Eric Balaban (admitted *pro hac vice*)
Gabriel Eber (admitted *pro hac vice*)
ACLU National Prison Project
915 15th Street, N.W., 7th Floor
Washington, D.C. 20005
(202) 548-6605
ebalaban@aclu.org
geber@aclu.org

Daniel J. Pochoda, 021979
James Lyall
ACLU of Arizona
3707 N. 7th Street, Suite 235
Phoenix, Arizona 85014-5059
(602) 650-1854
Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Fred Graves, et al., Plaintiffs, v. Joseph Arpaio, et al., Defendants.	No. CV 77-479-PHX-NVW **PLAINTIFFS' RESPONSE TO DEFENDANTS' REPORTS OF COMPLIANCE**

Defendants have asserted compliance with the implementing provisions of the Revised Fourth Amended Judgment (Doc. 2299). In accordance with the Court's order directing Plaintiffs to respond (Doc. 2334), Plaintiffs hereby respond to Defendants' briefs.

I. Background

On September 30, 2014, the Court entered Findings of Fact and Conclusions of Law (Doc. 2283), in which it denied Defendants' Motion to Terminate Third Amended Judgment (Doc. 2142). The Court found that Defendants were providing constitutionally inadequate medical and mental health care at its facilities. Doc. 2283 at 4. It ordered that the existing relief of the Third Amended Judgment continue and granted additional relief to address the constitutional violations it identified. *Id.* at 57-58.

The same day, the Court entered the Fourth Amended Judgment. Doc. 2284. The Fourth Amended Judgment retained the three general orders from the Third Amended Judgment, requiring Defendants to (1) provide adequate intake receiving screenings, (2) ensure that prisoners have ready access to care, either at the Maricopa County Jail (Jail) or an appropriate outside facility, and (3) ensure prisoners' timely access to prescription medications. *Id.* at 1-2. The Fourth Amended Judgment also required Defendants to adopt and comply with thirty-one additional implementing remedies to demonstrate compliance with the three general orders. *Id.* at 2. On December 20, 2014, the Court issued a Revised Fourth Amended Judgment (Doc. 2299).

The Court ordered that, by December 1, 2014, Defendants adopt policies and procedures or amend existing policies and procedures to track the specific requirements of the thirty-one implementing remedies. *Id.* It ordered Defendants to file with the Court their new or amended policies and procedures by December 16, 2014, and they did so. *See* Doc. 2304.

The Court further ordered that, by February 27, 2015, Defendants fully implement the provisions set out in the Fourth Amended Judgment. Doc. 2284 at 6. It ordered Defendants to collect data for a period of 180 days, beginning March 2, 2015, showing Defendants' compliance with the Fourth Amended Judgment and to file by September 15, 2015 a report of the data collected and summarized. *Id.* at 6-7. On

September 15, 2015, Defendants filed their Report of Data Collected and Summarized (Doc. 2333) ["Compliance Report"], asserting compliance with the thirty-one implementing remedies of the Revised Fourth Amended Judgment. On September 16, 2015, the Court ordered Defendants to file a supplemental report regarding subparagraphs 5(a)(6), (8), (15), (18), (20), (29), and (31) of the Revised Fourth Amended Judgment. Doc. 2334. The Court also ordered that Plaintiffs file a response to Defendants' reports. *Id.* at 2. On September 25, 2015, Defendants filed their Supplemental Report of Data Collected and Summarized (Doc. 2336) ["Supplemental Report"].

To evaluate Defendants' assertions of compliance with the remedies, Plaintiffs and their experts conducted site visits at the Jail and reviewed prisoner records and other materials provided through document requests. Plaintiffs' medical experts, Robert Cohen, M.D., and Madeleine LaMarre, MN, FNP-BC, conducted a site visit on December 2-4, 2015. Their findings are documented in their Report on Compliance with the Revised Fourth Amended Judgment, filed herewith. Plaintiffs' mental health expert, Pablo Stewart, M.D., conducted site visits in October 2015 and February 2016. He documented his findings in a declaration, filed herewith. Plaintiffs' corrections expert Eldon Vail prepared a report, filed herewith, based on his review and analysis of documents provided by Defendants through discovery.

II. Defendants Have Failed to Comply With All Implementing Remedies in the Revised Fourth Amended Judgment

Plaintiffs' experts have identified 90% as an appropriate threshold for compliance, based on their experience in assessing correctional health care systems and compliance with similar decrees. A 90% threshold is also consistent with Ninth Circuit law requiring a party that seeks dismissal of a consent decree to reach "substantial compliance" with its terms. *See Jeff D. v. Otter*, 643 F.3d 278, 283-84 (9th Cir. 2011). While substantial compliance "is not susceptible of mathematically precise definition," the standard implies "something less than a strict and literal compliance

with the contract provisions but fundamentally it means that the deviation is unintentional and so minor or trivial as to not substantially to defeat the object which the parties intend to accomplish." *Id.* at 284.

As set out in detail below, Defendants have not shown compliance with the specific implementing provisions of the Revised Fourth Amended Judgment. First, with respect to some provisions, Defendants' own reported rates do not demonstrate a sufficient level of compliance. Second, in their own reviews, Plaintiffs and their experts have calculated compliance rates that fall short of the rates Defendants have asserted in their compliance reports, and show a failure to comply. Finally, Plaintiffs and their experts have identified a number of methodological flaws in Defendants' computations that render their asserted compliance rates unreliable, and should lead the Court to conclude that Defendants have failed to demonstrate compliance.

Defendants have argued that their claimed compliance rates should lead the Court to dismissing the case. Even if Defendants demonstrate compliance with the specific implementing remedies, such compliance is not sufficient to show that termination of the Revised Fourth Amended Judgment is warranted. Defendants have not shown that they have effectuated the general purpose of the relief. When a party seeks to terminate relief under Rule 60(b) of the Federal Rules of Civil Procedure, it is not enough for the court to look narrowly to the party's compliance with specific implementation measures. *See Jeff D.*, 643 F.3d at 288-89.

Rather, the party seeking relief must show—and the court must consider—whether the "basic purposes" of the relief have been satisfied. *Id.* The Ninth Circuit has held that a trial court errs when it considers only specific implementation measures in evaluating a party's compliance with a consent decree and fails to consider the "overall objectives" of the decree. *Id.* at 288. Rather, "[e]xplicit consideration of the goals of the decrees . . ., and whether those goals have been adequately served, must be part of the determination to vacate the consent decrees." *Id.* at 289.

In *Jeff D.*, the lower court found that defendants were in substantial compliance with the consent decrees in question because they had complied with numerous "Action Items," specific measures that had been entered by the court as a means of implementing the broader requirements of the decrees. *Id.* at 280-81. The Ninth Circuit reversed, holding that the "Action Items," while relevant, were "not the only matters to be considered in determining whether the consent decrees have served their purpose." *Id.* at 288. The trial court instead was required to look more broadly to the overall purpose and goals of the relief in question and to "'whether the [defendant] has demonstrated . . . its good-faith commitment to the whole of the court's decree and to those provisions of law and the Constitution that were the predicate for judicial intervention in the first instance.'" *Id.* (quoting *Freeman v. Pitts*, 503 U.S. 467, 491 (1992)).

When the Court considers whether to terminate relief, it must assess not only whether Defendants have met their burden to show compliance with each discrete implementing provision, but also whether they have achieved the basic purpose of the Revised Fourth Amended Judgment. As to the 31 implementing remedies, the Court stated their purpose is to "show compliance with" the general remedies retained from their Third Amended Judgment. *See* Doc. 2284 at 2. The general remedies, in turn, require the following:

> 2. Defendants shall provide a receiving screening of each pretrial detainee, prior to placement of any pretrial detainee in the general population. The screening will be sufficient to identify and begin necessary segregation, and treatment of those with mental or physical illness and injury; to provide necessary medication without interruption; to recognize, segregate, and treat those with communicable diseases; to provide medically necessary special diets; and to recognize and provide necessary services to the physically handicapped.
>
> 3. All pretrial detainees confined in the jails shall have ready access to care to meet their serious medical and mental health needs. When necessary, pretrial detainees confined in jail facilities which lack

> such services shall be transferred to another jail or other location where such services or health care facilities can be provided or shall otherwise be provided with appropriate alternative on-site medical services.
>
> 4. Defendants shall ensure that the pretrial detainees' prescription medications are provided without interruption where medically prescribed by correctional medical staff.

Doc. 2284 at 1-2.

In retaining these remedies from the Third Amended Judgment, the Court found they "remain necessary to ensure that pretrial detainees have ready access to adequate medical, dental, and mental health care; are not subjected to conditions that are likely to cause future serious illness and needless suffering; and are not deprived of timely medical, dental, or mental health care except where denial or delay of care is reasonably related to a legitimate governmental objective other than financial cost." Doc. 2283 at 2.

Termination of relief here is not warranted. Defendants have not proved they have complied with the implementing remedies of the Revised Fourth Amended Judgment. Defendants have also not shown compliance with the general remedies. Furthermore, Defendants have not shown that they have satisfied its basic purpose: to provide constitutional levels of medical and mental health care to prisoners at the Jail.

A. Subparagraph 5(a)(1)

Subparagraph 5(a)(1) requires the following: "A registered nurse will perform the receiving screening for each pretrial detainee processed in the 4th Avenue jail intake center." Doc. 2299 at 2. The receiving screening is an important first step in identifying health care issues and timely initiating or continuing necessary treatment. *See* Doc. 2283 at 26-27. In their Compliance Report, Defendants reported compliance rates of 99.98% in March and 100% in all subsequent months. Doc. 2333 at 5.

Plaintiffs' medical experts, Robert L. Cohen, MD, and Madeleine LaMarre, MN, FNP-BC, found that a registered nurse performed the receiving screening for each pretrial detainee in 48 out of 49 records reviewed, or 98%.

B. Subparagraph 5(a)(2)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of Subparagraph 5(a)(2). This provision requires, "If the receiving screening indicates a pretrial detainee is suffering from a serious acute or chronic health condition, a physician, physician assistant, or nurse practitioner will conduct a face-to-face examination of the pretrial detainee within 24 hours after the receiving screening." Doc. 2299 at 2. In its Findings of Fact, the Court stated that pretrial detainees with a serious or acute condition "in most cases should be seen by a medical provider on an emergency or urgent basis, no later than within 24 hours." Doc. 2283 at 27 ¶ 31. A timely provider assessment is essential to ensure that necessary treatment is initiated. *See id.* at 28 ¶ 41. Otherwise, patients are at risk of deteriorating. Defendants reported compliance rates of 89% in March, 84% in April, 83% in May, 88% in June, 92% in July, and 87% in August. Doc. 2333 at 6.

As an initial matter, one month of compliance above 90%, as Defendants reported, does not demonstrate sufficient compliance with the requirements of this provision. Further, Plaintiffs' medical experts found a low rate of compliance among the records they reviewed. Defendants complied with the requirements of this provision in 29 out of 48 applicable cases, for a compliance rate of 60%. Dr. Cohen and Ms. LaMarre noted the importance of urgent provider evaluations and stated that the failure to ensure that patients with serious medical problems receive urgent provider evaluations seriously compromises the medical care system. One sixty-year-old patient with hypertension and diabetes, for example, was not seen by a provider until more than a week later, when he was sent to the emergency room due to severe congestive heart failure, presenting with low blood pressure, dizziness, and a slow heart rate.

Dr. Cohen and Ms. LaMarre also identified methodological weaknesses in Defendants' data analysis. Although all the patients reviewed by Dr. Cohen and Ms. LaMarre suffered from serious chronic or acute health problems, most of them were not included in Defendants' data analysis. Plaintiffs' experts further noted that three

patients who they found had not been seen within 24 hours, as required, were included in Defendants' data as compliant entries that had been seen.

C. Subparagraph 5(a)(3)

Subparagraph 5(a)(3) requires the following: "If the receiving screening indicates a pretrial detainee has symptoms of tuberculosis, the pretrial detainee immediately will be placed in an Airborne Infection Isolation Room and evaluated promptly for tuberculosis." Doc. 2299 at 2. As the Court has noted, tuberculosis occurs at disproportionate rates among persons who are incarcerated. Doc. 2283 at 32 ¶ 60. Because tuberculosis is spread through the air, the identification and immediate isolation of a symptomatic prisoner can prevent tuberculosis from spreading throughout the facility. *Id.* Defendants reported compliance rates of 100% for each month, noting that "100% of all patients were either placed in isolation promptly, or found to not need isolation after a chart review by the medical director." Doc. 2333 at 7. Among the 49 records Plaintiffs' medical experts reviewed, no patient reported symptoms of tuberculosis; therefore, they were unable to assess compliance with this provision.

D. Subparagraph 5(a)(4)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of Subparagraph 5(a)(4). The provision requires the following: "If the receiving screening indicates a pretrial detainee is known to have HIV infection or is at risk for HIV infection with unknown status, a chest x-ray of the pretrial detainee will be performed and the results reviewed by a physician, physician assistant, or nurse practitioner before the pretrial detainee is placed in a housing unit." Doc. 2299 at 3. Because concomitant HIV infection is a risk factor for the progression of latent tuberculosis to active tuberculosis, a chest x-ray is necessary to rule out tuberculosis among those with HIV or at risk for HIV infection; this practice is recommended by the CDC. Doc. 2283 at 33 ¶ 64, 35 ¶ 74. Defendants reported compliance rates of 85% in March, 100% in April, 97% in May, 100% in June, 100% in July, and 100% in August. Doc. 2333 at 9.

Dr. Cohen and Ms. LaMarre found that among the 15 applicable patient records with known or risk of HIV infection, a chest x-ray was ordered prior to placement in a housing unit in 4 of the records, or 27%. This low rate of compliance is likely due to Defendants' failure to test patients who are *at risk* of HIV infection. Thus, while Defendants may be performing chest x-rays on many (but not all) patients *known to have* HIV infection, they are failing to comply with the part of the provision that requires chest x-rays for at-risk patients. The 11 cases in which a chest x-ray was not ordered, the experts found, primarily involved patients who were at risk of HIV infection due to intravenous drug use, but whose HIV status was unknown. At least three of the noncompliant cases involved patients whose medical histories included HIV/AIDS.

The experts also noted problems with Defendants' methodology: They found that most of the cases they reviewed with respect to this provision were not included in Defendants' compliance analysis. Additionally, two of the cases the experts found to be noncompliant with the provision were reported as compliant in Defendants' data.

E. Subparagraph 5(a)(5)

Defendants have failed to demonstrate compliance with Subparagraph 5(a)(5), which requires the following: "If a pretrial detainee has a positive mental health screening or does not respond to all of the mental health screening questions, the detainee will be assessed by mental health staff while the pretrial detainee is in the intake center. The mental health staff will identify the urgency with which the pretrial detainee must be seen by a mental health provider." Doc. 2299 at 3. The initial mental health assessment and triage are important as a means of timely referring seriously mentally ill prisoners to a provider. *See* Doc. 2283 at 30 ¶ 50. This remedial provision was necessary because, as the Court found, prisoners with serious mental health needs were not consistently "timely assessed by a mental health provider to initiate or continue necessary mental health treatment, including continuation of psychotropic medications prescribed before arrest." *Id.* at 32 ¶ 59.

In their Notice of Defendants' Compliance with Revised Fourth Amended Judgment, Defendants set out their updated Standard Operating Procedures, purporting to comply with the requirements of the Revised Fourth Amended Judgment. Dkt. 2304 at 1-2. Defendants' updated procedures set out mental health screening indicators and provide that "[a]ll patients who are nonresponsive or who endorse mental health questions on the receiving screen are seen by mental health staff before leaving the intake center." SOP J-E-05 (Dkt. 2304-1 at 36-37). Intake mental health staff "determines level of acuity and urgency of provider appointment to be scheduled . . . . All patients who endorsed the [mental health] questions, or are unresponsive are scheduled for a psychiatric provider appointment." *Id.* (Dkt. 2304-1 at 37). Those prisoners triaged as "urgent" must be seen by a provider within 24 hours; those triaged as "priority" must be seen within 72 hours; and those triaged as "routine" do not carry a specified time frame within which they must be seen by a provider. *Id.* The selection of the code is "based on triage and clinical need." *Id.*

Defendants measured compliance with this provision by calculating the percentage of prisoners with positive mental health screenings who were evaluated by mental health staff while in intake. Doc. 2333 at 10. They reported compliance rates of 43% in March, 57% in April, 82% in May, 85% in June, 93% in July, and 98% in August. *Id.*

Two months of compliance rates above 90% does not amount to satisfactory compliance with this provision. Setting aside their poor compliance rates, Defendants have failed to measure the core indicator of compliance with this provision and with their own policy: that is, whether patients with serious mental health needs received a timely provider assessment. Defendants' calculation stops short, evaluating only whether patients were seen and triaged by mental health staff. *See id.* at 10. Their reported rates do not reflect compliance with the CHS policy, or with the essential purpose of this provision that patients be seen by providers to begin or continue their mental health treatments. *See* Declaration of Pablo Stewart, M.D. filed herewith, ¶ 18.

Also, Defendants' methodology for calculating compliance is flawed. Defendants' TechCare reports include a column listing the triage category, if any, assigned by mental health staff to patients following a positive mental health screening at intake.[1] As Plaintiffs' mental health expert, Dr. Stewart, reported, these triage codes did not appear in the patient medical charts he reviewed. In fact, the Jail's mental health director, Dr. Noggle, informed Dr. Stewart that there are no triage codes documented as part of the intake process. Dr. Noggle stated that CHS determined the triage category for each patient listed in Defendants' data by reading the intake records and then deciding post-hoc what urgency category had been assigned to the provider appointment. Dr. Stewart was also informed by CHS staff that there is no designated place on the intake form to note the triage code. Defendants have admitted to violating Subparagraph 5(a)(5) and their own policies and procedures. *See id.* ¶ 16.

Absent documented triage codes, the only way to determine whether mental health staff appropriately triaged patients for provider assessments based on clinical need is to determine when the patient was first seen by a provider. Dr. Stewart identified records in which patients were triaged for provider assessments but were not, in fact, seen within the required timeframes. Dr. Stewart also identified patients who were not timely continued on their community-prescribed medications after intake. He further identified patients who were absent from Defendants' data, despite positive mental health screenings. Among Dr. Stewart's 47 record reviews, 28 patients were booked during the six-month reporting window; 22 of those patients indicated positive mental health screenings. None was compliant with Subparagraph 5(a)(5) because, as Dr. Stewart reported, no urgency codes were noted for provider appointments following intake screenings. Dr. Stewart found other areas of noncompliance with the remedy in 9 (41%) of the records. *See id.* ¶¶ 19-27.

[1] In approximately half of the entries, the "Urgency Identified" column row has been left blank.

F. Subparagraph 5(a)(6)

Subparagraph 5(a)(6) requires the following: "If the receiving screening indicates a pretrial detainee is at risk for suicide, a psychiatrist, psychiatric nurse practitioner, or physician assistant will conduct a face-to-face assessment of the pretrial detainee within 24 hours after the receiving screening." Doc. 2299 at 3. Most suicides occur within the first 48 hours of incarceration. Doc. 2283 at 52 ¶ 206. A timely provider assessment is necessary to ensure that any prisoner at risk of suicide is transferred to an appropriate level of care. The Court found that Defendants failed to show that the receiving screening resulted in "timely placement of pretrial detainees who presented with serious . . . mental health needs at intake in units within the [Jail] or facilities outside the Jail that provided access to adequate treatment." *Id.* at 36 ¶ 81. The Court also found that Defendants failed to show that pretrial detainees at risk for suicide were consistently transferred to the MHU. *Id.* at 31 ¶ 54.

Defendants calculated compliance by determining whether each prisoner identified at intake as a suicide risk and placed on suicide watch was assessed within 24 hours by a provider. Doc. 2333 at 11-12. An entry was deemed compliant if the patient was seen by a provider within 24 hours or was released from custody within 24 hours. *Id.* at 12. Defendants reported low initial compliance rates: 79% in March, 71% in April, 71% in May, 76% in June, 81% in July, and 81% in August. Doc. 2333 at 12. As required by the Court, Defendants supplied updated compliance rates, which were much improved: 98.7% in June, 99.5% in July, and 98.9% in August. Doc. 2336 at 3.

Defendants based compliance on whether the patient was seen by a provider within 24 hours. *Id.* at 11-12. They did not evaluate whether the patient was placed into an appropriate level of care—namely, the MHU—as a result of the provider assessment, which was a chief concern of the Court in ordering this remedy. *See* Doc. 2283 at 31 ¶ 54.

There are also methodological problems with Defendants' rates that render them unreliable. In calculating their compliance rates, Defendants included as compliant

patients who were released from custody within 24 hours. Doc. 2333 at 3; Doc. 2336 at 2-3. These patients should not have been included in the compliance calculation. The focus of this provision is provider contact within 24 hours for those at risk of suicide, not patients who were released early and were not required to see a provider. Adding this population to the compliant entries artificially inflates Defendants' rate of compliance. Further, Defendants arrived at their supplemental compliance rates by conducting "chart audits for all pretrial detainees who appeared on the TechCare reports to not have been seen within 24 hours (nor released)." Doc. 2336 at 3.

G. Subparagraph 5(a)(7)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of Subparagraph 5(a)(7), which provides, "Pretrial detainees will be tested for tuberculosis within 14 days after the receiving screening unless they have been tested with negative results within the past year." Doc. 2299 at 3. Defendants reported compliance rates of 98% in March and April and 99% in the remaining months. Doc. 2333 at 13-14. Dr. Cohen and Ms. LaMarre found that 39 of the 46 applicable records, or 85%, were compliant with the requirements of the provision. In addition, the experts noted that two of the relevant cases they reviewed were not included in Defendants' data. Furthermore, four of the cases the experts identified as noncompliant were reported by Defendants as compliant.

H. Subparagraph 5(a)(8)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of Subparagraph 5(a)(8), which requires the following: "Pretrial detainees with serious acute and chronic medical conditions will be evaluated face-to-face by a medical provider and will receive an initial health assessment within 24 hours after the receiving screening." Doc. 2299 at 3. This remedy was enacted after Defendants failed to show that pretrial detainees were "proactively assessed and treated" in a timely fashion, "including ordering and accessing basic laboratory tests." Doc. 2203 at 37 ¶ 92. Defendants reported initial compliance rates of

89% in March, 83% in April, 83% in May, 87% in June, 89% in July, and 86% in August. Doc. 2333 at 14-15. In their Supplemental Report, Defendants added to their initial compliance rates the percentage of prisoners released from custody within 24 hours each month. Doc. 2336 at 4. They reported revised compliance rates of 93% in March, 87% in April, 86% in May, 92% in June, 94% in July, and 96% in August. *Id.*

Plaintiffs' medical experts first noted a methodological flaw in Defendants' calculation of their revised compliance rates: adding to the compliant entries the prisoners who were released within 24 hours artificially inflated their reported levels of compliance. Prisoners who were released might have been either compliant or noncompliant. The appropriate course of action would have been to exclude this population from the analysis altogether. Their critique of this methodology tracks that of Plaintiffs' mental health expert, Dr. Stewart, who, in his own declaration, discussed the same flaw with respect to several of the mental health provisions.

Dr. Cohen and Ms. LaMarre interpreted this provision to require that pretrial detainees with serious acute and chronic medical conditions will be evaluated face-to-face by a medical provider within 24 hours of the receiving screening and will receive an initial health assessment with a medical provider within 24 hours of the screening. They found that in 23 out of the 47 applicable records reviewed, or 49%, prisoners with serious acute and chronic medical conditions were evaluated face-to-face by a medical provider and received an initial health assessment within 24 hours of the receiving screening. Of note, at the Jail, a RN, rather than a medical provider, performs the initial health assessment. This practice is improper per the Court's Findings of Facts and Conclusions of Law: "Registered nurses with Certified Nurse Examiner training are not qualified to perform comprehensive assessment of serious medical conditions and plan treatment and monitoring for serious medical conditions." Doc. 2283 at 38 ¶ 99. In 3 of the noncompliant cases, neither a provider nor a RN performed an initial health assessment.

The experts also noted that most of the cases they reviewed were not included in Defendants' compliance data. Additionally, Dr. Cohen and Ms. LaMarre identified approximately 8 noncompliant cases that were listed as compliant in Defendants' underlying data.

I. Subparagraph 5(a)(9)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of Subparagraph 5(a)(9). This provision requires the following: "A medical provider will develop plans for treatment and monitoring for pretrial detainees with serious medical conditions." Doc. 2299 at 3. Again, patients risk decompensating in the absence of a timely and effective treatment plan. Defendants reported compliance rates of 98% in March, 98% in April, 98% in May, 97% in June, 96% in July, and 96% in August. Doc. 2333 at 15-16.

In conducting their reviews, Plaintiffs' medical experts considered a patient's record to comply with this provision if, within 24 hours of admission, a provider assessed face-to-face prisoners with urgent or chronic conditions and ordered medications, labs, and follow-up assessments for their acute and chronic conditions as clinically appropriate. They also considered a record compliant where a RN contacted a provider for orders addressing each acute and chronic disease. Records were considered noncompliant where the provider either addressed only the acute problems but not the chronic problems or only the chronic problems but not the acute problems. Prisoners released from custody within 24 hours were not considered. Dr. Cohen and Ms. LaMarre found that providers developed treatment plans in compliance with Subparagraph 5(a)(9) in 29 out of the 47 applicable records they reviewed, or 62% of cases. The experts further found that many of the cases they reviewed were not included in Defendants' analysis.

J. Subparagraph 5(a)(10)

Plaintiffs' record review found that Defendants were compliant with Subparagraph 5(a)(10), which requires that "[a]ll medical Health Needs Requests will

be triaged within 24 hours of their submission." Doc. 2299 at 3. The Health Needs Request (HNR) process is a chief means by which prisoners can communicate their medical needs to Jail staff and receive appropriate treatment by qualified staff. *See* Doc. 2283 at 38 ¶ 101. Defendants reported compliance rates of 99% in March, 98% in April, 98% in May, 99% in June, 99% in July, and 99% in August. Plaintiffs' experts found that 31 out of 31, or 100%, of HNRs reviewed were triaged in compliance with this provision.

K. Subparagraph 5(a)(11)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with the requirements of this provision. Subparagraph 5(a)(11) requires that "[e]ach pretrial detainee who submits a medical Health Needs Request stating or indicating a clinical symptom will be seen by a nurse within 48 hours of submitting the Health Needs Request." Doc. 2299 at 4. The HNR system is an effective means of communicating medical needs only where the patients who file HNRs are timely evaluated and treated by the appropriate medical staff. Defendants reported compliance rates of 84% in March, 84% in April, 81% in May, 83% in June, 81% in July, and 84% in August. Doc. 2333 at 18.

Defendants have not reported a compliance rate over 84%; even by their own figures, they have not shown compliance with this provision. In their review of records, Plaintiffs' experts corroborated these low compliance rates. They found that 28 out of 33, or 85%, of Health Needs Requests stating a clinical symptom resulted in patients being timely seen by a RN.

L. Subparagraph 5(a)(12)

Subparagraph 5(a)(12) requires the following: "When a physician, physician assistant, or nurse practitioner orders a lab test or radiological study, the physician, physician assistant, or nurse practitioner will identify the urgency with which the test or study must be performed, *e.g.*, within 24 hours, 72 hours, or 7–10 days, and the urgency with which the results of the test or study must be returned. The test or study will be

performed within the timeframe ordered by a physician, physician assistant, or nurse practitioner." Doc. 2299 at 4. The Court entered this remedy after finding that Defendants failed to show that lab tests and radiological studies were consistently timely performed after being ordered, made available for review, and reviewed. Doc. 2283 at 39 ¶¶ 106-07. The timely ordering, performance, and review of tests and studies are all vital to ensure that patients receive prompt medical attention; a delay at any stage of the process places the patient at unnecessary risk of serious harm. Defendants reported that 100% of patients in each reporting month either received timely lab and x-ray results or were released from custody prior to the deadline.

Plaintiffs' experts found that the electronic health record does not document the urgency—urgent, emergent, or routine—with which each laboratory or radiological test must be performed. The Jail's Medical Director, Dr. Jeffrey Alvarez, advised them that many labs are sent to the local hospital to be performed. Orders for these labs are contained in progress notes, rather than physician orders; they do not consistently specify the timeliness with which a given test must be performed. Other labs are documented on a physician order, where the provider may designate the lab as "priority." All other labs and radiology tests do not designate an urgency code; they are considered "routine," to be performed within 30 days.

The remedial provision specifically requires that the urgency of labs and tests be identified. As the experts noted, some tests are intentionally scheduled for months in advance, whereas other tests—for example, testing the kidney function of a patient on a medication whose known side effects include kidney damage—are urgent and must be conducted frequently to ensure careful, contemporaneous monitoring. Practitioners at the Jail routinely failed to identify the urgency or non-urgency of a lab or test. Accordingly, Defendants are not in compliance with this provision.

M. Subparagraph 5(a)(13)

Plaintiffs' review of medical records indicates that Defendants are in compliance with Subparagraph 5(a)(13), which provides the following: "Pretrial detainees

identified during the receiving screening as being at risk of serious harm from alcohol or drug withdrawal will be assessed by a registered nurse twice a day for at least seven days regardless of whether they are assigned to a housing unit designated for withdrawing inmates or their classification status. The nurse will document each assessment and identify the urgency with which the pretrial detainee should be seen by a physician, physician assistant, or nurse practitioner. If a pretrial detainee is not seen face-to-face by a physician, physician assistant, or nurse practitioner within the timeframe recommended by the nurse, the reason will be documented in the pretrial detainee's medical record." Doc. 2299 at 4. Withdrawal is a serious and potentially life-threatening condition that may manifest in a number of different symptoms. *See* Doc. 2283 at 39 ¶¶ 108-110. The elements of this provision are designed to ensure that patients in withdrawal are monitored closely and moved, where necessary, to the appropriate level of care. *See id.* at 39-40. Defendants reported the average length of detox and average number of RN assessments over the reporting period for several populations: those in detox for alcohol withdrawal (7.6 days in detox and 6.6 assessments); those in detox for benzodiazepine withdrawal (8.3 days in detox and 7.2 assessments); and those in detox for opiate withdrawal (9.1 days in detox and 8.1 assessments). Doc. 2333 at 21. Defendants further reported the percentage of prisoners timely seen face-to-face by a provider within the timeframe requested: 88% in March, 94% in April, 87% in May, 89% in June, 95% in July, and 87% in August. *Id.* at 22.

Dr. Cohen and Ms. LaMarre found that 31 out of 34 applicable records, or 91%, showed that the patient was assessed twice a day for at least seven days.

N. Subparagraph 5(a)(14)

Subparagraph 5(a)(14) requires the following: "All mental health Health Needs Requests stating or indicating a clinical symptom will be triaged face-to-face within 48 hours of their submission." Doc. 2299 at 4. The HNR triage process is a vital means by which seriously mentally ill prisoners gain access to providers; it is an important communication tool to ensure that they do not suffer and decompensate without an

appropriate assessment and treatment by a provider. As the Court held, only providers can"[d]evelop[] or modify[] the pretrial detainee's treatment plan, and deciding when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care." Doc. 2283 at 48. Defendants revised their policies accordingly, requiring that patients with "urgent psychiatric need" be seen by a provider within 24 hours. SOP J-E-07.

Defendants calculated compliance by determining whether prisoners who submitted an HNRs stating a clinical symptom were seen by mental health staff within forty-eight hours. *Id.* at 22-23. Defendants reported compliance rates of 82% in March, 94% in April, 96% in May, 94% in June, 95% in July, and 94% in August. *Id.* at 23.

Defendants did not include data on whether mental health staff actually assessed the patient, as the provision requires. Although Defendants' data purports to measure whether patients were triaged within the specified timeframe, it is not clear from the data that an actual assessment took place. Relatedly, Defendants' data does not capture whether those patients who were triaged for provider assessment were ever, in fact, timely assessed by a provider following the triage, as their policy requires. Instead, the data indicates only whether some face-to-face contact with mental health staff occurred. *See* Doc. 2333 at 22-23. Triage of prisoners stating clinical symptoms in their HNRs is a means to meaningful provider access; it is not an end in itself. Follow-up provider assessments are an integral component of the provision of adequate care with respect to the HNR process, as Defendants' own policy requires. Data on the disposition of the HNR, including the triage category assigned and date of follow-up provider assessment, if any, would more accurately depict compliance with this provision. *See* Stewart Dec. ¶ 42.

Because Defendants' underlying data for this provision consisted of monthly summaries, rather than itemized dispositions of individual HNRs, Dr. Stewart was unable to evaluate their underlying compliance data for accuracy. However, he identified violations of the provision, including both cases in which the patient was not

timely seen face-to-face by mental health staff and cases in which the patient was not referred to a provider following assessment by mental health staff, despite remaining symptomatic. *Id.* ¶ 43-46.

Among his 47 record reviews, Dr. Stewart identified 12 relevant mental health HNRs; of those, 6 (50%) were noncompliant with the requirements of this provision. *Id.* ¶ 47.

O. Subparagraph 5(a)(15)

Defendants have failed to show compliance with Subparagraph 5(a)(15), which requires the following: "Upon referral by detention, intake, medical, or mental health staff, pretrial detainees who display active symptoms of mental illness or otherwise demonstrate an emergent mental health need will be seen face-to-face by a mental health provider within 24 hours of the referral." Doc. 2299 at 4. Referrals and triage for timely provider assessments are, along with the HNR process, the chief means by which prisoners with serious mental health needs may make those needs known. The purpose of the referral process is to ensure that prisoners experiencing serious mental health symptoms have access to adequate care by a psychiatric provider. As the Court found, patients referred with an urgent mental health condition "can and must be seen face-to-face by a mental health provider within 24 hours of identification." Doc. 2283 at 47 ¶ 169.

Defendants revised their procedures to require that mental health staff evaluate patients who are referred to determine whether an appointment with a provider or other mental health follow-up is necessary. *See* Doc. 2333 at 23-24. If the patient displays an "emergent mental health need," he or she will be seen within twenty-four hours. *Id.* Defendants calculated compliance by evaluating whether those prisoners who were referred to CHS "as displaying active symptoms of mental illness or demonstrating an emergent mental health need" were seen by a provider within twenty-four hours of the referral. *Id.* at 24. Defendants reported poor compliance rates in their initial

Compliance Report: 69% in March, 45% in April, 50% in May, 72% in June, 74% in July, and 75% in August. *Id.* at 25.

Defendants submitted revised rates of compliance in their Supplemental Report, in which they reported compliance rates of 94% for June, 95% for July, and 96% for August. Doc. 2336 at 7. In producing their revised compliance rates, Defendants added to the compliant entries all those prisoners who were released from custody within 24 hours. *Id.* at 5. Those entries should have been excluded from the data altogether; such prisoners are not material to the question of whether prisoners were timely seen by a provider following a referral. Also, Dr. Stewart reviewed the medical charts for a sampling of 25 patients whose referrals Defendants changed from noncompliant to compliant or removed from their data when calculating their revised compliance rates. He found that 7 of them (28%) were in fact noncompliant and should not have been changed in the revised compliance calculations. *See* Stewart Dec. ¶ 51-52. An error rate of close to 30% shoes that Defendants' revised compliance rates are unreliable.

Furthermore, Defendants' underlying methodology in calculating compliance with this provision was deficient. Defendants' method of capturing referrals to be included in their TechCare data excluded a large swath of referrals. Defendants reported that their TechCare data included every referral made from detention staff to mental health staff, whether or not the patient was triaged as needing a provider assessment. *See* Doc. 2336 at 6. Defendants stated, "The TechCare reports generated included every referral in the data population, including those that were deemed to not qualify under subparagraph 5(a)(15) upon assessment by mental health staff." *Id.* In fact, as Dr. Stewart noted in his patient record reviews, numerous referrals are missing from the TechCare data. It appears that Defendants added entries to the TechCare reports by looking at documented correspondence between MCSO and CHS. Referrals that were documented by notes from mental health staff were not included in the TechCare reports. *See* Stewart Dec. ¶¶ 54-62.

Provision 5(a)(15) requires that any patient who displays "active symptoms of mental illness" or demonstrates "an emergent mental health need" must be seen by a provider. Doc. 2299 at 4. The essence of this provision is its mandate that symptomatic patients have access to a provider. Defendants' revised procedures provide that, following a referral from detention, intake, medical, or mental health, mental health staff will evaluate the patient to determine whether an appointment with a provider or other mental health follow-up is needed. CHS SOP J-E-07 (Dkt. 2304-1 at 106-07); *see also* CHS SOP J-E-05 (Dkt. 2304-1 at 101-02). If staff determine that "the mental health condition is emergent," then they will "schedule a face-to-face psychiatric provider appointment within 24 hours." *Id.*

Dr. Stewart found dozens of cases of seriously mentally ill prisoners who did not receive timely provider assessments following referrals because they were inaccurately triaged by mental health staff. For example, while she was housed in segregation, Patient FA was referred by detention staff to mental health staff on multiple occasions for command auditory hallucinations and other danger-to-self (DTS) statements. Mental health staff did not triage her for a provider assessment consistent with CHS policy or the remedy, and she was not seen by a provider until she was transferred to the MHU. This pattern repeated after Ms. FA was released back to segregation. *See* Stewart Dec. ¶¶ 63-69.

Of the 47 records Dr. Stewart reviewed, 32 were relevant to this provision. Of those, 21 (66%) were noncompliant with the remedy and CHS policy.. Many of the records demonstrated a pattern of repeated failures by mental health staff to timely refer patients to a provider, as required by the remedy and CHS policy. Many of the records were not included in Defendants' TechCare data. *See id.* ¶ 70.

P. Subparagraph 5(a)(16)

Defendants have not shown compliance with Subparagraph 5(a)(16). This provision requires the following: "Mental health providers will assess pretrial detainees in an area outside of their cells that affords sound privacy except when there are

legitimate safety, security, and treatment reasons for not doing so." Dkt. 2299 at 4. Confidential, private visits lead to more accurate, effective assessments. Cell-side contacts are not an adequate substitute and may compromise the clinical relationship between provider and patient. As the Court noted, "Evaluating a pretrial detainee's mental health condition, developing or modifying the pretrial detainee's treatment plan, and deciding when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care must be performed by a mental health provider after the provider has assessed the pretrial detainee face-to-face in a space that at least provides sound privacy." Doc. 2283 at 47 ¶168.

The two policies cited by Defendants in their Compliance Report pertain only to two limited categories of provider assessments: assessments conducted in the MHU by providers for admission, transfer, or discharge determinations; and assessments conducted for psychotropic medication administration and management. *See* Doc. 2333 at 25. The language of Subparagraph 5(a)(16) requires that all provider assessments—not just assessments pertaining to those limited categories—be conducted in a confidential setting. As noted by Dr. Stewart, however, Defendants have calculated compliance with this provision based on all provider assessments, not just assessments that fall under the limited categories specified in their revised procedures. *See* Stewart Dec. ¶ 74.

Defendants measured compliance by determining whether a provider assessment either was conducted in a private setting or was conducted cell-side with a "legitimate reason." Doc. 2333 at 25-26. Where an assessment was conducted cell-side, rather than in a confidential setting, Defendants conducted chart audits "to determine whether a legitimate reason was documented for not doing so." *Id.* at 26. The "legitimate reasons" noted by Defendants in their TechCare data include "Safety Concerns," "Security Concerns," "Treatment Reasons," "Patient Refusal," and "Patient Unavailable." Defendants reported compliance rates of 89% in March, 100% in April, 99% in May, 89% in June, 99.5% in July, and 96% in August. *Id.*

Although the remedial provision includes an exception for cell-side assessments, the Court mandated that patients be seen in an area that affords sound privacy. Doc. 2283 at 47 ¶168. The Court's mental health expert Kathryn Burns, M.D. testified to the important role that confidentiality and privacy in generating a productive evaluation. *See* Mar. 5, 2014 TT at 22:18-23:22 (Burns). By producing compliance rates that combine all private assessments and all cell-side assessments that Defendants claim fall under an exception, Defendants have obscured the actual rate at which patients receive private, confidential assessments. Non-confidential assessments constituted a significant portion of all compliant entries—almost 30% in August, for example. *See* Stewart Dec. ¶¶ 75-76.

To comply with the requirements of Subparagraph 5(a)(16), there must be a legitimate reason for the non-private assessment. Dr. Stewart found that the reason supplied in the TechCare data for a non-private assessment frequently was unsupported or, in many cases, contradicted by the patient's medical chart. In many cases, the patient's record included only the term "safety reasons," "security reasons," or "treatment reasons," providing no meaningful explication of any existing safety, security, or treatment rationale dictating a cell-side visit. In some cases, Dr. Stewart found that the provider's accompanying note actually undercut the reason listed. For example, some cell-side assessments were deemed compliant in the TechCare data for "treatment reasons;" the corresponding provider notes in patient records, however, showed that the patient was seen cell-side due to "provider's time constraints." This is not a legitimate treatment reason, and such entries should not have been deemed compliant in Defendants' data. *See* Stewart Dec. ¶ 77-89.

In all, Dr. Stewart reviewed 33 records for compliance with this provision. Of those, 16 (48%) were noncompliant with the remedy and CHS policy. Most of the records contained multiple instances of noncompliance with the provision. Dr. Stewart further noted that a number of the noncompliant assessments he identified were absent from Defendants' TechCare data. *See id.* ¶ 91.

Q. Subparagraph 5(a)(17)

Defendants have failed to demonstrate compliance with Subparagraph 5(a)(17), which requires the following: "Defendants will adopt and implement written criteria for placing pretrial detainees in each level of mental health care, including subunits within the Mental Health Unit." Doc. 2299 at 5. As the Court found, "Although there are criteria for placement in each level of mental health care, including subunits within the [MHU], Defendants have not shown that the placement criteria are clearly articulated in writing and consistently and timely applied." Doc. 2283 at 47-48 ¶170.

Absent well-defined standards for the placement of prisoners into the appropriate level of care, as the Court further found, prisoners cycle in and out of the MHU. *See id.* at 47 ¶164. They "are transferred directly from an acute unit to the general population housing without transition placement within the [MHU], they are not stable enough to remain in general population housing, and they are transferred back to the [MHU]." *Id.*

Defendants updated their policies to provide written criteria for admission to the MHU and for placement in the step-down units of the MHU. Doc. 2333 at 26; Doc. 2304-1 at 137-38, 142. They also set out three levels of care for mental health patients in outpatient housing. Doc. 2304-1 at 144-45. Defendants have asserted compliance with the requirements of Subparagraph 5(a)(17) by simply updating their policies and procedures. *See* Doc. 2333 at 26-27. They have not, however, shown compliance with this provision. Defendants have provided no data assessing whether their updated policies and procedures have been implemented. The clear language of this provision requires Defendants not only to "adopt" but also to "implement" written criteria. Doc. 2299 at 5. *See* Stewart Dec. ¶¶ 94-97.

Defendants have not adhered to their own newly revised criteria for making level of care determinations. The problems identified by the Court—necessitating the entry of this remedial provision—persist at the Jail. The MHU admission criteria remain too high and the MHU discharge criteria remain too low. As a result, prisoners who are seriously mentally ill languish in the outpatient facilities without appropriate care, and

clinically unstable patients are discharged back to outpatient care. Dr. Stewart further found that Defendants have not utilized the MHU's step-down units. Once admitted to the MHU, patients often remain locked down in its acute units, denied access to important psychosocial rehabilitation programming. Finally, and relatedly, patients in outpatient levels of care continue to receive inadequate care as a result of the Jail's ill-managed levels of care. *See* Stewart Dec. ¶¶ 98-106.

Among the 47 records Dr. Stewart reviewed, 29 (62%) show non-compliance with the remedy and CHS' level of care policy, embodied the problems of delayed MHU admissions, premature MHU discharges, insufficient use of the step-down units, and inadequate outpatient care. *See* Stewart Dec. ¶¶ 107-194.

R. Subparagraph 5(a)(18)

Defendants have not shown compliance with Subparagraph 5(a)(18). That provision requires the following: "A mental health provider will determine the placement of each seriously mentally ill pretrial detainee after performing a face-to-face assessment, including upon admission into, transfer within, and discharge from the Mental Health Unit." Doc. 2299 at 5. As the Court found, a qualified mental health provider must "[e]valuat[e] a pretrial detainee's mental health condition, develop[] or modify[] the pretrial detainee's treatment plan, and decid[e] when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care" only after conducting a face-to-face assessment in an area "that at least provides sound privacy." Doc. 2283 at 47 ¶168. The harms that result from inadequate placements into the appropriate level of care are discussed above with respect to Subparagraph 5(a)(17).

As described in their Compliance Report, Defendants measured compliance by comparing the date and time of a patient's MHU placement or discharge against the date and time of the corresponding provider assessment, if any. Doc. 2333 at 28. Compliance rates were calculated by combining the percentage of prisoners who were assessed prior to their admission into, transfer within, or discharge from the MHU with

the percentage of prisoners who were released within twenty-four hours. *Id.* In their original Compliance Report, Defendants reported poor levels of compliance: 72% in March, 74% in April, 73% in May, 83% in June, 82% in July, and 85% in August. Doc. 2333 at 28. In their Supplemental Report, Defendants conducted chart audits for the months of June, July, and August 2015 and reported compliance rates of 92% in June, 87% in July, and 96% in August. Doc. 2336 at 9.

Defendants' methodology for calculating compliance is flawed in several respects. First, Defendants assessed only MHU placements; they did not assess the placement of seriously mentally ill patients in any of the outpatient levels of care. By its plain terms, Subparagraph 5(a)(18) applies to all levels of care, including both the MHU and outpatient levels. Additionally, as in other provisions, Defendants added to their compliant entries all those who were released within twenty-four hours of their assessment. Doc. 2333 at 28. This population does not reflect whether providers are timely assessing patients on their MHU admissions, transfers, and discharges. These entries are irrelevant to the mandate of Subparagraph 5(a)(18) and should not have been included in the compliance data. Defendants' methodology in auditing their compliance data and providing updated compliance rates was flawed. . *See* Stewart Dec. ¶¶ 198-202.Dr. Stewart also identified a number of discrepancies with Defendants' TechCare data. He identified a number of missing entries. He also found instances of noncompliance that were reported as compliant in Defendants' TechCare data. *Id.* ¶ 203-04. Taken together, these methodological problems render Defendants' reported compliance rates unreliable.

Most importantly, Dr. Stewart found that Defendants' reported rates of compliance do not capture their true compliance with the underlying purpose behind this provision. As discussed above, this remedy was entered to ensure that patients are placed in an appropriate level of care in order to receive adequate treatment. Defendants have measured only whether patients were seen by a provider within the appropriate timeframe; they have made no effort to discern whether the ordered MHU

admissions and discharges were appropriate based on the patients' clinical presentation, as required by CHS policy. Nor have Defendants evaluated whether patients were timely moved from the acute units of the MHU into step-down units, as required by policy. Indeed, as the patient narratives Dr. Stewart listed with respect to Subparagraph 5(a)(17) suggest, Defendants have not shown compliance with Subparagraph 5(a)(18) or CHS policy. *Id.* ¶ 205.

S. Subparagraph 5(a)(19)

1. Subparagraph 5(a)(19), requires the following: "Pretrial detainees discharged from the Mental Health Unit will be assessed by mental health staff within 48 hours after discharge." Doc. 2299 at 5. As the Court found, Defendants failed to show that patients in the MHU were being properly stabilized before being discharged to an outpatient level of care. *See* Doc. 2283 at 47 ¶164. Discharging clinically unstable patients from the MHU results in their decompensating in outpatient care and necessitates re-admission to the MHU. *Id.* A timely assessment following MHU discharge would identify those patients who are not stable for outpatient care and need to be assessed by a provider to determine if they need to be re-admitted to the MHU or some other form of treatment. As the Court recognized, "[e]valuating a pretrial detainee's mental health condition, developing or modifying the pretrial detainee's treatment plan, and deciding when a pretrial detainee should be placed in or discharged from a specific facility to obtain appropriate mental health care must be performed by a mental health provider after the provider has assessed the pretrial detainee face-to-face in space that at least provides sound privacy." Doc. 2283 at 47. Defendants reported compliance rates of 93% in March, 90% in April, 85% in May, 88% in June, 96% in July, and 92% in August. Doc. 2333 at 29.

Defendants' asserted compliance rates do not respond to the underlying deficiency the Court sought to address through this provision. The Court entered this remedy to address the problem of clinically unstable patients being prematurely discharged from the MHU and lingering in outpatient care without being timely re-

admitted to the MHU. Dr. Stewart found numerous records in which a patient was discharged from the MHU while still clinically unstable and remained unstable in outpatient care through their post-MHU discharge assessment. *See* Stewart Dec. ¶¶ 210-15.

Dr. Stewart reviewed 18 records to assess Defendants' compliance with this provision. He identified 3 violations of the requirement that patients be seen my mental health staff within 48 hours of their MHU discharge. He identified 11 other records where patients were prematurely discharged from the MHU and remained clinically unstable at the time of their post-MHU discharge assessment, but were not timely referred on to a provider to determine appropriate housing and treatment. *Id.* ¶ 217.

T. Subparagraph 5(a)(20)

Defendants have not shown compliance with the requirements of Subparagraph 5(a)(20). That provision requires the following: "MCSO will consult with CHS mental health staff before placing a seriously mentally ill pretrial detainee in any type of segregated confinement." Doc. 2299 at 5. Seriously mentally ill prisoners are prone to decompensation when placed in segregation. As the Court found, "[t]he longer a pretrial detainee with mental illness is in isolation, the greater the risk the pretrial detainee's mental condition will deteriorate." Doc. 2283 at 48 ¶ 177. Mental health input is an important safeguard to ensure that, where clinically contraindicated, seriously mentally ill prisoners are not placed in isolation.

Defendants measured compliance by generating "data for each seriously mentally ill pretrial detainee for which MCSO requested an evaluation during the reporting month." Doc. 2333 at 29-30. Per Defendants' policies and procedures, before a seriously mentally ill patient is placed in segregation, CHS must "review and document considerations regarding impact of segregation in the patient's health record and provide written considerations to MCSO" regarding the appropriateness of segregation for the patient. *See id.* Defendants measured compliance by determining whether the consultation occurred prior to the segregation placement. *Id.* at 30. In their original

Compliance Report, Defendants reported poor rates of compliance: 59% in March, 50% in April, 67% in May, 61% in June, 57% in July, and 80% in August. *Id.* Defendants conducted chart review audits for June, July, and August 2015 and reported updated compliance rates of 61% in June, 80% in July, and 92% in August.[2]

Even on their face, Defendants' rates do not demonstrate compliance with the requirements of Subparagraph 5(a)(20). A single month of compliance over 90% is insufficient to show full compliance during the six-month reporting period. Furthermore, Defendants arrived at their data—both in their Compliance Report and Supplemental Compliance Report—using unsound methodologies. First, Defendants generated entries by looking to all instances in which MCSO "requested an evaluation during the reporting month." Doc. 2333 at 29-30. The data apparently do not account for any prisoners who were placed into segregation without any consultation requested—whether before or after the placement. Rather than relying on requests for consultation, Defendants should have generated entries based on all admissions into segregated confinement by seriously mentally ill prisoners. Doing so would provide a more accurate and reliable picture of Defendants' compliance with this provision.

Defendants' decision to structure their data around requests for consultation rather than actual placements resulted in additional methodological problems beyond under-inclusiveness. For numerous patients, Defendants' TechCare data includes multiple entries—based on multiple consultations—pertaining to a single placement.

---

[2] In reporting their revised compliance rates, Defendants stated that many of the consultations and placements listed were actually compliant or should have been removed from the data population altogether. Defendants supplied to Plaintiffs lists of the entries they changed from non-compliant to compliant or removed from the data set for the months of July and August 2015. The numbers in the lists they provided do not match the numbers they reported in their Supplemental Report. For example, they stated that 17 entries were removed because the individual was already in segregation. Doc. 2336 at 9-10. The list they provided to Plaintiffs, however, contained 74 entries. These discrepancies make Defendants' revised compliance rates unreliable. *See* Declaration of Eldon Vail filed herewith, ¶¶ 75-76.

The TechCare data is warped based on the number of duplicate entries. Defendants seemed to recognize this problem in their Supplemental Report, in which their chart audits of noncompliant entries revealed twenty-nine duplications from the June, July, and August 2015 data. Doc. 2336 at 9-10. However, again, Defendants audited only the noncompliant entries. *Id.* In generating revised compliance rates for their Supplemental Report, Defendants apparently removed the noncompliant duplicates but left the compliant duplicates untouched. Even after identifying this methodological problem, Defendants failed to fully resolve it. *See* Stewart Dec. ¶ 222-24.

In his review of patient records, Dr. Stewart found a pattern of noncompliance and discrepancies between the underlying records and Defendants TechCare reports. He identified numerous cases in which patients were placed in segregation with no documented mental health consultation. Many of the noncompliant segregation placements he found were absent from Defendants' data. *See id.* ¶¶ 226-238. In all, Dr. Stewart reviewed 20 relevant patient records in which a patient was placed into segregation within the reporting period. Among those, 10 (50%) were noncompliant with the consultation requirement. *Id.* ¶ 251. Many of these records included multiple segregation placements which were not preceded by a mental health consultation. Many of the placements are not included in Defendants' TechCare data. Plaintiffs' corrections expert, Eldon Vail, reported similar findings. In his review of the medical charts of the 30 patients who received a sanction of segregation after a planned use of force from June-August 2015,[3] he found documentation of the required mental health consultation in 20 (67%). Vail Dec. ¶ 72.

Beyond identifying serious problems with the quality and accuracy of Defendants' TechCare data, both Dr. Stewart and Mr. Vail noted the superficiality of CHS consultations, to the extent they were documented in patient records. Looking at

[3] Mr. Vail identified these patients by comparing the list of names in Defendants' TechCare reports for Subparagraphs 5(a)(22) and 5(a)(23) against their corresponding Disciplinary Action Reports.

the underlying patient records, as Dr. Stewart noted, the "consultation" is an empty exercise that generally results in boilerplate language approving the placement into segregation. Even in the few records in which CHS found that segregation was likely contraindicated, it again relied on boilerplate language. Furthermore, despite the concern noted, these patients were still placed in segregation. Dr. Stewart found no instance, in the forty-seven patient records he reviewed, in which consultation with CHS resulted in a patient's diversion from segregation. Stewart Dec. ¶¶ 239-50.

Mr. Vail made similar findings. He found that, even where contraindicated, patients are still placed in segregation. He identified just one case in the six month reporting period in which a mental health consultation successfully diverted a patient from a segregation placement. He found that the volume of seriously mentally ill prisoners subjected to segregation indicates the poor quality of the consultation and review process. Vail Dec. ¶¶ 77-88.

U. Subparagraph 5(a)(21)

Defendants have not shown compliance with this provision. Subparagraph 5(a)(21) requires the following: "Seriously mentally ill pretrial detainees who are confined to single cells for 22 or more hours a day will have face-to-face communication with mental health staff at least twice per week." Doc. 2299 at 5. As the Court noted, the longer a seriously mentally ill prisoner remains in segregation, the greater the risk of decompensation. Doc. 2283 at 48 ¶177. Given the significant risks of clinical deterioration associated with placing seriously mentally ill prisoners in isolation, meaningful bi-weekly assessments are necessary "to identify adverse effects of segregation" on the mental health of seriously mentally ill prisoners. *Id.* at 49 ¶ 180. These face-to-face assessments "would mitigate the risks of isolation inherent" in segregating seriously mentally ill prisoners. *Id.* at 50 ¶ 185.

Defendants revised their policies and procedures to require that mental health staff "[h]ave twice weekly face to face contact with all seriously mentally ill or mental health chronic care patients who are confined to single cells for 22 hours or more a

day." SOP J-E-09 (Dkt. 2304-1 at 188). "Contact includes 1:1, group psychoeducational sessions, and/or rounds; . . . mental health assessments and updates, [and] psychiatric provider appointments." *Id.* Contact must be documented in patients' electronic health records. Mental health staff must "conduct[] rounds at cell front that consist of verbal interaction, mental status and observations. Each patient is given the opportunity to communicate health care concerns." *Id.* Rounds must be documented, including patient refusals. *Id.*

To measure compliance, Defendants conducted manual audits of the third week of each month for those seriously mentally ill prisoners who were housed in a segregation unit during that month. Doc. 2333 at 31. Where the patient was seen two times during the week in question, the entry was deemed compliant. *Id.* Defendants reported compliance rates of 88% in March, 98% in April, 98% in May, 99.6% in June, 98% in July, and 95% in August. *Id.*

Defendants' measure of compliance provides no indication of whether the bi-weekly contacts satisfy the requirements of their own policies and procedures regarding the content of the assessments. It thus ignores the underlying purpose behind the remedy: to identify and treat patients who are deteriorating in isolation. Defendants have measured compliance based on bare mental health rounds; they have not accounted for whether the rounds included, as required by Defendants' policies, "verbal interaction, mental status and observations." Doc. 2304-1 at 188. Dr. Stewart's review of patient records revealed that the mental health segregation rounds do not supply prisoners in segregation the meaningful face-to-face contact that Defendants' policies and procedures require. Mental health staff conducting segregation rounds typically use forms on which they merely check off boxes for "no health concerns noted" and "no observable change in mental status," without noting patient symptoms or ongoing problems. Meanwhile, other assessments by mental health staff or providers during the same time period documented these patients' decompensation, psychosis, and squalid cell conditions. For example, Patient AD is noted in Defendants' data as compliant for

her March, May, June, and July 2015 segregation placements. Notes from the patient's segregation rounds indicated "no observable change in mental status" and "no health concerns noted." In stark contrast, other assessments over the same periods of time noted that she was talking to herself and experiencing auditory and visual hallucinations. She reportedly stated her belief that she was being fed people in her food. This example, typical of many such patient records, demonstrates the poor quality of segregation rounds. *See* Stewart Dec. ¶¶ 256-268.

Dr. Stewart identified 39 records in which a patient was housed in segregation during the reporting timeframe. Among those, he looked closely at the weekly mental health rounds for 13 of the patients. He found that, in each case, Defendants were noncompliant with their own policy requiring meaningful face-to-face rounds with mental health staff. *Id.* ¶ 270.

V. Subparagraphs (22)-(23)

Defendants have failed to show compliance with Subparagraphs (5)(a)(22) and 5(a)(23). As required by Subparagraph 5(a)(22), "A mental health provider or professional will be consulted before each planned use of force or involuntary treatment on a seriously mentally ill pretrial detainee." Doc. 2299 at 5. As required by Subparagraph 5(a)(23), "Mental health staff will be involved in the implementation of any planned use of force or involuntary treatment on a seriously mentally ill pretrial detainee." *Id.* A seriously mentally ill prisoner's mental illness may impair his ability to comply with orders. The consultation and involvement requirements ensure that mental health staff is available to assess the prisoner's condition and intervene to de-escalate the situation. As the Court noted, mental health staff "have specialized training that makes them especially equipped to de-escalate a potential confrontation with detention staff." Doc. 2283 at 50 ¶ 189. The consultation and involvement requirements are intended to reduce the incidence of planned uses of force or involuntary treatment through mental health interventions. *See id.*

Defendants generated compliance data for both provisions together by compiling the number of instances in which CHS was consulted on a planned use of force involving a prisoner designated Seriously Mentally Ill (SMI) or Mental Health Chronic Care (MHCC). Doc. 2333 at 32. Defendants arrived at their compliance rates by comparing the date and time at which a mental health consultation was requested against the date and time at which the planned use of force incident—with mental health involvement—took place. *Id.* A planned use of force incident was deemed compliant where the consultation preceded the planned use of force. *Id.* Defendants reported compliance rates of 100% for all months during the reporting period.

Defendants' methodology is also flawed in several respects, rendering their reported rates unreliable. Defendants drew their data from only those instances in which MCSO requested a consultation with CHS. The TechCare data is limited to planned use of force events in which CHS was contacted. It fails to include any planned use of force event in which there was no documented consultation because CHS was not contacted. Rather than rely on consultations, a more appropriate measure of compliance would have compiled a list of planned use of force events based on incident reports, use of force reports, or other data indicating a use of force event. Additionally, Defendants drew their data from those already designated SMI or MHCC; it therefore excluded any patients suspected of being seriously mentally ill but who were not yet designated. In its Findings of Fact and Conclusions of Law, the Court noted, "The fact that a pretrial detainee has not been designated Seriously Mentally Ill by the county public mental health provider does not mean the pretrial detainee does not have serious mental illness." Doc. 2283 at 51 ¶ 195; *see* Stewart Dec. ¶ 277.

In his review, Dr. Stewart identified 5 planned use of force events; of those, 2 were noncompliant. He also noted that 2 of the incidents were not included in Defendants' TechCare reports. Stewart Dec. ¶ 282.

Furthermore, Plaintiffs' corrections expert Eldon Vail assessed all relevant documentation described in both MCSO and CHS policies that Defendants wrote to

effectuate these provisions.. Among the 64 incidents listed in Defendants' June-August 2015 TechCare data for Provisions (22) and (23), Mr. Vail found that mental health involvement was documented among Incident Summaries, Disciplinary Action Reports (DARs), forced medication records, and OJ Query files[4] for just 32 (50%) of the incidents. Further, in reviewing the electronic patient medical charts for each of the 64 entries, Mr. Vail found documentation of mental health consultation and involvement for just 38 (59%) of the incidents. Vail Dec. ¶¶ 25-34.

W. Subparagraphs (5)(a)(24)-(26)

Defendants have failed to demonstrate compliance with Subparagraphs 5(a)(24), (25), and (26), which relate to the use of discipline on seriously mentally ill prisoners. Subparagraph 5(a)(24) requires that Defendants "adopt and implement a written policy regarding the use of discipline for behavior resulting from serious mental illness." Doc. 2299 at 5. Subparagraph 5(a)(25) requires Defendants to "adopt and implement a written policy regarding the use of isolation in a disciplinary segregation unit as a sanction against seriously mentally ill pretrial detainees." *Id.* Subparagraph 5(a)(26) requires that Defendants "adopt and implement a written policy requiring that mental health staff be consulted regarding discipline of any seriously mentally ill pretrial detainee." *Id.* at 6. These provisions stem from the recognition that seriously mentally ill prisoners risk being subject to disciplinary sanctions for behavior that is the product of their mental illness. Mental health staff must be consulted in the disciplinary process to assess whether a prisoner's mental illness requires that disciplinary charges be mitigated. As the Court noted, no seriously mentally ill prisoner should be disciplined for behavior driven by their mental illness "without the approval of a mental health provider." Doc. 2283 at 50 ¶ 193. The Court further found that "[s]eriously mentally ill pretrial detainees should not be placed in isolation as a disciplinary sanction." *Id.* at 51 ¶ 194.

[4] "OJ Query" files appear to be selected log entries.

Defendants set out updated procedures to be followed before discipline—including disciplinary segregation—may be imposed on seriously mentally ill individuals. *See* Doc. 2333 at 32-34. The procedures require that CHS receive from MCSO a Disciplinary Action Report (DAR) regarding the use of any discipline on a seriously mentally ill prisoner. SOP J-A-08. CHS must then "provide recommendations," to be documented by MCSO on the DAR, as to (1) the relationship between the prisoner's mental illness and the behavior which resulted in disciplinary sanctions; (2) the potential impact of sanctions on the patient's mental health, particularly segregation; and (3) whether discipline should be imposed. *Id.* Plaintiffs' expert Mr. Vail believes these are the three appropriate criteria that should be assessed to ensure compliance with the remedy.

Defendants have asserted compliance with Subparagraphs 5(a)(24), (25), and (26) on the basis of their revised policies and procedures. *See* Doc. 2333 at 32-34. The provisions require that Defendants not only adopt policies and procedures but also "implement" them. Doc. 2299 at 5-6. Defendants, however, have produced no compliance data to show implementation of their revised policies on discipline.

Dr. Stewart identified among his record reviews 8 instances in which disciplinary sanctions were imposed, among 6 patients; of those, 6 (75%) were noncompliant. *See* Stewart Dec. ¶¶ 287-93.

Mr. Vail found that mental health staff does not follow the CHS policy requiring findings on the three critical factors listed in the policy. In his review of 470 DARs from March through August 2015, Mr. Vail found documentation of CHS input in approximately a dozen emails addressing approximately 40 patients, only 13 of whom matched to specific names and dates in the DAR files. To the extent it was documented, the actual CHS input was scant; the emails failed to address the three items required by the CHS policy and instead consisted of boilerplate language from staff approving the use of sanctions. Vail Dec. ¶ 42-43.

Looking to the DARs, Mr. Vail found that, in making determinations about sanctions, MCSO hearing officers check boxes on the DAR form to indicate a prisoner's mental illness. In approximately 65 of the 470 DARs he reviewed, the "SMI Inmate" box is checked "yes," but the "Approved for Sanctions" box is left blank, with neither "yes" nor "no" checked. Another 24 DARs left both of these sections blank. Mr. Vail further found 9 instances in which sanctions were assigned despite the fact that the "Approved for Sanctions" box was checked "no." Defendants do not even consistently adhere to the limited mental health input and documentation on the DARs. Mr. Vail found just 10 instances among the DAR files in which sanctions were not imposed on a patient where the "Approved for Sanctions" box ws checked "no." *See* Vail Dec. ¶¶ 44-52.

Mr. Vail also reviewed the medical charts for the patients listed in Defendants' June-August 2015 TechCare data for Provisions (22) and (23). In his review of 31 records in which a sanction was issued in connection with the use of force event, he found that mental health consultation was documented on a MCSO-CHS Correspondence form in the patient's chart, as required by the CHS policy, in 12 cases (39%). Where consultations were documented in the record, they consisted only of boilerplate language. Again, mental health staff fails to make recommendations based on the three criteria set out in Defendants' policy. In only one instance did CHS find that sanctions were contraindicated. In reviewing the incidents in which sanctions were imposed, Mr. Vail noted that, in many instances, the behavior for which the prisoners were sanctioned was likely driven by their mental illness. *See id.* ¶¶ 53-65.

X. Subparagraphs 5(a)(27)-(28)

Defendants have not shown compliance with the requirements of Subparagraphs 5(a)(27) and 5(a)(28). Subparagraph 5(a)(27) requires that "[a] potentially suicidal pretrial detainee will not be placed in isolation without constant supervision." Doc. 2299 at 6. Subparagraph 5(a)(28) requires that "[a] potentially suicidal pretrial detainee will be placed into a suicide-resistant cell or safe cell only with 'direct, continuous

observation until a treatment plan is determined by medical staff.'" *Id.* These required updates to Defendants' policies and procedures followed a number of reported suicides at the Jail between 2008 and 2013. *See* Doc. 2283 at 51 ¶ 199. Continuous observation is the standard of care for a prisoner at risk of self-harm and is an important component of any suicide prevention system. Constant supervision while in isolation is also essential because isolation increases the likelihood of suicide. *Id.* at 52 ¶¶ 207-08.

Defendants submitted updated policies and procedures regarding potentially suicidal prisoners. With respect to Subparagraph 5(a)(27), SOP J-E-05 mandates that all prisoners identified at intake to be "actively suicidal" "[w]ill not be placed in isolation without constant supervision." SOP J-E-05 (Dkt. 2304-1 at 258). Defendants further updated SOP J-G-05 to require that, at intake and receiving screening, "[a]ll patients at imminent risk for suicide will not be placed in isolation without constant supervision." SOP J-G-05 (Dkt. 2304-1 at 261). Defendants' Policy DA-5 further mandates that, because "[i]solation greatly increases the likelihood of suicide[,] . . . a potentially suicidal inmate shall never be placed into isolation unless the inmate is constantly supervised." Policy DA-5 (Dkt. 2304-1 at 268).

Defendants define "Active Suicide Watch" patients as "those who are engaging in self injurious behavior and/or are threatening suicide with a specific plan." *See* SOP J-G-05 (Dkt. 2304-1 at 266). Defendants define "Potentially Suicidal" patients as those "not actively suicidal but [who] express suicidal ideation and/or have a recent history of self-destructive behavior." *See id.* For patients on active watch, CHS or MCSO staff must be "physically present and maintain[ ] visual inspection of the patient continuously." *Id.* at 290. For patients on potential watch, "[m]onitoring is at staggered intervals not to exceed every 15 minutes by Detention." *Id.* "Closed circuit television can be used as part of monitoring at Intake and MHU provided that CHS licensed staff are onsite and immediately available to respond." *Id.*

With respect to Subparagraph 5(a)(28), Defendants updated SOP J-E-05 to mandate that, at intake, all "actively suicidal" patients "[w]ill be placed in a safe cell

only with direct, continuous observation until a treatment plan is determined by CHS mental or medical staff." Dkt. 2304-1 at 285. They further updated SOP J-G-05 to require that, at intake and receiving screening, all patients "at imminent risk for suicide" "[w]ill be placed in a safe cell only with direct, continuous observation until a treatment plan is determined by medical staff." SOP J-G-05-01 further provides that, "at acute risk suicidal patient[s]" at intake "will be assigned a Safe Cell Monitor Observer," who will "keep [the] patient under direct, continuous observation until a treatment plan is determined by CHS mental health or medical staff." Dkt. 2304-1 at 296-97. The Observer must document "in 15 minute intervals on the Suicide Watch Log." *Id.* at 297. Defendants further submitted Policy DS-1, Safe Cell Placement, which requires that, when detention staff implements a safe cell placement, "[a]n officer will be assigned to conduct observations of the inmate every 15 minutes and maintain a record of the observations on a *Notification of Inmate Isolation Form*." Dkt. 2304-1 at 301

To assess compliance with these provisions, Defendants generated data reports for every prisoner "admitted to active suicide watch during the reporting month." Doc. 2333 at 35, 36. Defendants then conducted "manual audits" for each prisoner on suicide watch in a given month. *Id.* With respect to Subparagraph 5(a)(27), Defendants reviewed suicide watch flow sheets and therapeutic restraint flow sheets to "determine whether each [patient] received constant supervision while in isolation." *Id.* at 35. Defendants asserted compliance rates of 72% in March, 86% in April, 72% in May, 89% in June, 97% in July, and 95% in August. *Id.* at 35. With respect to Subparagraph 5(a)(28), Defendants reviewed the suicide watch flow sheets and therapeutic restraint flow sheets to "determine whether each [patient] had a treatment plan determined by medical staff, and whether each received direct, continuous observation until the treatment plan was determined." *Id.* at 36. Defendants asserted compliance rates of 72% in March, 91% in April, 72% in May, 89% in June, 97% in July, and 100% in August. On their face, the compliance rates reported by Defendants do not show

adequate compliance. Compliance rates above 90% in just two or three out of six months of reporting does not demonstrate compliance with the provisions.

Dr. Stewart identified other problems with respect to Defendants' methodology. Defendants reported that their data capture only those patients placed on "active suicide watch" for each month. *See* Doc. 2333 at 35, 36. The implementing provisions and Defendants' own updated policies and procedures, however, require that all "potentially suicidal prisoners"—not just those on active suicide watch—be under constant supervision and continuous observation, at least until a treatment plan is developed. Thus, any potentially suicidal prisoner not on active suicide watch is excluded from Defendants' data. Stewart Dec. ¶ 302.

Dr. Stewart further identified instances of noncompliance with these provisions and with Defendants' own policies and procedures. Dr. Stewart reviewed the suicide watch flow sheets and therapeutic restraint flow sheets, on which Defendants relied to produce their compliance data. *See* Doc. 2333 at 35, 36. He found limited documentation in the flow sheets of the timing of patients' placement on suicide watch, the presence of a 1:1 sitter, or whether patients were under continuous observation or constant supervision as required by the provision. Stewart Dec. ¶¶ 303-316.

Dr. Stewart reviewed 21 patient records for compliance with this provision; of those, he found noncompliance with 15 (71%). *Id.* ¶ 317.

Y. Subparagraph 5(a)(29)

Defendants' TechCare data does not show compliance with Subparagraph 5(a)(29). The provision requires the following: "When a pretrial detainee is discharged from suicide watch or a safe cell, the pretrial detainee will be assessed by mental health staff within 24 hours of discharge." Doc. 2299 at 6. Again, the Court ordered the implementation of several provisions relating to suicide prevention in the wake of the several suicides that occurred at the Jail between 2008-2013. Doc. 2283 at 51 ¶ 199. Prisoners coming off suicide watch are at an increased risk of attempting suicide;

therefore, it is essential that they be timely assessed and their clinical condition be monitored following any discharge from suicide watch.

Defendants measured compliance with this provision by comparing, for all prisoners released from suicide watch in a given month, the date and time of the release from suicide watch against the date and time the patient was seen by mental health staff following the discharge. Doc. 2333 at 37. Defendants reported poor initial compliance rates of 68% in March, 65% in April, 62% in May, 73% in June, 76% in July, and 82% in August. *Id.* In their Supplemental Report, Defendants revised their compliance rates by adding all patients who were released from custody within 24 hours of being discharged from suicide watch. Doc. 2336 at 11. Again, this population of prisoners is not pertinent to the determination of whether patients are timely assessed by mental health staff following discharge from suicide watch. Prisoners released during this window should have been excised from the data altogether. Even with this flawed methodology, Defendants still reported poor compliance rates: 79% in March, 75% in April, 72% in May, 84% in June, 87% in July, and 91% in August. *Id.* Defendants were unable to report a compliance rate above 91% in any of the six months. *See* Stewart Dec. ¶ 320.

Of the 18 records Dr. Stewart reviewed for compliance with this provision, 5 (28%) were noncompliant. *Id.* ¶ 324. He also noted a number of discrepancies with Defendants' TechCare reports.

Z. Subparagraph 5(a)(30)

Plaintiffs' review of medical records indicates that Defendants are not in compliance with Subparagraph 5(a)(30), which requires the following: "Defendants will document in pretrial detainees' health records evidence of timely administration of prescription medications or reasonably diligent efforts to administer all medications prescribed and explanation for any delay." Doc. 2299 at 6. The Court found that Defendants failed to timely and consistently provide patients with medications from intake. *See* Doc. 2283 at 54 ¶¶ 221. This documentation requirement is important both

to ensure that timely and appropriate medication practices are employed and to record clinical decision-making around changes to medication prescriptions. *See id.* at 54 ¶ 224, 55 ¶ 225. Defendants reported compliance rates of 97.3% for March, 97.4% for April, 97.4% for May, 97.1% for June, 97.3% for July, and 97.6% for August. Doc. 2333 at 38.

Plaintiffs' medical experts found that Defendants complied with the requirements of this provision in 37 out of 49 records reviewed, or 76%. Dr. Cohen and Ms. LaMarre documented the cases in which problems with the continuity of medications caused serious harm to patients. In one case, a pregnant patient with severe heart failure who was on multiple medications was admitted. She was taken off most of her cardiac medications after she was admitted, likely due to the pregnancy; however, when her pregnancy terminated, she was not timely re-started on her medications and was not referred to a cardiologist for over a month. In addition, she did not receive all her medications consistently. The patient's condition deteriorated at the Jail and she died approximately three months into her incarceration.

AA. Subparagraph 5(a)(31)

Defendants have not shown compliance with Subparagraph 5(a)(31), which requires, "A pretrial detainee's psychotropic medications will not be prescribed, altered, renewed, or discontinued without a face-to-face examination by a psychiatrist, psychiatric physician assistant, or psychiatric nurse practitioner in an area that affords sound privacy." Doc. 2299 at 6. The Court found that prisoners were not consistently receiving psychiatric evaluations in conjunction with their medication orders. *See* Doc. 2283 at 55 ¶ 228. Face-to-face provider assessments are important to ensure that there is a clinical reason supporting every prescription modification and discontinuation. *See id.* at 55 ¶ 226.

Defendants measured compliance with this provision by conducting, for each month, manual audits of a sample of 20 pretrial detainee charts per day over a three-day period, for a total of 60 chart reviews each month. Doc. 2333 at 39. Entries were

deemed compliant where the patient was assessed by a provider "face-to-face in a confidential area." Defendants reported poor initial compliance rates: 79% in March, 78% in April, 89% in May, 80% in June, 85% in July, and 90% in August. *Id.* at 40. In their Supplemental Report, Defendants produced revised compliance rates by adding those patients who were seen cell-side, rather than in a private setting, due to an exception to the "sound privacy" requirement. Doc. 2336 at 12. Defendants also conducted audits of all other noncompliant entries in the June, July, and August 2015 TechCare reports and amended their compliance rates to 96% in June, 100% in July, and 98% in August. *Id.* at 13. Again, Defendants audited only the noncompliant entries for errors. *See id.* at 12-13. This is not a sound methodology for re-evaluating collected data. Stewart Dec. ¶¶ 328-29.

Furthermore, Dr. Stewart reviewed the medical charts of a sample of the entries that were changed from noncompliant to compliant or removed from the data in Defendants' calculation of its revised compliance rates. He found several discrepancies. Specifically, he found inadequate documentation in the records for several patients who, according to Defendants, were seen cell-side for a "legitimate security reason." In 11 of 14 additional records reviewed, he found—contrary to Defendants' assertion in their Supplemental Report—no documented evidence of a face-to-face assessment before a medication order was entered. *Id.* ¶ 332.

Dr. Stewart's review of Defendants' data identified other methodological problems. Though Defendants purport to measure compliance based on whether the patient was seen face-to-face prior to a medication order, a number of entries were deemed "compliant" despite the fact that the assessment occurred after the order was entered. Many other entries were deemed compliant, even though the listed provider assessment occurred so far in advance of the medication order that the two seem wholly unrelated. In some cases, entries were deemed compliant even though the assessment date was weeks in advance of the order. . *Id.* ¶¶ 330-31.

DATED this 1st day of April, 2016.

ACLU NATIONAL PRISON PROJECT

By s/ERIC BALABAN
Eric Balaban (admitted *pro hac vice*)
Gabriel Eber (admitted *pro hac vice*)
ACLU National Prison Project
915 15th Street, N.W., 7th Floor
Washington, D.C. 20005

Daniel J. Pochoda
James Duff Lyall
American Civil Liberties Union of Arizona
3707 North 7th Street, Suite 235
Phoenix, Arizona 85014-5059

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2016 I electronically transmitted the attached document and appended exhibits to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

- Michele M. Iafrate
- Thomas P. Liddy
- Sherle R. Flaggman
- Daniel J. Pochoda
- Victoria Lopez
- James Duff Lyall
- Gabriel Eber

By s/ERIC BALABAN
Eric Balaban