	0	0		**0**
Perryville		92	92	76	0	81		**68**
Phoenix		93	94	100	90	50		**85**
Safford		100	100	91	80	80		**90**
Tucson		0	68	41	34	3		**29**
Winslow		100	90	92	88	75		**89**
Yuma		0	0	32	24	32		**18**
Monthly Statewide Average		**39**	**44**	**56**	**41**	**39**		**44**

Access to Care # 10 – Medications Transferred Between Prisons Without Interruption

		March	April	May	June	July		**5 Month Average**
Douglas			33	100	45	60		**60**
Eyman			16	47	38	56		**39**
Florence		18	22	16	41	42		**28**
Lewis			17	0	0	0		**4**
Perryville			100	100	100	100		**100**
Phoenix		100	80	0		100		**70**
Safford		70	50	78	65	30		**59**
Tucson		100	76	6	8	10		**40**
Winslow		45	8	36	0	0		**18**
Yuma		100	16	61	69	59		**61**
Monthly Statewide Average		**72**	**42**	**44**	**41**	**46**		**49**

Chronic Care # 2 – Chronic patients seen as specified, at least every 180 days

		March	April	May	June	July		5 Month Average
Douglas		91	91	93	100	59		**87**
Eyman		48	42	54	68	60		**54**
Florence		58	42	38	44	47		**46**
Lewis		70	66	45	31	37		**50**
Perryville		89	80	50	65	66		**70**
Phoenix		91	100	48	33	64		**67**
Safford		100	86	88	70	70		**83**
Tucson		73	43	67	52	46		**56**
Winslow		40	65	100	100	95		**80**
Yuma		37	86	82	74	90		**74**
Monthly Statewide Average		**70**	**70**	**67**	**64**	**63**		**67**

Chronic Care # 3 – Chronic disease management guidelines implemented

		March	April	May	June	July		5 Month Average
Douglas		100	94	100	86	100		**96**
Eyman		68	34	41	56	50		**50**
Florence		N/A	44	49	40	45		**45**
Lewis		100	100	43	41	60		**69**
Perryville		100	100	60	77	76		**83**
Phoenix		100	100	86	83	68		**87**
Safford		100	100	100	85	75		**92**
Tucson		100	75	82	78	55		**78**
Winslow		50	65	100	100	100		**83**
Yuma		100	100	92	66	96		**91**
Monthly Statewide Average		**91**	**81**	**75**	**71**	**73**		**78**

Access to Care # 9 – Hospital discharge instructions reviewed /acted upon by provider within 24 hours

		March	April	May	June	July		5 Month Average
Douglas		NA	100	0	40	NA		**47**
Eyman		67	71	90	80	100		**82**
Florence		96	90	83	100	88		**91**
Lewis		53	73	81	74	74		**71**
Perryville		100	81	100	100	100		**96**
Phoenix		100	100	NA	NA	100		**100**
Safford		NA	NA	NA	100	100		**100**
Tucson		50	64	63	57	73		**61**
Winslow		100	88	100	83	100		**94**
Yuma		50	83	0	60	75		**54**
Monthly Statewide Average		**77**	**83**	**65**	**77**	**90**		**78**

Specialty Care # 5 – Specialty consultation reports reviewed /acted upon by provider within 7 days

		March	April	May	June	July		5 Month Average
Douglas		18	50	42	90	10		**42**
Eyman		61	84	86	54	60		**69**
Florence		57	61	57	54	30		**52**
Lewis		65	79	89	81	60		**75**
Perryville		66	80	68	77	52		**69**
Phoenix		100	100	100	100	40		**88**
Safford		100	94	95	94	100		**97**
Tucson		30	54	37	47	89		**51**
Winslow		91	100	86	78	86		**88**
Yuma		86	78	55	44	33		**59**
Monthly Statewide Average		**67**	**78**	**71**	**72**	**56**		**69**

Specialty Care # 7 – Abnormal diagnostic/pathology reports reviewed / acted upon by provider within 5 days

		March	April	May	June	July		5 Month Average
Douglas		74	55	42	85	35		**58**
Eyman		56	48	48	52	64		**54**
Florence		32	9	20	12	7		**16**
Lewis		34	49	39	46	49		**43**
Perryville		56	64	60	76	67		**65**
Phoenix		58	85	38	38	45		**53**
Safford		95	90	95	100	70		**90**
Tucson		28	34	49	53	39		**41**
Winslow		55	85	85	95	85		**81**
Yuma		76	46	66	64	58		**62**
Monthly Statewide Average		**56**	**57**	**54**	**62**	**52**		**56**

Appendix B

Arizona Department of Corrections

1601 WEST JEFFERSON
PHOENIX, ARIZONA 85007
(602) 542-3133
www.azcorrections.gov

DOUGLAS A. DUCEY
GOVERNOR

CHARLES L. RYAN
DIRECTOR

MEDICAL GRIEVANCE APPEAL: TO THE DIRECTOR

Inmate Name: [redacted]

Institution: ASPC-FLORENCE/SOUTH Date Received: May 4, 2015

I have reviewed your Grievance Appeal in which you state that Ms. Pereira's response "failed to answer the Grievance completely". Specifically, you state that "access to care dealing with HNRs be dealt within 24 hours, timed, dated, stamped with the name, and signed so we can read it".

Your Grievance Appeal has been investigated including a review of your medical records. Based on our findings, your appeal is granted. The reasons for this decision are:

1. During our investigation, the 16 Health Needs Requests (HNRs) you submitted dated from 3/8/15 to 6/7/15 were reviewed and 10 of them were found to be deficient. ASPC-Florence's Facility Health Administrator (Dr. C. Pereira) has been directed to investigate and address these deficiencies expeditiously and ensure they do not happen again.

2. Please submit a Health Needs Request (HNR) if you have additional medical concerns or needs which you wish to discuss with a medical provider.

This response concludes the medical grievance process per Department Order 802.06 Medical Appeals to the Director.

By _____ 6/22/15

Charles L. Ryan, Director — Date

cc: Facility Health Administrator, ASPC-Florence
Cindy Black, Corizon Vice President of Operations
Shelley Wilson-Howard, Corizon Director of Operations
C.O. Inmate File

Appendix C

LEGAL DEPARTMENT
NATIONAL PRISON
PROJECT

September 9, 2015

VIA EMAIL ONLY

Daniel P. Struck
Struck, Wieneke & Love
3100 West Ray Road, Suite 300
Chandler, AZ 85226-2473
dstruck@swlfirm.com

AMERICAN CIVIL
LIBERTIES UNION FOUNDATION

PLEASE RESPOND TO
NATIONAL PRISON PROJECT
915 15TH STREET, NW
7TH FLOOR
WASHINGTON, DC 20005-2112
T/202.393.4930
F/202.393.4931
WWW.ACLU.ORG

DAVID C. FATHI
DIRECTOR
*ATTORNEY AT LAW**

**NOT ADMITTED IN DC;
PRACTICE LIMITED TO
FEDERAL COURTS*

Re: ***Parsons v. Ryan***
Prisoner in need of immediate mental health care
[redacted]

Dear Mr. Struck:

We write to notify you of an ADC prisoner in need of immediate mental health care.

[redacted] is classified as MH3A and Seriously Mentally Ill; his diagnoses include psychotic disorder NOS. On August 10, 2015, he was taken off watch by Ms. Qualls. On August 17, a mental health staff person wrote "On approach IM was laying naked on the cement next to feces and a puddle of urine … Unable to assess due to IM's current mental status."

According to his medical record, Mr. [redacted] was not seen again by mental health until a full week later. On August 24, mental health staff noted that he was again "laying on the floor naked." Once again, there was no follow-up until a week later; on August 31, mental health staff wrote "not able to fully assess I/M at this time as he is actively psychotic." On September 3, mental health staff noted "the inmate was standing in a puddle of his own urine" and "the inmate appears to be psychologically unstable."

It is extremely disturbing that, over a period of more than two weeks, Mr. [redacted] – a prisoner who had recently been removed from watch – was repeatedly observed by mental health staff to be in this extremely decompensated state, and yet no action was taken. We request that Mr. [redacted] be urgently evaluated by a psychiatrist for possible placement in an inpatient

mental health facility. We look forward to your response, and to ADC's and Corizon's prompt attention to Mr. [redacted] mental health needs.

Very truly yours,

David C. Fathi

cc: All counsel

AMERICAN CIVIL LIBERTIES
UNION FOUNDATION

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
Alison Hardy
Corene Kendrick
Kelly Knapp
Millard Murphy
Lynn Wu

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

September 16, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] – Florence South

Dear Mr. Struck,

Our office previously contacted you on March 9, 2015 regarding Mr. [redacted] urgent need for referral to oncology regarding a possible recurrence of his cancer and problems receiving post-surgery wound care. After reviewing Mr. [redacted] medical records and speaking with him on September 1 during our tour, we want to notify you that Mr. [redacted] still has not had a biopsy or lab test done regarding the possible recurrence of cancer first identified in August 2013, and that his left hip replacement surgery that was supposed to occur in June has not occurred due to apparent miscommunication among Corizon staff. Because of the failure to perform the hip surgery, he is confined to a wheelchair and encounters difficulties in performing activities of daily living.

Mr. [redacted] medical records for the period of March 2014-March 2015 show that the Florence provider Dr. Sharp has made multiple urgent requests for urology, orthopedic, and oncology consults but these requests repeatedly are delayed in the Corizon Utilization Management approval process, or the referrals get approved but then inexplicably are not scheduled or are cancelled.[1] Dr. Sharp's most recent request for a referral to oncology/ hematology was submitted to Utilization Management on January 9, with the stated purpose

[1] See, e.g. 3/12/15 Sharp encounter at ADCM003680-81; 1/9/15 Sharp encounter at ADCM003683-84, 003916; 10/17/14 and 11/5/14 urgent requests cancelled on 12/10/14, ADCM003710-12; 8/12/14 request for orthopedist scheduled for 11/24/14 does not actually occur, ADCM003721-22. In addition to Dr. Sharp, Dr. Straton requested a urology consult on 4/28/14, but Mr. [redacted] did not see the urologist until 2/4/15.

being that Mr. [redacted] needed biopsies and tests done of the multiple hepatic cysts and masses found on Mr. [redacted] kidneys in a 12/29/14 CT scan (which itself was greatly delayed).[2] This specialty referral was approved, but the appointment with the oncologist was scheduled to occur in July – six months after Dr. Sharp's request was made. (ADCM003683-84, 3916).

Performance Measure # 51 of the *Parsons v. Ryan* Stipulation (Specialty Care # 4 on the CGARs) requires that routine specialty consults be scheduled and completed within 60 days of the provider's request. Performance Measure # 50 of the Stipulation (Specialty Care # 3) requires that all urgent specialty consults occur within 30 days of the provider's request. Performance Measure # 48 of the Stipulation (Specialty Care # 1) requires that all denials of specialty referrals must be sent to the requesting provider within 14 days of the request, and Measure # 49 (Specialty Care # 2) requires that the patient be told of the denial and his or her next scheduled appointment, no more than 30 days after the denial.

Mr. [redacted] reports that he finally did see an oncologist in July, but it was a brief encounter of only a few minutes, and he did not have any of the biopsies or tests that Dr. Sharp had wanted to be done by the oncologist.

Also, as a result of the intensive radiation from his previous bout of cancer in 2010, Mr. [redacted] hips are so degraded that they are ball and joint and have dysplasia. As a result, he cannot walk and is confined to the wheelchair. Since at least 2013, specialists have recommended replacement of both hips. Additionally, Dr. Sharp wrote on 8/22/14 in an orthopedics consult request that Mr. [redacted] has "major urology problems, kidney blockage, but urology won't treat [him] until his hips are fixed." (M003721-22)

Mr. [redacted] reports that he finally had his right hip replacement surgery done in April 2015, with the surgeon stating that the left hip replacement surgery should be done eight weeks later (in June). This did not occur. He reports that in early August, without any notice, he was called out by custody staff and transported to the specialist to have his surgery. Unfortunately, the surgery could not be done because Mr. [redacted] is on Coumadin, and Corizon staff had not coordinated with one another to stop his Coumadin at least a week prior to the surgery. He reported that rather than simply rescheduling this surgery, the provider now has had to start over in the specialty referral process. At the time of our interview, Mr. [redacted] reported that the

[2] These delays are especially egregious in light of the fact that a PET scan done in August 2013 – two years prior to the scheduled oncology appointment – indicated a right neck and oropharynx uptake suspicious for malignancy, and a questionable osseous metastatis that should be confirmed with a bone scan. *See* the 8/21/14 grievance response (log #A02-095-014) signed by Director Ryan and attached to our March 9 letter.

provider has submitted a request for the surgery to Corizon headquarters, which he believed was still pending review, approval, and scheduling.

We request that Mr. [redacted] right hip replacement surgery be approved and rescheduled promptly, and that Corizon health care staff coordinate with one another so that his Coumadin is discontinued the medically-indicated time period prior to the surgery. We also request he have all necessary biopsies and lab tests regarding the suspicious cysts that Dr. Sharp requested in January. We ask that all recommendations and prescriptions made by specialists be reviewed and implemented by health care staff in a timely manner pursuant to the requirements of the *Parsons* settlement.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
Alison Hardy
Corene Kendrick
Kelly Knapp
Millard Murphy
Lynn Wu

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

September 16, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Mental Health Care
[redacted] Florence North-Unit 3 ("Tent City")

Dear Mr. Struck,

I write regarding a prisoner in need of immediate mental health care, and transfer to a housing unit more appropriate for his psychotropic medications, so that he does not suffer injury due to the heat in his current living unit.

Mr. [redacted] is seriously mentally ill, and housed in Tent 28 in Florence-North. On September 1, 2015, I attempted to interview him at his bed. He told me he did not feel well because of the heat and his medication. I saw him lying on his bed, rolling around, speaking to himself, crying and moaning. The tent was already stifling hot, even though it was the morning. Mr. [redacted] was observed by counsel for Defendants, Corizon, and ADC staff, including the deputy warden who spoke with him.

Other prisoners housed in the tent reported to us that Mr. [redacted] suffers from active mental health symptoms, is not receiving proper mental health treatment, and is inappropriately housed in the tent. They described his florid psychosis, how he is often up and awake at night due to his audio and visual hallucinations, and that he tries to sleep during the day because the heat is too much for his medication. They also reported that he frequently defecates and urinates on himself or in his bed, and has on occasion smeared his feces inside the tent.

Paragraph 15 of the Stipulation (Settlement Agreement Measure # 2 in the CGARs) requires that "[i]f a prisoner who is taking psychotropic medication suffers a heat intolerance reaction, all reasonably available steps will be taken to prevent heat injury or illness. If all other

steps have failed to abate the heat intolerance reaction, the prisoner will be transferred to a housing area where the cell temperature does not exceed 85 degrees Fahrenheit."

We request that Mr. [redacted] be moved immediately out of the tent and in a housing unit appropriate to his custody level where the temperature does not exceed 85 degrees. We request that Mr. [redacted] be evaluated urgently by a psychiatrist for possible hospitalization in an in-patient mental health unit until his symptoms are under control, and that he receive all prescribed medications and recommended therapy services without interruption.

We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
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www.prisonlaw.com

BY EMAIL ONLY

September 17, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence - Central

Dear Mr. Struck:

We write to notify you of a class member who may be in need of immediate medical care.

Mr. [redacted] reports that he was diagnosed with testicular cancer in March 2015 and had surgery (an orchiectomy) in June or July 2015. Through review of his health care records, it appears that he had a specialty referral dated 7/2/15, labeled "ASAP", that was referred to Utilization Management (UM) on 7/7/15 and was pending as of 9/1/15. There was another referral to Urology dated 8/5/15 that was referred to UM on 8/6/15. It did not appear that either had occurred. In addition, Mr. [redacted] reported that he had seen an oncologist in August 2015 who recommended chemotherapy; however, as of 9/1/15, Mr. [redacted] indicated that had not been seen regarding this recommendation.

We request that Mr. [redacted] pending specialty referrals be reviewed by UM urgently based on the apparent delay in processing of these specialty referral requests. We also request that any alternative treatment plans that are recommended be implemented in a timely manner. Finally, we request that Mr. [redacted] be seen urgently by his provider regarding the oncologist's recommendation for chemotherapy. Thank you for your attention to this matter.

Sincerely yours,

/s/ Alison Hardy

Alison Hardy
Staff Attorney

Cc: Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
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September 17, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence - Central

Dear Mr. Struck:

We write to notify you of a class member who may be in need of immediate medical care.

Mr. [redacted] reports that his orbital bone and nose were broken during an assault while housed at Yuma Complex. As a result, he indicates that he had a plate implanted in his face, and requires additional surgery to add plates. According to his health care records, he was referred for an oculoplastics surgery consult on 7/6/15, and the referral hadbeen pending Utilization Management (UM) review since 7/7/15, as of 9/1/15.

We request that Mr. [redacted] pending specialty referral be reviewed by UM urgently based on the apparent delay in processing of this specialty referral request. We also request that any alternative treatment plans that are recommended be implemented in a timely manner. Thank you for your attention to this matter.

Sincerely yours,

/s/ Alison Hardy

Alison Hardy
Staff Attorney

Cc: Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
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Corene Kendrick
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September 17, 2015

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Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence - Central

Dear Mr. Struck:

We write to notify you of a class member who may be in need of immediate medical care.

Mr. [redacted] was diagnosed with throat cancer in or around November 2014, for which he reports he had emergency surgery about six months ago. He states that he has undergone chemotherapy and radiation treatment and is currently waiting to have a PET scan to determine whether the cancer has been eradicated.

According to his health care records, he was referred for the PET scan on 7/1/15, and the referral had been pending at Utilization Management (UM) review since 7/13/15, as of 9/1/15. The records indicate that Mr. [redacted] was seen at the Cancer Center on 7/8/15, and the recommendation was to have him return to the ENT in 1 – 2 months for an edoscopy, and to return to the Cancer Center in two months. That recommendation was referred to UM on 7/13/15 and was also apparently still pending on 9/1/15.

We request that Mr. [redacted] pending specialty referrals be reviewed by UM urgently based on the apparent delay in processing of these specialty referral requests. We also request that any alternative treatment plans that are recommended be implemented in a timely manner. Thank you for your attention to this matter.

Sincerely yours,

/s/ Alison Hardy

Alison Hardy
Staff Attorney

Cc: Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
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VIA EMAIL ONLY

September 17, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence-East

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care. Mr. [redacted] has COPD, hypertension, and a history of prostate cancer and chronic T-cell leukemia. He has received no follow up care after prostate cancer treatment, and is concerned his leukemia has become symptomatic.

In recent months, Mr. [redacted] has experienced and reported to medical staff, alarming symptoms including large visible hematomas, edema, and rash on his arms and body, an 18 pound weight loss, nausea, cold sweats, and exhaustion. Understandably, Mr. [redacted] is concerned that these are symptoms of that the disease has progressed to symptomatic leukemia. Mr. [redacted] also reports that after a delay in diagnosis and treatment, approximately 18 months ago he was diagnosed with prostate cancer and had radiation treatment. The oncologist recommended a follow-up consult four months after the radiation ended, but Mr. [redacted] reports this consult has not occurred, nor is his PSA level regularly tested and monitored.

According to Mr. [redacted] medical file, he was seen on 6/12/15 by the provider for couging up blood and his weight loss, nausea, and cold sweats. The provider concluded he had bronchitis, and started him on Cipro on 6/16/15. The provider also ordered labwork be done, and the results provided on 6/25/15 showed that his lymphocyte levels were well above normal range. When Mr. [redacted] T-cell leukemia was asymptomatic, he needed monthly blood tests to monitor his lymphocyte levels, but there was no evidence in his medical record that he had monthly blood tests. Additionally, we could find no evidence in Mr. [redacted] record that he has been provided any

follow up care or testing to determine if the raised lymphocyte level was a temporary result of the lung infection, or a marker (along with his other symptoms) that his leukemia has progressed and become symptomatic.

We request that Mr. [redacted] be urgently referred to an oncologist to evaluate whether his T-cell leukemia has progressed, and for follow-up on his prostate cancer treatment. We ask that all treatment plans and medication recommended by the specialist be provided in a timely manner without interruption, and that Mr. [redacted] be provided education on his treatment plan.

We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
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Alison Hardy
Corene Kendrick
Kelly Knapp
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Lynn Wu

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September 17, 2015

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Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted]

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care and accommodations for his mobility impairments.

Mr. [redacted] suffered a massive stroke on July 7, and was taken by helicopter to the hospital for emergency care. He is still experiencing the effects of the stroke, including a severe inability to speak or remember words, partial paralysis, and great difficulty walking and standing. He reports that he spent eight days in the hospital after the stroke, and was told by the hospital specialists that he would need medication to reduce the likelihood of another stroke, and intensive physical and occupational therapy.

Mr. [redacted] reports that as of September 1, he has received no physical or occupational therapy, and as far as he knows, he is not receiving medication to prevent a stroke. He also has problems walking but has not been provided a cane, walker, or wheelchair to assist him. He has problems standing for long periods of time, and recently fainted from the heat while standing in the pill line and injured his wrist and arm, which now are in a splint.

Mr. [redacted] states that he has filed HNRs asking about physical therapy, but has not received any responses. He does not speak English and has to rely upon others to write his HNRs in English, or write them himself in Spanish.

We request that Mr. [redacted] be referred and seen promptly by a rehabilitative specialist who can evaluate him and develop a treatment plan involving all necessary treatment such as occupational, physical, and speech therapy. We ask that he be evaluated for and provided all necessary mobility devices such as a cane or walker, and all necessary preventative medication. Finally, we ask that Mr. [redacted] be educated about his diagnosis and the treatment plan either by health care staff who are fluent in Spanish, or with the assistance of a qualified interpreter, as required by Paragraph 14 of the *Parsons v. Ryan* Stipulation.

We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted] (trans.)

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
Alison Hardy
Corene Kendrick
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VIA EMAIL ONLY

September 17, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence-North

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care who is experiencing lapses in all prescribed chemotherapy treatment. Mr. [redacted] began treatment for Stage 3 colorectal cancer on 6/26/15, after more than nine months of reporting alarming symptoms. He reports that he was told by a radiologist who performed a CT scan several months ago that the cancer had metastacized to his liver and anus, but he has not been told of the extent of the spread of the cancer. He also is experiencing symptoms consistent with prostate cancer, but the referral request is pending with Corizon headquarters. Mr. [redacted] also reported during his September 1 meeting with me that in previous days he had not received all of his prescribed chemotherapy medication; after I reviewed his medical file's MARs and confirmed the accuracy of his statement, I notified Lucy Rand from the Attorney General's Office to ensure that Corizon provided Mr. [redacted] with all needed chemotherapy medication immediately, and without interruption or gaps in the future.

Starting in early October 2014, Mr. [redacted] reported via HNRs that he was experiencing frequent diarrhea with blood in his stool, as well as nausea and problems keeping a food down. He also informed health care staff that he has a family history of cancer. He reports that he was seen on nurse's line, and told by the nurses that he had hemorrhoids. He was not referred for a colonoscopy, nor was a colonoscopy performed on him. Finally, on 3/25/15 while waiting at the clinic to see the provider, he passed so many blood clots in his stool that he was rushed to the outside hospital.

Mr. [redacted] reports that at the hospital, he underwent an emergency colonoscopy and the specialists discovered a cancerous mass the size of a grapefruit. He had emergency surgery, where the mass, his entire colon, and part of his intestine were removed. He also received a nonreversible stoma and colostomy. Mr. [redacted] was discharged from the hospital on April 1, and he reports that he was told by the hospital specialists that he needed to begin chemotherapy and radiation as soon as he healed from the surgery. According to the June CGAR report (ADCM120812) and his medical record, on May 21 the provider submitted an urgent oncology consult to Corizon headquarters, but he was not seen by an oncologist until June 25,[1] and the chemotherapy treatment did not begin until three weeks later, almost three months after the specialist had recommended he start chemo.

Mr. [redacted] reports that he had a PT scan in that period after seeing the oncologist and before beginning chemo, and the radiologist told him that it appeared that the cancer had spread to his liver and anus. However, he has not been educated as to the extent of the spread of his cancer, including whether it has spread to his bones or other organs. He also states he has not been informed if the chemotherapy he currently is undergoing will remove all other cancer in his body, or if he needs additional surgeries. During the summer, Mr. [redacted] has reported symptoms including difficulty and pain while urinating, and tenderness and pain in his urethra. The provider made an urgent referral for a urology consult in August to evaluate if the cancer had spread to his prostate, but as of September 1 he had not seen a urologist.

Finally, he is now in a treatement cycle of receiving chemotherapy pills twice a day for 14 days, followed by one week off and liquid chemotherapy infusion, and then starting the pills again. He told me during our September 1 interview that for the past few days the pill line had not had all of the pills. I reviewed his MARs in his medical file, and confirmed that there was at least one medication he had not received since August 24, and another that was not provided the morning of the interview. I notified Ms. Rand of this gap in his cancer treatment, and asked that he be provided the medication immediately, and without interruption. Mr. [redacted] also reported side effects including nausea and vomitting as a result of the chemo.

We request that Mr. [redacted] be provided all necessary chemotherapy medication and infusions without interruption, and be provided all treatment and accommodations to manage the side effects of the chemo. We request that he have a meaningful consultation with the oncologist and/or his provider where he can be educated on the extent of his cancer, and the specialist's treatment plan. We request that he be seen promptly by the urologist to evaluate whether his cancer has spread to his prostate, and be provided all appropriated and medically necessary treatment subsequent to the diagnosis.

---

[1] Performance Measure # 50 of the Stipulation (CGAR Specialty Care # 3) requires that all urgent specialty consults occur within 30 days of the provider's request.

We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
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VIA EMAIL ONLY

September 18, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence-East

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care.

Mr. [redacted] has battled ulcerative colitis and other gastrointestinal symptoms for more than ten years. He reports that several years ago he saw a GI specialist who told him he needs surgery to remove the problematic and infected sections of his colon. The specialist has renewed this recommendation several times. Mr. [redacted] stated that East yard's provider, NP Armenta, also has submitted referral requests for the surgery, but that Wexford, and now Corizon, will not approve the surgery because it is not "medically necessary." However, Mr. [redacted] disease greatly affects his ability to complete activities of daily living, including the simple act of leaving his living unit, because of symptoms such as frequent and violent diarrhea.

Mr. [redacted] reports, and his medical record confirmed, that on 6/12/15, he was sent out for a colonoscopy to evaluate the extent of his disease. However, there appears to have been a miscommunication between specialty scheduling staff and yard health care staff, because he was not provided the required enemas the night before the exam. When he arrived at the specialist's office, the colonoscopy could not be done because Mr. [redacted] had not undergone the appropriate pre-procedure preparation.

Mr. [redacted] reported that rather than simply rescheduling this colonoscopy, the provider has had to start over in the specialty referral process. His medical records show that on 8/20/15, an

urgent GI consult request was submitted by the provider, but it was listed as pending approval by Utilization Management as of 9/1/15.

We request that Mr. [redacted] pending urgent specialty referral for a colonoscopy be approved and rescheduled pursuant to Performance Measure # 50 of the *Parsons* stipulation, and that Corizon health care staff coordinate with one another so that he is provided all pre-procedure medications and treatment, including the required enemas. We ask that UM review the specialists' and provider's past recommendations for surgery and approve it in a timely manner. We ask that all recommendations and made by the specialist be reviewed and implemented by health care staff in a timely manner pursuant to the requirements of the *Parsons* stipulation. We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
Alison Hardy
Corene Kendrick
Kelly Knapp
Millard Murphy
Lynn Wu

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

September 18, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence-South

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care for a likely-broken hand. Mr. [redacted] has suffered two strokes in the past year, his most recent one was in June. As a result, he has difficulty walking. He reports he fell on the yard while at Central Unit in late July, and he thinks he broke his left hand. It is visibly swollen to almost twice the size of his right hand, and he has difficulty moving his fingers or trying to make a fist. He states that he has filed HNRs about his hand, and was told in response that he is on the provider line, but that he has not yet had an X-ray. He reports that he saw a physical therapist on August 30 for rehabilitation of his ability to walk, and the PT told him that his hand appeared to be broken.

We request that Mr. [redacted] be evaluated urgently by the provider, and undergo an X-ray of his hand or any other necessary diagnostic exams pursuant to Performance Measure # 45 of the *Parsons* stipulation. We ask that he be provided all necessary specialty appointments to repair his hand in a timely manner pursuant to the requirements of the *Parsons* stipulation. We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted]

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September 18, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence-North

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care.

Mr. [redacted] is 71 years old and has thromboangiitis obliterans, also called Buerger's disease, a disorder in which arteries and veins become inflamed, swell and are blocked with blood clots that ultimately destroy skin tissue and may lead to infection or gangrene. Prior to his incarceration in May 2013, Mr. [redacted] was seen by a vascular specialist, Dr. Nitin Patel, at Prescott Valley Cardiac Care (928-759-7009). Dr. Patel notified the Yavapai County judge as well as ADC in writing that Mr. [redacted] critically needed in his leg arteries because they were 75% blocked, and that he needed blood thinners to lessen the risk of thrombosis and clots. Mr. [redacted] showed me the letter Dr. Patel sent to ADC, which he states he has shown to several Corizon providers. Mr. [redacted] also reports his sentencing judge ordered ADC to provide the treatment when he was sentenced to prison. However, Mr. [redacted] reports he has not been given the stents, nor provided Coumadin or another blood thinner. He experiences pain in his legs, and is concerned that the failure to receive blood thinners has increased his risk of stroke or heart attack.

We request that Mr. [redacted] be promptly referred to a specialist for any necessary diagnostic exams and the procedure to place the stents that Dr. Patel recommended in 2013. We request that he be provided all medically necessary medication without interruption pursuant to the requirements of the *Parsons* stipulation. We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
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Alison Hardy
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Kelly Knapp
Millard Murphy
Lynn Wu

PRISON LAW OFFICE
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www.prisonlaw.com

VIA EMAIL ONLY

September 21, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical and Mental Health Care
[redacted], Lewis-Rast MDU

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical and mental health care.

Mr. [redacted] has psoriatic arthritis, osteomyelitis in his spine and leg, hypertension, GERD, and since 2013 has had a large open wound on his right leg below his knee. When Amy Fettig and I interviewed him on 9/2/15, he showed us the wound on his knee as well as other wounds on his shin. The wounds were red, inflamed and smelled. As a result of the wounds on his leg and the osteomyelitis in his spine, he has to use a wheelchair. He has not seen an infectious disease or wound care specialist for more than a year, and an orthopedics consult requested in July 2014 for a bone biopsy and treatment of his osteomyelitis did not occur, and was cancelled for unknown reasons in March 2015. Despite the excruciating pain caused by the large open wounds, his severe psoriasis, and the osteomyelitis, he is receiving no pain medications, after they were vindictively and abruptly cut off in May 2015 without any examination, after he had an outburst during a medical encounter. Mr. [redacted] also suffers from anemia that is so severe that he has had to get emergency blood transfusions. He also reports that he has lost close to 90 pounds in the last two years, and Corizon providers have not identified the cause of the extreme weight loss. He reports that he is not receiving his wasting diet. Mr. [redacted] also reported that he suffers from PTSD, ADHD, and depression, but is not receiving any regular mental health counseling or therapy, and that his psychiatric medication is not consistently delivered to him.

We requested Mr. [redacted] medical records in August, and they confirmed his allegations. Many of the documents cited here are attached to this letter.

Despite Mr. [redacted] complex health needs, his last chronic care appointment was on 1/9/15, when he was housed at Eyman SMU-I.[1] (ADCM091679-82). NP McKamey documented at this appointment that the largest wound was approximately 7 cm by 3 cm by 3 mm deep. Five months earlier, Dr. Burciaga at ASPC-Tucson had requested an orthopedics consult on 7/31/14 for a bone biopsy of this area of his leg, but he never saw an orthopedist, and the consult was cancelled on 3/11/15 by Lewis NP Taylor for re-evaluation of the need for the referral.[2] (ADCM092763). There is no documentation in his medical record that such a re-evaluation or referral has occurred since March.

Mr. [redacted] has been provided a variety of topical creams to treat his open sores, but the treatment appears to not be working, as he has had the open wound since 2013.[3] Despite the wound's failure to heal for more than two years, Mr. [redacted] last saw a wound clinic specialist on 7/14/14, (M092765, 091221-22), and his last infectious disease encounter was 5/5/14, where MRSA was identified in his wound. (M092766, 92441-44). He has had a standing order for daily wound dressing changes by nurses for more than a year, (M091449), but there is no documentation of any wound care or dressing changes being done between 8/15/14 at Tucson, and 11/11/14 at SMU-I. (M092361, 92369). His medical record shows that at Lewis, the nurse is coming at best every three or four days to the MDU to change the dressing, and there was a two week period from June 26 to July 7 where there is no documented wound care. (ADCM091451). The records we were given were through 7/28/15, but July 7 is the last documented day he got a dressing change.[4] (Id.)

As of 6/24/15, Mr. [redacted] weighed 138 pounds and he is 6 feet tall. (ADCM091816-17). Mr. [redacted] special needs order for a wasting diet expired on 8/17/15, (ADCM091450) and he reports that it has not been renewed and he is not getting additional food.[5]

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[1] The *Parsons v. Ryan* Stipulation Performance Measure (hereinafter "PM") # 54 (Chronic Care # 2 on CGARs) requires that chronic disease patients be seen a minimum of every 180 days for chronic care appointments.

[2] PM # 51 (Specialty Care # 4 on CGARS) requires that routine specialty consults be scheduled and completed within 60 days of the provider's request.

[3] PM # 55 (Chronic Care # 3 on CGARS) requires that disease management guidelines be implemented for chronic diseases. There is no evidence in the medical record that there is a treatment plan for Mr. [redacted] chronic psoriatic arthritis.

[4] PM # 42 (Access to Care # 7 on CGARS) requires that follow-up sick call encounters will occur on the time frame specified by the medical provider.

[5] PM # 71 (Medical Diets # 1 on CGARS) requires that inmates with diagnosed and documented diseases or conditions that necessitate a special diet will be provided that diet.

Mr. [redacted] medical record also documents that the site medical director, Dr. Malachinski, ordered his pain medications be decreased after an April 1 incident where he was disruptive and cursed at health care staff. According to the notes made by NP Taylor, Mr. [redacted] was called up to the clinic to discuss his lab tests and extremely low hemoglobin level (his level was 4, the normal range is 18 to 464). NP Taylor wanted to send him to the hospital for an emergency blood transfusion. He became upset about the idea of going to Tempe St. Lukes because he said he had a pending lawsuit against staff there, and was concerned he would be mistreated. According to NP Taylor's notes, he became extremely agitated and cursed at her and other nursing staff about the fact that he was only getting his pain medication once a day, when it was prescribed to be given to him twice a day. He was returned to his cell by security staff, and NP Taylor wrote that the "SMD [was] notified of encounter and directed to decrease pain medication." (ADCM091643-46).

Mr. [redacted] statements to NP Taylor that he was receiving less than his prescribed medication were correct – at the time, he was prescribed 10 mg. of morphine to be given twice a day. (ADCM091368-69, 91372, 91384-85). But according to his MARS, during much of March he was only getting the morphine in the mornings, plus there was an almost month-long gap where there was no documentation of receiving any morphine between 2/17/15 and 3/12/15.[6] (M091385). The prescription for 10 mg. twice a day continued to be valid from 4/1/15 to 4/22/15, although there were days in the weeks after the medical director ordered the decrease in pain medication, that he received no pain medication at all. (4/2-4/4, 4/10-4/12, 4/14-4/15 and 4/21). (ADCM091368-69, 91372, 91384-85). Then, on 4/23/15, without seeing Mr. [redacted] or documenting any basis for the decision, Dr. Malachinski discontinued the active prescription for 10 mg. twice a day, (M091384), and slashed it to 5 mg. once a day for two weeks. (M091364, 91366). May 6, 2015 was the last day Mr. [redacted] was given morphine. (M091366). A week later, on 5/13/15, Dr. Malachinski prescribed him 600 mg ibuprofen to be taken twice a day for three days for pain. Mr. [redacted] was given the ibuprofen only once, on 5/15/15, and that is the last documented day he received any pain medication. (ADCM091362). Mr. [redacted] reported to Ms. Fettig and me that the pain from his open wounds and the osteomyelitis is so severe that he resorts to pulling his toenails out to distract himself from the pain. Mr. [redacted] was squirming in visible pain during the interview, sitting in the wheelchair without a cushion.

Mr. [redacted] has a mental health diagnosis of depression, is classified as MH-3, and is prescribed 50 mg. of Paxil every evening. His MARS show that the evening medication is not provided consistently – from one day to the next, he receives it as early as 2 pm or as late as midnight. (ADCM091349-53). He was put on suicide watch on 6/26/15 because of a cut on his arm that staff thought was self-inflicted, but Mr. [redacted] denied any suicidal ideation, and

[6] PM # 13 (Pharmacy # 2 on CGARS) requires chronic care and psychotropic medication renewals be completed such that there is no interruption or lapse in medication.

insisted that the cut happened when he fell off his wheelchair while transferring to his toilet.[7] (ADCM092576-81). He was on suicide watch until 7/2/15. (ADCM092557-62). He was not seen by mental health staff for four days after being put on watch, and was only seen twice, 6/30 and 7/1.[8] (ADCM092513). There also is no documentation of any encounters with mental health staff between 3/19/15 and 5/20/15, even though he was housed at the MDU.[9] Additionally, on two occasions in May, Mr. [redacted] reported to the nurse changing his wound dressing that he was experiencing auditory hallucinations, but there was no referral to mental health staff. (ADCM092047-51, 92019-22). Despite the placement on suicide watch, and the fact that he is on psychotropic medication for depression, Mr. [redacted] last psychiatrist appointment was 3/19/15, when his Paxil was increased because he reported worsening symptoms of depression.[10] (ADCM092610-18).

We request that Mr. [redacted] be evaluated promptly by a provider regarding his osteomyelitis, and be evaluated and referred for an orthopedist for the bone biopsy that Dr. Burciaga had requested in July 2014. We ask that the provider evaluate the unhealed wounds that he has had for more than two years, and make appropriate referrals for infectious disease and/or a wound specialist, to follow up on the specialty consults he had in May and July 2014. We ask that he be evaluated and provided pain medication that ameliorates the excruciating pain he is experiencing from the large open wounds, his severe psoriasis, and the osteomyelitis. We ask that the provider request all medically appropriate tests to identify the cause of his severe anemia and extreme weigh loss. We request that all specialty referrals be reviewed and completed without delay, and that the specialists' recommendations be reviewed and implemented. We ask that Mr. [redacted] be educated about his diseases and the treatment plans. We ask that his SNO for the wasting diet be reinstated, and that he be provided the nutritional supplements and additional food he needs. We ask that he be provided all medically necessary chronic care and psychiatric medication without interruption pursuant to the requirements of the *Parsons* stipulation.

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[7] This same day Mr. [redacted] was sent to West Valley Hospital for an emergency blood transfusion because his iron levels were below the lower panic level. (ADC091897-91902).

[8] PM # 94 (Mental Health # 22 on CGARS) requires all prisoners on suicide or mental health watch be seen daily by a licensed mental health clinician, and by a registered nurse on weekends and holidays.

[9] PM # 92 (Mental Health # 20 on CGARS) requires MH-3 and above prisoners housed in maximum custody units be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days. PM # 93 (Mental Health # 21 on CGARS) requires mental health staff (not to include LPNs) make weekly rounds on all MH-3 and above prisoners housed in maximum custody units.

[10] PM # 83 (Mental Health # 11 on CGARS) states that MH-3B prisoners prescribed psychotropic medications for depression shall be seen by a mental health provider a minimum of every 90 days.

We appreciate your prompt response, and ADC/Corizon's attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted] (w/o enclosures)

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
Penny Godbold
Alison Hardy
Corene Kendrick
Kelly Knapp
Millard Murphy
Lynn Wu

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

September 22, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted]

Dear Mr. Struck,

I write regarding a prisoner in need of immediate medical care. Mr. [redacted] has a history of cancer, has not received the medically necessary follow up and monitoring, and now has a large mass in his abdomen and troubling gastrointestinal symptoms.

In 2007, while in the community, he was treated for bladder cancer. He is supposed to see a urologist and have a MRI every six months to monitor if the cancer has recurred. He reports, and his medical record appears to confirm, that he has not had a MRI since 12/7/11 when he was hospitalized. He also has not seen a urologist in over a year: an appointment on 10/28/14 was cancelled because he had not had the necessary pre-appointment prep work done; and a new referral requested on 12/12/14 was cancelled on 1/8/15 without explanation.

He also reports that at least since May 2015, he has had a big lump the size of a grapefruit below his ribs on the top right side of his abdomen. He has filed numerous HNRs because around the same time he started being severely constipated. Mr. [redacted] reports being constipated for weeks on end, and unable to eat much food because he vomits it up due to being so backed up. He thinks the lump might be a bowel obstruction because of his symptoms, but he said medical staff told him that given the location, it could also be his liver that is enlarged. Regardless of what it is, he reported that as of 9/3/15, no biopsy or imaging of the mass had been done, and he had not seen a gastrointestinal specialist.

According to Mr. [redacted] medical record, he was seen on nurse's line on 7/5/15, stating that he had not had a bowel movement since 6/13/15. He reports that he was given GoLytely,

which normally is given to people prior to a colonoscopy. He was referred to the provider on 7/7/15, but there are no SOAPE notes or documentation of any kind that he was actually seen that day. He saw the provider on 8/12/15, reporting that he had not had a bowel movement for 19 days, and the provider documented Mr. [redacted] history of cancer and the fact that he hadn't had a MRI since December 2011. Mr. [redacted] record also shows that a referral to a gastrointestinal specialist from 10/28/14 was cancelled without explanation.

We request that Mr. [redacted] be urgently referred for a biopsy and imaging of the large abdominal mass, and that the diagnostic results be reviewed promptly by his provider. We ask that once the mass has been diagnosed, that he promptly be referred to all necessary specialists to address the problem. We also request that he be referred urgently to the urologist and for a MRI, as medically indicated follow up treatment from his bladder cancer. We request that he be provided all medically necessary treatment and medication without interruption pursuant to the requirements of the *Parsons* stipulation. Thank you for your attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted]

Director:
Donald Specter

Managing Attorney:
Sara Norman

Staff Attorneys:
Rana Anabtawi
Rebekah Evenson
Steven Fama
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Alison Hardy
Corene Kendrick
Kelly Knapp
Millard Murphy
Lynn Wu

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BY EMAIL ONLY

September 23, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: *Parsons v. Ryan*, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Florence - Central

Dear Mr. Struck:

Our office has been contacted regarding a class member who may be in need of immediate medical and dental care.

Mr. [redacted] reports a history of diabetes and amputations of his lower extremeties. Mr. [redacted] indicates that earlier this year he developed a major infection in his left big toe after he was issued improperly fitting orthopedic shoes. As a result of this infection, Mr. [redacted] reports that he had his left foot and lower leg amputated in early July. Upon his return to the Florence infirmary, his wound became infected and he was subsequently diagnosed with gangrene. He returned to the hospital and had another amputation, removing an additional portion of his lower left leg. Shortly following the second amputation, Mr. [redacted] continued to have the infection. Approximately a month after his first surgery, he returned to the hospital for the third time and underwent an above-the-knee amputation on his left leg. Mr. [redacted] states he has had inadequate pain management following the above-the-knee amputation, including only being given medication (Tylenol) that he is allergic to.

Following the above-the-knee amputation, Mr. [redacted] states that he has not returned to the surgeon for follow-up, removal of the staples, or removal of valve / shunt that was placed in the wound. In addition, Mr. [redacted] reports that the orthopedic surgeon recommended he start intensive physical therapy to relearn how to walk on crutches and eventually a prosthesis, and that his provider at Florence submitted specialty referral requests but as of 9/10/15, he had not seen a physical therapist. (Mr. [redacted] does not know if the

speciality referrals have been approved by Corizon headquarters). As a result, Mr. [redacted] is wheelchair bound and experiences severely limited mobility and extreme difficulty completing basic activities of daily living, including simply transferring from his wheelchair to his toilet.

We request that Mr. [redacted] be referred urgently and seen by the orthopedic surgeon for all follow-up treatment. We also request that the referrals for physical therapy be reviewed by UM, if not already done so, and scheduled urgently based on Mr. [redacted] severe mobility challenges. We request that he receive all necessary medical appliances, prosthetic, or mobility devices recommended by the physical therapist or the surgeon. We ask that he be given all necessary medication, including antibiotics sufficient to ensure he does not have another infection, and pain medication for which he doesn't have an allergy. Finally, we request that all specialists' recommendations are implemented in a timely manner pursuant to the requirements of the *Parsons v. Ryan* Stipulation. Thank you for your attention to this matter.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick
Staff Attorney

cc: Mr. [redacted]

PRISON LAW OFFICE
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www.prisonlaw.com

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September 23, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: Parsons v. Ryan, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Lewis-Buckley

Dear Mr. Struck:

I write regarding an ADC prisoner in immediate need of medical care. Mr. [redacted] only recently started treatment for prostate cancer that was diagnosed almost a year ago, and it appears that the cancer may have metastasized during the delays in treatment.

Mr. [redacted] was diagnosed with prostate cancer in October 2014 while he was housed at the Red Rock facility. He reports that he was transferred to Lewis in early 2015 in part to receive medical treatment. He reports that he began filing multiple HNRs regarding difficulty urinating and asking when he would receive cancer treatment. He reports that he was told he would be seen on nurse's line and scheduled to see the provider.

According to his medical record, on 3/2/15 Dr. Malachinski made an urgent consult request for urology, noting that Mr. [redacted] was diagnosed with prostate cancer on October 14, 2014, but "no f/u yet." Despite the notation that Mr. [redacted] had not been treated for cancer for five months, this referral request was denied two days later by Dr. Arnold at Utilization Management (UM). Dr. Arnold's denial suggested an alternate treatment plan of only PSA tests and prostate exam every six months, and if Mr. [redacted] situation were "more complicated please explain and resubmit." The next day, March 5, Mr. [redacted] PSA level was tested and found to be 17.2 ng/ML.

On 3/12/15, Dr. Malachinski made an urgent referral request for oncology and provided more information to UM about the urology request, writing "PT never had follow up after

biopsy and diagnosis. This is first f/u." This urology request was subsequently cancelled without explanation.[1] Mr. [redacted] was not seen by the oncologist until 6/16/15.

On 3/19/15 Dr. Malachinski made a second urgent request for urology and a request for a bone scan. This urology request was authorized, but was then was listed as cancelled on May 22.[2] It is unclear from his medical record if Mr. [redacted] has ever seen the urologist; he reports that to his knowledge, he has not seen one. The bone scan was completed on May 13, and according to Mr. [redacted] medical record, at that time his PSA level had increased to 18.6 ng/ML.

On May 18, the provider requested an urgent radiology consult. Mr. [redacted] was not seen by the radiologist until almost three months later, on August 13, 2015.[3]

On June 16, Mr. [redacted] was finally seen by the oncologist Dr. Rakkar at Palo Verde Cancer Center, in response to the March 12 urgent request.[4] Dr. Rakkar recommended surgery, radiation, and six months of chemotherapy (two months hormonal treatment to start, then two months hormonal + intensity modulated radiation therapy, and then two months hormonal). Dr. Rakkar prescribed 50 mg. of Casodex (an androgen receptor inhibitor) and a six month chemotherapy injection. Dr. Rakkar's June 16 report also requested that Mr. [redacted] return to Palo Verde within two months, which as of 9/3/15 had not happened.

At the August 13 radiology appointment at Arizona Tech Radiology, the radiologist found suspicious masses on Mr. [redacted] lungs, a suspicious 13 mm. mass on his adrenal gland, numerous abnormal lymph nodes in his abdomen (the largest 19 x 14 mm), and he had an enlarged spleen. The radiologist recommended further PT scans to determine the extent of these suspicious masses, but his medical records do not show that a referral for the PT scans had been made, or the PT scan done, as of 9/3/15.

Mr. [redacted] received chemo and radiation on August 25, and there is an entry for a chronic care appointment on August 31 with Dr. Malanchinski, but there are no SOAPE notes or other evidence he was actually examined and seen by the provider, the only documented observations from that day are his vitals that were taken by the nurse.

---

[1] The *Parsons v. Ryan* Stipulation's Performance Measure (hereinafter "PM") # 48 (Specialty Care # 1 on CGARs) requires that documentation, including the reasons for the denial of the request for specialty care, be documented in the patient's medical record.

[2] *Id*.

[3] PM # 50 (Specialty Care # 3 on CGARs) requires that urgent specialty consultations be scheduled and completed within 30 days of the provider's request.

[4] *Id*.

Mr. [redacted] reports that in the past year he lost 30 pounds, and he is having the side effect of vomiting from the chemo. He has asked to be on a wasting diet, but it either has not been prescribed, or was prescribed and is not being provided [5]

We request that Mr. [redacted] urgently be provided the PT scans recommended by the radiologist to determine if the suspicious masses on his lungs, adrenal gland, and lymph nodes are cancerous. We request that he be provided all biopsies and other diagnostic tests in a timely manner. We ask that he be seen by the oncologist for the requested follow-up and to determine if the current prostate cancer treatment plan needs to be adjusted if the cancer has spread. We ask that he be provided all necessary medication, including anti-nausea medication, and a wasting diet. We request that all specialty referrals be reviewed and completed without delay, and that the specialists' recommendations be reviewed and implemented promptly. We ask that Mr. [redacted] be educated about his diseases and the treatment plans. We ask that he be provided all medically necessary specialty care without interruption pursuant to the requirements of the *Parsons* stipulation. Thank you for your attention to this matter.

Sincerely,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. [redacted]

[5] PM # 71 (Medical Diets # 1 on CGARS) requires that inmates with diagnosed and documented diseases or conditions that necessitate a special diet will be provided that diet.

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www.prisonlaw.com

BY EMAIL ONLY

September 23, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: Parsons v. Ryan, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical/Dental Care
[redacted] Lewis – Rast MDU

Dear Mr. Struck:

Our office has been contacted regarding an ADC prisoner in immediate need of medical and/or dental care for a serious health condition. This prisoner also alleges that he has been improperly housed out of level in the Rast MDU isolation unit for eight weeks not due to any conduct on his part, but because of a lack of infirmary bed space at the Lewis prison.

On July 8, Mr. [redacted] while housed on the Rast close yard, was elbowed in the face during a basketball game. According to his medical records, he was seen that day by the dentist Dr. Pond, who diagnosed a mandible fracture and made an emergency request for offsite transport for emergency oral surgery. However, Mr. [redacted] was not taken to an oral surgeon until July 14. In the intervening six days, he reports that he was placed in a mental health suicide watch cell at the MDU (3-A-6) pending the surgery. He reports that during that time, he was treated as if he was suicidal, was denied hygiene items and other privileges he had while on the close yard, and subjected to repeated searches.

After his surgery to wire his jaw shut, the oral surgeon wrote in the notes that "it is critical the patient receive amoxicillin 500 mg TID [three times a day] x 14 d" but Mr. [redacted] reports that he was not provided the antibiotics, and on 7/17 he was sent out on an emergency transport for an infection of the surgery site. Upon his return from the 7/17 hospital trip, Corizon staff had to go to a CVS to get his antibiotics. Mr. [redacted] reports that he was again put in mental health watch cells between 7/14 and 7/17, and for several days after his 7/17 return. He was then moved to MDU 4-C, where he remains. He states that he was told that he has to be housed in the Rast MDU despite being custody level 4/3, because there are no available beds in the L-11 infirmary for him to recover until his jaw is unwired. Mr. [redacted] reports he has lost

weight, because he is consuming only two cartons of milk and mashed potatoes per day, along with chicken broth and jello powder.

We request that Mr. [redacted] immediately be moved out of the isolation unit into an infirmary or other setting appropriate for his custody level and health care needs, and that he be evaluated by mental health staff in light of his extended time in isolation. We request that he be provided all necessary medication and be seen by the timetable requested by the oral surgeon for future treatment. We request that all specialist recommendations are reviewed, approved, and implemented in a timely manner by Mr. [redacted] dentist. Thank you for your attention to this matter.

Sincerely,

/s/ Corene Kendrick

Corene Kendrick

cc: Counsel of Record
Mr. [redacted]

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

BY EMAIL ONLY

September 25, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: Parsons v. Ryan, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted], Lewis-Buckley

Dear Mr. Struck:

I write regarding an ADC prisoner in immediate need of medical care. Mr. [redacted] broke his clavicle bone on his right shoulder on August 7, 2014, when he fell off of his top bunk and hit a locker. It took 11 months before Mr. [redacted] was seen by an orthopedist, and the orthopedist's treatment recommendations have not been implemented.

According to Mr. [redacted] he had his collarbone and shoulder X-rayed approximately three days after his injury, and the X-ray showed that the clavicle was broken. He was told that he would see the provider within three days, but he reports that did not occur. We also could not find records in his medical file showing such an encounter occurred. Mr. [redacted] filed HNRs (enclosed) on September 3, 16, 20, and 22, 2014 asking to be treated for the broken shoulder, and reporting that he had filed HNRs in August as well. He either received no response, or a response stating "You will be scheduled."[1] The time to receive and respond to these various HNRs ranged from eight to almost 20 days.[2] He filed a HNR on 10/14/14, and he reports he was finally seen and told that he would be referred to an orthopedic surgeon. He also filed HNRs on 1/27/15 and 2/4/15 and received no response.

[1] *Parsons v. Ryan* Stipulation Performance Measure ("PM") # 37 (Access to Care # 2 on CGARS) requires that prisoners be seen by a RN within 24 hours after a HNR is received. PM # 39 (Access to Care # 4) requires that routine provider referrals will be seen within 14 days of the referral.

[2] PM # 36 (Access to Care # 1) requires a LPN or RN screen HNRs within 24 hours of receipt.

Mr. [redacted] filed the enclosed informal complaint on October 15, 2014 his shoulder not being treated. In a January 12, 2015 response, his CO-III told him that there still was no response from Medical on the issue and "please feel free to go [to] the next level." Mr. [redacted] filed a grievance on 2/4/15, which apparently was forwarded to Corizon by the ADC grievance coordinator. The Corizon grievance coordinator rejected the grievance because it had not been assigned a case number, a task that apparently is done by the ADC grievance coordinator.

He reports that in March, his CO-III was so disturbed by the ongoing visible injury, that the CO-III called medical on 3/16/15 and asked that he be seen, and was told Mr. [redacted] was scheduled (see grievance response). I observed Mr. [redacted] on September 2, 2015 and noted that his right collarbone visibly sticks up higher than his left, and he demonstrated for me that he has an extremely limited of range of rotation of his right arm, including moving it in a forward flexion, in moving his arm in an abduction, or internal and external rotations. He is right handed and he reports that the inability to move his arm is affecting his ability to perform activities of daily living, including writing, dressing, and eating.

His record shows that orthopedics consult was finally requested on 5/21/15, and he was seen on 7/6/15 (11 months after the accident) by Dr. Aschenbrener at Banner Hospital. The orthopedist diagnosed a scapula fracture that had healed broken and crooked, and adhesive capsulitis (more commonly known as "frozen shoulder"). The orthopedic report (which was received by Corizon on 7/7 but not reviewed until 7/21/15)[3] recommended physical therapy and regular cortisteroid injections, but neither had been requested as of the 9/2/15 review of file, and Mr. [redacted] reports he has not been told of a request for these specialty services.

We request that Mr. [redacted] be referred and seen promptly and regularly by a physical therapist to develop and implement a treatment plan that will help him in regaining strength and range of motion in his right arm and shoulder, and in treating his frozen shoulder. We request that he be provided regular cortisteroid injections and all other necessary medications and treatments for his frozen shoulder. We ask that Mr. [redacted] be educated of his treatment plan. Thank you for your attention to this matter.

Sincerely,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted]

[3] PM # 52 (Specialty Care # 5) requires that specialty reports be reviewed and acted on by a provider within 7 calendar days of receiving the report.

PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

BY EMAIL ONLY

October 12, 2015

Daniel Struck
Struck Wieneke & Love, P.L.C.
3100 West Ray Road, Suite 300
Chandler, Arizona 85226-2473
BY EMAIL: dstruck@swlfirm.com

RE: Parsons v. Ryan, 2:12-CV-00601
ADC Prisoner in Need of Immediate Medical Care
[redacted] Lewis-Buckley

Dear Mr. Struck:

I write regarding an ADC prisoner in immediate need of medical care.

Mr. [redacted] has stage IV kidney failure and he has waited for two months to have a port installed so that he can begin dialysis. Mr. [redacted] also has insulin-dependent diabetes, which further compromises his kidneys.

Mr. [redacted] was sent to the hospital twice in August due to kidney failure, fluid retention, and fatigue. On or around August 21, Mr. [redacted] finally saw an outside nephrologist, Dr. Masute, who said that his kidney failure was acute and it was critical that he immediately begin dialysis. According to his medical record, Mr. [redacted] saw the Lewis Medical Director Dr. Malachinski on September 1 for a follow up on the specialist appointment. On that date, Dr. Malachinski submitted urgent requests to Corizon Utilization Management for vascular surgery and a Doppler procedure so that he can have the port installed.

Mr. [redacted] reports that as of last week, he still has not seen the surgeon to have the port installed, and thus he obviously has not started dialysis yet.[1] He reports worsening symptoms and complications.

[1] *Parsons v. Ryan* Stipulation Performance Measure # 50 (Specialty Care # 3) requires urgent specialty consultations and diagnostic services be scheduled and completed within 30 days of the provider's request for the consultation.

We ask that Mr. [redacted] be seen immediately by the vascular surgeon and have the dialysis port installed. We ask that he receive all dialysis with the frequency and duration recommended by the nephrologist. We request that he be provided all necessary medications and accommodations to assist him with the side effects of dialysis. Thank you for your attention to this matter.

Sincerely,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Mr. [redacted]
Counsel of Record

Appendix D

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 4: MEDICAL SERVICES	Effective Date: 8/08
CHAPTER 12: EMERGENCY MEDICAL RESPONSE	Revision Date(s): 7/2/12
4.12.1: EMERGENCY MEDICAL RESPONSE SYSTEM POLICY	Attachments: Yes ☐ No ☒

I. POLICY

California Correctional Health Care Services (CCHCS), the California Department of Corrections and Rehabilitation (CDCR), and the Division of Correctional Health Care Services (DCHCS) shall ensure that medically necessary emergency medical response, treatment, and transportation is available, and provided twenty-four (24) hours per day to patient-inmates, employees, contract staff, volunteers, and visitors.

A. It is the responsibility of CCHCS to plan, implement, and evaluate the Emergency Medical Response System (EMRS). The organized pattern of readiness and response services within CDCR is set forth in this policy. The DCHCS will collaborate in the implementation of this policy by participating in drills and events.

B. Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) treatment will be provided consistent with the American Heart Association (AHA) guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care according to each individual's training, certification, and authorized scope of practice.

C. BLS and ACLS shall be documented on the CDCR Form 7462, Cardiopulmonary Resuscitation Record.

D. Trained CCHCS and CDCR staff or contractors will perform the functions of First Aid, BLS, and ACLS.

E. The standard guidelines for responding to emergencies are:

1. The response time for BLS capable personnel (First Responders) shall not exceed four (4) minutes (the First Responder Response Time).

2. The response time for health care staff shall not exceed eight (8) minutes (Health Care Staff Response Time).

II. PURPOSE

The purpose of this policy is to standardize:

A. The structure and organization of the CDCR EMRS facilities, equipment, and personnel training.

B. Procedures for emergency medical response.

C. Mechanisms for documentation, data management, medical oversight, and quality improvement activities.

III. DEFINITIONS

Advanced Cardiac Life Support: Emergency care consisting of BLS procedures and definitive therapy including the use of invasive procedures, medications, and manual defibrillation.

Allied Health Care Staff: Respiratory Therapists, Physical Therapists, Occupational Therapists, Radiology Technicians, Laboratory Technologists/Technicians and Phlebotomists, and registered dieticians.

Basic Life Support: Emergency care performed to sustain life that includes CPR, automated external defibrillation, control of bleeding, treatment of shock, and stabilization of injuries and wounds.

First Aid: Emergency care administered to an injured or sick patient-inmate before Health Care Staff is available.

First Responder: The first staff member certified in BLS on the scene of a medical emergency.

First Responder Response Time: The time interval starting at the placement of the first call for an emergency medical response and ending with the arrival of treating personnel trained in CPR at the scene of the incident.

Health Care First Responder (HCFR): The first health care staff member certified in BLS to arrive at the scene of a medical emergency.

Health Care Staff: Physicians, Dentists, Registered Nurses (RNs), Physician Assistants, Nurse Practitioners, Licensed Vocational Nurses, Certified Nursing Assistants, Psychiatrists, Psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Psychiatric Technicians, Registered Dental Assistants and Registered Dental Hygienists.

Health Care Staff Response Time: The time interval starting at the placement of the first call for an emergency medical response and ending at the time a physician, mid-level provider, or RN has contact with the patient-inmate, or communicates via radio or telephone with the HCFR.

Medical Emergency: A medical emergency as determined by medical staff includes any medical, mental health, or dental condition for which evaluation and treatment are necessary to prevent death, severe or permanent disability, or to alleviate disabling pain. A medical emergency exists when there is a sudden marked change in a patient-inmate's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient-inmate or others.

Triage and Treatment Area Registered Nurse: A RN assigned to work in the Triage and Treatment Area (TTA).

IV. RESPONSIBILITIES

The Chief Executive Officer (CEO) and the Wardens at each institution are responsible for implementation of this policy.

V. GENERAL REQUIREMENTS

A. System Organization and Management

1. Patient-inmates may request medical attention for urgent/emergent health care needs from any CDCR employee. The employee shall, in all instances, notify health care staff.
2. Direct contact with the patient-inmate by an RN or physician, either in person or by telephone, shall be provided for all patient-inmates requesting urgent/emergent medical attention or who are referred by staff. The RN or physician on duty shall choose one of the following options for evaluating the patient-inmate:
   a. Arrange to have the patient-inmate brought to the clinic.
   b. Arrange to have the patient-inmate brought to the TTA.
   c. Evaluate the patient-inmate in his/her housing unit or current location.
   d. Talk directly to the patient-inmate via telephone, complete a telephone triage, and give direction to the patient-inmate for subsequent care.
3. At least one RN shall be available on-site at each institution twenty-four (24) hours a day, seven (7) days a week for emergency health care. During those hours in which a physician is not on-site, the highest priority for the RN shall be emergency care. A Provider On-Call (POC) or Medical Officer of the Day (MOD) shall be available twenty-four (24) hours a day, seven (7) days a week to provide consultation and on-site care as necessary.
4. TTAs, General Acute Care Hospitals, standby licensed emergency departments, and all clinical areas shall be properly staffed and equipped.
5. Local Operating Procedures approved by the designated management team shall be in place for communications, response, evaluation, treatment, and transportation of patient-inmates, staff, and visitors.
6. Community Emergency Medical Services responders have ready entry and ready exit into and out of the institution through the vehicle sally port and throughout the facility in order to access the patient-inmate.
7. CCHCS shall maintain a system to manage and track physician and mid-level staff ACLS certification requirements.

B. Facilities and Equipment

1. Emergency equipment and supplies, emergency medical bags, oxygen and Automated External Defibrillators shall be maintained according to manufacturer's specifications and readily accessible to Health Care Staff in the TTA, all clinic areas, emergency medical response vehicles, and all other areas deemed appropriate by the CEO and the Warden in the institution.
2. The location of the equipment shall be clearly identified by signage.
3. The equipment will be maintained, appropriately secured, and inventoried each shift.

C. Personnel: Staffing and Training

1. The CEO is responsible for assuring a system is in place to manage and track clinical staff BLS certification requirements.
2. All correctional peace officers (custody) shall, within the previous two years, have successfully completed a course in CPR that is consistent with AHA guidelines. Custody staff shall maintain a system to manage and track correctional peace officers CPR requirements.
3. For Allied Health Care Staff who have direct patient-inmate contact, BLS certification is recommended but not required.
4. All health care staff with the exception of dental staff and LCSWs shall, within the previous two years, have successfully completed a health care provider-level course in BLS that is consistent with the AHA guidelines. Psychologists who belong to the organized medical staff at their institutions and who have admitting privileges must also complete this course.
5. Certification Requirements:
   a. Dentists, dental hygienists, and dental assistants must provide proof of BLS certification which meets the requirements of their respective licensing Board or Committee.
   b. Psychologists who do not have admitting privileges and LCSWs are not required to maintain BLS certification, although certification is recommended.
   c. All primary care physicians and mid-level providers are required to obtain and maintain ACLS certification and submit proof of certification/recertification to institutional management and the headquarters credentialing unit.
   d. Physicians and mid-level providers who are currently certified in ACLS are not required to have BLS certification.
   e. Contract specialty consultants who may perform procedures requiring procedural sedation at CDCR institutions shall, within the last two years, have successfully completed a course in BLS that is consistent with the AHA guidelines. Proof of certification/recertification must be received by the institutional CEO and the headquarters credentialing unit prior to the contract specialist's start date and/or prior to the expiration of the contract specialist's BLS certification.
6. ACLS certification and maintenance of certification is desirable for the Supervising Registered Nurse in charge of the TTA, and TTA RNs.
7. Nursing staff, based on their level of licensure and training, shall provide emergency care only under patient-inmate specific individual orders based on clinical indications. The orders may be given verbally or telephonically when the provider is not present.
8. Nursing staff, based on their level of licensure and training, shall provide ACLS emergency care requiring cardiac rhythm interpretation only under orders of a provider who is at the scene and directly assessing the patient-inmate.

D. Institutions will conduct em ergency m edical response training drills and will provide access to skills train ing on an ongoing basis (refer to Inmate Medical Services Policies and Procedures, Volum e 4, Chapter 12, Policy 4.12. 3 Em ergency Medical Response Training Drill and Nursing Skills Lab policy).

VI. REFERENCES

- California Code of Regulations, Title 15 § 3351 (a) and § 3354 (f)(1)
- California Code of Regulations, Title 16, §1016
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 10, Suicide Prevention and Response
- California Department of Corrections and Rehabilitation, Emergency Alarm Response Plan
- Inmate Medical Services Policies and Procedures, Volume 4, Medical Services, Chapter 12, Policy 4.12.3, Emergency Medical Response Training Drill and Nursing Skills Lab Policy
- American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care
- 2005 Policy Memorandum entitled "Policy Regarding Peace Officer's Responsibility for Use of Cardio Pulmonary Resuscitation – Overall Directives"

VOLUME 4: MEDICAL SERVICES	Effective Date: 8/08
CHAPTER 12: EMERGENCY MEDICAL RESPONSE	Revision Date(s): 7/2/12
4.12.2: EMERGENCY MEDICAL RESPONSE SYSTEM PROCEDURE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

Implementation of this procedure will ensure that medically necessary medical response, treatment, and transportation is available and provided twenty-four (24) hours per day to patient-inmates, employees, contract staff, volunteers, and visitors.

II. DEFINITIONS

Definitive Care: The completion of appropriate care in a setting such as a hospital emergency department under the care of physician(s).

First Responder (FR): The first staff member certified in Basic Life Support (BLS) on the scene of a medical emergency.

First Responder Response Time: The time interval starting at the placement of the first call for an emergency medical response and ending with the arrival of treating personnel trained in cardiopulmonary resuscitation (CPR) at the scene of the incident.

Health Care First Responder (HCFR): The first health care staff member certified in BLS to arrive at the scene of a medical emergency.

Health Care Staff Response Time: The time interval starting at the placement of the first call for an emergency medical response and ending at the time a physician, mid-level provider, or Registered Nurse (RN) has contact with the patient-inmate, or communicates via radio or telephone with the HCFR.

Urgent Condition: Any medical condition that would not result in further disability or death if not treated immediately, but requires professional attention and has the potential to develop such a threat if treatment is not provided within 24 hours.

Urgent Health Care Request: An urgent health care request for immediate medical attention is based on the patient-inmate's or non-health care staff's belief that a medical condition, signs, or symptoms require immediate attention by staff trained in the evaluation and treatment of medical problems.

III. GENERAL INSTRUCTIONS

- All staff has the authority to initiate a 9-1-1 call for Emergency Medical Services (EMS).
- Any individual who encounters a medical emergency is responsible for summoning assistance by the most expeditious means available, e.g., personal alarm device, two-way radio, whistle, shouting, or telephone.
- Any patient-inmate may request medical attention for an urgent or emergent health care need from any California Department of Corrections and Rehabilitation (CDCR) or

California Correctional Health Care Servic es em ployee. The em ployee shall in all instances notify health care staff without unreasonable delay.

- To efficiently activate a community EMS respons e and notify appropriate facility staff of a medical emergency, Local Operating Procedures (LOP) shall identify a single point of contact for reporting m edical emergencies and estab lish the m echanism to contac t appropriate parties.
- Activation of the institu tional Em ergency Medical Response System and the community EMS system shall occur as neces sary to ensu re the m ost appropriate level of emergency medical care is available in the shortest time interval.
- Preservation of a crime scene shall not preclude or interfere with the delivery of emergency medical care. Preservation of life shall tak e precedence ov er the pres ervation of a crim e scene.
- Custody requirem ents shall not unreasonably delay m edical care during a m edical emergency unless the safety of staff, patie nt-inmates, or the ge neral public would be compromised.
- If a patient-inmate is unable to be resuscitated, the decision to terminate CPR shall be made by a physician or a mid-level provider, community EMS personnel, or by a RN if CPR wa s initiated for a patient-inm ate who exhibits cl ear signs of death as described in Section IV.B.4(a) below. Pronouncem ent of death s hall only be determ ined and m ade by a physician or a mid-level provider per LOP.

IV. PROCEDURE

A. Urgent Response, Treatment, and Transportation

1. Upon notification or discovery of an urgent h ealth care need, the staf f m ember shall call the designated clinical area.
2. The requesting staff mem ber shall provide a brief description of the nature of the request to the clinical staff.
3. Direct contact with the patient-inmate by licensed clinical staff shall occur in person or by phone, and be provided for all patient-inmates requesting urgent medical attention.
4. A RN, phys ician, or m id-level provider shall evaluate the patient-i nmate's request by one of the following options:
   a. Arrange to have the patient-inmate brought to the clinic.
   b. Arrange to have the patient-inm ate brought to the Triage and Treatm ent Area (TTA).
   c. Evaluate the patient-inmate in his/her housing unit or current location.
   d. Talk directly to the patient-inm ate via telephone, and th oroughly docum ent the encounter on a CDCR Form 7230, Interdisciplinary Progress Notes.
5. The licensed clin ical staff m embers shall document the evaluation in the Unit Hea lth Record (UHR) using an appropriate form. Documentation of the encounter must clearly state the disposition and the rationale for the disposition decision.

6. The RN, physician, or mid-level provider may direct other licensed staff to obtain vital signs and other clinical data and report the information to them.
7. All urgent encounters resolved in the yard or yard clinic after hours shall be documented on CDCR Form 7230, Interdisciplinary Progress Notes, and discussed by the Primary Care Team the following business day.
8. All dispositions for urgent conditions shall be made at the RN level of licensure or higher.

B. Emergency Medical Response

1. A FR shall evaluate the situation and initiate appropriate First Aid and/or BLS measures, including establishing airway, breathing, circulation, controlling bleeding, and administering CPR. The FR shall also:
   a. Briefly evaluate the patient-inmate and situation, then immediately notify health care staff of a possible medical emergency, and summon the appropriate level of assistance.
   b. Inform the health care staff of the general nature of the emergency including the general status of the patient-inmate. This may include whether the patient-inmate is conscious, breathing, bleeding, or other observable patient-inmate conditions and complaints.
   c. Immediately initiate CPR if appropriate.
   d. Initiate community EMS activation if necessary.

   If CPR is not initiated due to the condition of the patient-inmate, the reason(s) must be clearly documented.
2. Custody Protocol
   a. In medical emergencies, the primary objective is to preserve life. All peace officers who respond to a medical emergency shall provide immediate life support until medical staff arrives to continue life support measures. All peace officers must carry a personal CPR mouth shield at all times.
   b. The peace officer must evaluate and ensure it is reasonably safe to perform life support by effecting the following actions:
      1) Sound an alarm (a personal alarm or, if one is not issued, an alarm based on the LOP must be used) to summon necessary personnel and/or additional custody personnel.
      2) Determine and respond appropriately to any risk of exposure to blood borne pathogens by adhering to standard precautions.
      3) Determine, isolate, contain, and control the emergency and significant security threats to self or others including any circumstances causing harm to the involved patient-inmate.
      4) Initiate life saving measures consistent with training.

c. The responding peace officer will document on CDCR Form 837, Crime/Incident Report, the decisions made regarding immediate life support and actions taken or not taken (Section IV.B.4.(a) below), including cases where life support is not initiated consistent with training and/or situations which pose a significant threat to the officer or others.

3. RN/Licensed Vocational Nurse (LVN)/Licensed Psychiatric Technician (PT) shall:

   a. Respond as quickly as conditions permit to the scene of the medical emergency with an emergency medical response bag and Automated External Defibrillator (AED), and initiate and/or assist with CPR if indicated.

   b. Make an initial assessment of the situation and determine whether a medical emergency is present.

   c. Notify the TTA with relevant clinical information within eight (8) minutes of the initial call for an emergency medical response if an RN is not already at the patient-inmate location.

   In all cases, a RN or higher level of licensure shall be responsible for determining the disposition of the patient-inmate and communicating this information to the HCFR either in person or via radio/telephone.

   The HCFR shall initiate community EMS activation if needed and not already completed by the FR.

4. The HCFR shall begin appropriate medical treatment and assume responsibility for directing any medical care already in progress.

   a. The HCFR shall determine if CPR is appropriate and continue CPR in the absence of:

      1) Rigor mortis
      2) Dependent lividity
      3) Tissue decomposition
      4) Decapitation
      5) Incineration

   If one or more of the above signs is present, then the HCFR will determine the patient-inmate to be deceased. The official pronouncement of death is the responsibility of the physician or mid-level provider per LOP.

   b. CDCR Form 7462, Cardiopulmonary Resuscitation Record:

      1) The CDCR Form 7462, Cardiopulmonary Resuscitation Record, shall be maintained on the emergency/crash cart for immediate access, and be completed by a RN or designee during a respiratory and/or cardiac arrest event.

      2) All drugs administered during the respiratory and/or cardiac arrest event shall be read back and documented by the recorder, in the spaces provided on CDCR Form 7462, Cardiopulmonary Resuscitation Record, at the time of administration.

3) All other resuscitative measures shall be read back and documented in the spaces provided on CDCR Form 7462, Cardiopulmonary Resuscitation Record as they occur.

4) Names of the team members involved in the code shall be documented in the space provided. Sections of CDCR Form 7462, Cardiopulmonary Resuscitation Record that are not applicable to a specific patient-inmate shall be marked "***N/A***."

5) All team members involved in the code, e.g., Physician, RN, LVN, must sign CDCR Form 7462, Cardiopulmonary Resuscitation Record, next to their name under the "Team Member" column.

c. Once started, CPR shall continue until:

1) Resuscitative efforts are transferred to a rescuer of equal or higher level of training.

2) The patient-inmate is determined by a physician or mid-level provider to be deceased.

3) Effective spontaneous circulation and ventilation have been restored.

4) Emergency responders are unable to continue because of exhaustion or safety and security of the rescuer or others is jeopardized.

5) A written, valid Do Not Resuscitate (DNR) order is presented. If there is any suspicion that a patient-inmate's cardiopulmonary arrest is not part of a natural or expected death, e.g., the patient-inmate's condition is a result of an attempted suicide, resuscitation efforts shall be continued regardless of the existence of a DNR, Physician's Orders for Life Sustaining Treatment, or Advance Directive to the contrary, and resuscitative efforts shall be commenced and continued until other indications to cease are present.

6) RN determines that obvious signs of death are present (Section IV.B.4(a) above) and may direct that CPR be discontinued.

C. Definitive Care and Patient-Inmate Transportation

1. Based on the patient-inmate's clinical condition and emergency situation, the RN and the Primary Care Provider shall be responsible for:

a. The continuations of medical treatment until community EMS responders arrive and assume care and transport the patient-inmate.

b. Directing the transportation of the patient-inmate to the nearest site equipped and staffed for definitive care.

c. Continuing treatment on location and directing EMS personnel to the scene, if clinically appropriate.

2. Transportation Requirements

a. Patient-inmates shall only assist with transportation if they are part of the fire crew.

b. CDCR Form 7252, Request for Authorization of Temporary Removal for Medical Treatment, will be initiated by health care staff and given to the designated custody representative, e.g., Associate Warden of Health Care, Watch Commander, for final completion and approval. After the form is completed it is forwarded to the custody transportation team.

c. The transport of a patient-inmate via code three (3) ambulance shall not be unnecessarily delayed in order to complete the CDCR Form 7252, Request for Authorization of Temporary Removal for Medical Treatment, or to obtain other approvals from custody staff.

d. EMS personnel will transport the patient-inmate to a community emergency facility according to local EMS agency policies and procedures.

3. Notification

a. During regular business hours (Monday through Friday) the TTA RN shall notify the Chief Medical Executive (CME) or designee and TTA Supervising RN or designee of the medical emergency transport and the circumstances of the transport as soon as possible. The Chief of Mental Health shall be notified of all suicides, suicide attempts, and possible overdoses that require medical emergency transport.

b. During non-business hours on evenings, nights, weekends, and holidays the TTA RN shall notify the institution Medical Officer of the Day (MOD) or Physician-On-Call (POC) as soon as possible to inform him or her of the patient-inmate status and transport decision. The MOD or POC shall notify the CME or designee by the next business day.

c. For patient-inmates transferred to a community emergency facility, the TTA provider or RN shall contact the receiving facility and provide a report, including available clinical information.

D. Documentation

1. General Requirements

a. The RN will complete a CDCR Form 7219, Medical Report of Injury or Unusual Occurrence, for all work-related injuries or per custody requirements.

b. The HCFR shall document his/her findings and interventions on the CDCR Form 7463, First Medical Responder – Data Collection Tool and sign this form.

c. In the event of a patient-inmate death and if CPR is not initiated by non-health care staff, then non-health care staff will document the reason(s) on CDCR 837-A-1, Crime/Incident Report Supplement.

d. The use of an AED will be documented by a health care staff member. If the AED has download capability, the electronic information record shall be downloaded, printed, and added to the patient-inmates' UHR.

e. Notice of discharge of an AED shall be reported to the local county EMS utilizing the forms provided by that entity.

f. Documentation of any additional care and treatment provided by other clinical responders at the scene shall be completed on a CDCR Form 7230, Interdisciplinary Progress Notes.

g. The emergency medical response documentation shall be signed, dated, and timed. All documentation shall be delivered to the TTA RN immediately at the time the patient-inmate arrives in the TTA or as soon as possible if the patient-inmate was transferred directly to a community emergency department.

h. The TTA RN shall contact the psychiatrist on duty regarding patient-inmates who present with self-inflicted injuries.

2. TTA Documentation Requirements

a. A TTA Log shall be maintained in the TTA at each institution.

b. Care and treatment shall be documented on the CDCR Form 7464, Triage and Treatment Services Flow Sheet.

c. BLS and Advanced Cardiac Life Support (ACLS) shall be documented on the CDCR Form 7462, Cardiopulmonary Resuscitation Record.

d. Care delivered according to RN protocols shall be documented on the appropriate RN protocol forms.

e. On arrival at the TTA, the RN shall remain with the patient-inmate and continue monitoring the patient-inmate's status until any resuscitative efforts are terminated, or until emergency medical service personnel assume patient-inmate care. During this time, the RN shall record the following:

1) Patient-inmate identification data (CDCR number, or, if unavailable, other identifying data).

2) Description of initial events and patient-inmate presentation (patient-inmate location, position, and witness description of events).

3) Times various treatments and procedures are rendered.

4) Name and title of the RN, name and title of the person to whom the patient-inmate is transferred, the date and time of the transfer, and the RN's signature.

f. TTA staff shall attach all relevant documentation to the CDCR Form 7464, Triage and Treatment Services Flow Sheet, for inclusion in the patient-inmate's UHR.

3. Transport Documentation Requirements

a. Copies of the CDCR Form 7464, Triage and Treatment Services Flow Sheet, CDCR Form 7462, Cardiopulmonary Resuscitation Record, if applicable, and all attachments shall be provided to the emergency medical service transport staff if the patient-inmate is sent out of the institution.

b. CDCR Form 7252, Request for Authorization of Temporary Removal for Medical Treatment.

c. Sally port officers are to maintain a standardized log of all emergency vehicle traffic entrances and exits, including times.