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CORREO LEGAL-CONFIDENCIAL
Junio 2018

Estimado Señor o Señora:

Gracias por escribirnos solicitando una actualización sobre la demanda colectiva *Parsons v. Ryan* el pleito Federal en contra del Departamento de Correcciones de Arizona, atención médica, de salud mental y sistema de atención dental. La demanda también desafía las condiciones inhumanas en las unidades de aislamiento. Este caso es una "demanda colectiva" y cubre a todos los presos en las diez prisiones ADC. La demanda buscó solo cambios a las políticas y prácticas de ADC y no los daños monetarios.

El caso fue presentado en Marzo 2012 por la Prison Law Office, el ACLU y otros abogados. El 18 de febrero del 2015, el Juez Magistrado David K. Duncan, el juez federal que está viendo este caso, firmó una orden aprobando el establecimiento del mismo. El Juez Duncan ordenó a ADC poner en cada biblioteca de la prisión una copia de la transcripción de la audiencia, su orden escrita y el establecimiento del acuerdo. Si esto no está disponible para usted, por favor escríbanos y veremos de enviarle una copia gratuita del documento que usted solicitó.

El acuerdo exige que ADC componga su sistema de salud y cumpla con más de 100 medidas resultado de la atención médica, incluyendo atención a presos con condiciones crónicas, atención de salud mental y atención dental. ADC también debe replantear las reglas de las unidades de aislamiento. Más de tres años después el acuerdo establecido tomó efecto, ha sido claro que el ADC no ha cumplido con los términos.

El 22 de junio de 2018, el juez Duncan emitió una serie de órdenes, incluida una que halló a los Demandados Charles Ryan y Richard Pratt en desacato civil ante el tribunal por el incumplimiento de ADC con la Estipulación. (Legajo 2898). El juez Duncan también emitió una orden de nombramiento de un experto independiente para analizar la precisión del monitoreo de Corizon por parte de ADC, Legajo 2900; una orden que ordena a ADC / Corizon reinstalar las cajas HNR dentro de los 30 días en todos los patios donde fueron removidos, Legajo 2901; una orden que ordena a ADC / Corizon que presente un plan al tribunal dentro de 30 días sobre cómo reclutar y retener al personal de atención médica, Legajo 2904; y una orden para que los Demandados retengan a expertos en una variedad de temas relacionados con la prestación de servicios de salud, Legajo 2905. Se adjuntan copias de estos pedidos a esta carta.

Esperamos que estas órdenes motiven a ADC a mejorar la atención médica brindada a las personas encarceladas en sus prisiones y a cumplir con la Estipulación. Los funcionarios del estado prometieron apelar todas las decisiones del juez Duncan ante el Tribunal de Apelaciones

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del Noveno Circuito, y si eso sucede, defenderemos las órdenes en nombre de las personas encarceladas. El juez Duncan se retiró del banco a fines de junio de 2018 por razones médicas. El juez principal del tribunal del distrito federal ha reasignado el caso a la juez Roslyn Silver.

Para vigilar más efectivamente a ADC, hemos dividido los trabajos de vigilancia con nuestros abogados adjuntos. Nuestra oficina vigila los problemas de la atención médica y dental. El ACLU National Prison Project vigila los problemas de atención de salud mental y las unidades de máxima seguridad. Si su carta habló sobre atención de salud mental o problemas en las unidades de máxima seguiridad, le enviamos una copia de su carta. En el futuro ested puede escribirles de manera confidencial por Correo Legal al:

ACLU National Prison Project
Attn: David Fathi, Attorney at Law
915 15th Street, NW, 7th Floor
Washington DC 20005.

Cuando el Juez certificó el caso como una demanda colectiva, él nos escogió para representar a todos los presos relacionados solamente con el caso. Quizá podamos notificar a los abogados de ADC si sabemos de presos con casos serios y urgentes que no han tratado necesidades de atención de salud que pudieran llevarlos a la muerte o causarles lesiones permanentes. Si usted piensa que tiene una necesidad de atención de salud urgente, envíenos copias (no originales) de cualquier HNRs, quejas u otros documentos que usted piensa podrían ser de utilidad para nosotros. Lo revisaremos y le devolveremos los documentos. A parte de notificar a ADC, no podemos asistirle con su problema de salud individual. Gracias por su interés en el caso y le deseamos lo mejor.

Sinceramente,

Prison Law Office

Encls: Docs. 2898, 2900, 2901, 2904, 2905

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER AND JUDGMENT OF CIVIL CONTEMPT

In October 2014, the parties settled this case and signed a Stipulation to end the litigation. The Court approved the settlement and Stipulation after a fairness hearing in February 2015. (Doc. 1185 at 16; Doc. 1455) Under the Stipulation, Defendants agreed to provide health care to the Class Members as measured by 103 Performance Measures. (Doc. 1185)

In April 2016, after Defendants failed to meet many Performance Measures, Plaintiffs filed their first Motion to Enforce the Stipulation. (Doc. 1555) At the May 2016 Status Conference, the Court ordered Defendants to submit a responsive remediation plan ("First Remediation Plan"). (Docs. 1582, 1583, 1754) The Court thereafter informed Defendants of its concerns about the efficacy of the First Remediation Plan but, in deference to the Stipulation's framework, adopted it nonetheless. (Doc. 1619)

In November 2016, after three months under the First Remediation Plan, the Court "'determine[d] that the Defendants' [First Remediation] plan did not remedy the deficiencies' for the First Non-Compliant PMs. (Stipulation at ¶ 36)." (Doc. 1754) Citing to the Stipulation's acknowledgment that "[t]he Court has 'the power to enforce this Stipulation through all remedies provided by law,'" the Court ordered Defendants "to use the health care services in the community to ensure compliance with the" Performance Measures covered by the First Remediation Plan." ("Outside Provider Order") (Doc. 1754) The Court noted that "the current data show that Defendants have not been able to meet the Performance Measures by using their current procedures or by adopting the First Remediation Plan." (Doc. 1754) The Court further explained that it had "considered and rejected requiring the Defendants to submit a revised plan because of its concerns, expressed earlier on the record, about Defendants' grasp of the problem at hand, the failure, abject in some cases, of its first remediation plan to deliver compliance, and the health and safety danger posed by continued failures to meet the Performance Measures."

In May 2017, Defendant Pratt testified that he did not know of any instances of compliance with the Outside Provider Order. (Doc. 2071 at 742:1-4)

The Court continued to conduct monthly status conferences with the parties. These monthly status conferences were often lengthy and constituted the Court's efforts to understand the impediments to compliance and to prompt Defendants to meet their obligations under the Stipulation. The centerpiece of the status conferences, as with the Stipulation, was (and is) Defendants' compliance with the Stipulation as measured by the CGAR (Code Green Amber Red) results. The CGARs are the monthly report card on Defendants' performance under the Stipulation. For many of the PM/locations, particularly PMs addressing critical components of inmates' healthcare, compliance remained unattainable.

On June 14, 2017, the Court informed Defendants that, effective immediately, every single failure to comply with certain performance measures at certain prisons

("OSC PMs") would result in an order to show cause as to why a $1,000 fine should not be imposed. (Doc. 2124) Based on Plaintiffs' suggestion that Defendants should have time to cure their ongoing failure to comply with the Stipulation, the Court held off until October 2017 to enter its Order "that, effective immediately, Defendants shall comply" with specific performance measures at specified prisons "for every class member" ("OSC Order"). (Doc. 2373 at 3) The October 2017 Order required Defendants to "file a list of every instance of non-compliance with this Order during December 2017" by Friday, January 5, 2018. At the November 2017 Status Hearing, the Court added Performance Measure 52 at Eyman. (Doc. 2456) An order to show cause hearing was set for Tuesday, January 9, 2018. (Doc. 2373 at 4)

Defendants requested and received several extensions for submitting the list of every instance of non-compliance (the "OSC List") and for holding the show cause hearing. (Doc. 2456, 2526, 2605, 2620, 2640) As part of these extension requests, Defendants informed the Court—for the first time—that there was no system for collecting real time data on compliance with any performance measure covered by the Stipulation. Defendants submitted a partial OSC List but, without explanation or warning, did not timely comply with the Court's OSC Order for PM 54 at Eyman. (Doc. 2583) Subsequently, Defendants filed multiple revised OSC Lists. (Doc. 2595, 2648, 2662, 2786, 2812)

The Court heard testimony on March 26, March 27, and April 10, 2018, from the following witnesses: Arizona Department of Corrections Director Charles Ryan, Deputy Director Richard Pratt, Division Director Carson McWilliams, Dr. David Robertson, and William Upton. (Docs. 2689-1 at 5, 2769, 2770, 2724) Mr. Pratt has primary responsibility to ensure compliance with the Stipulation's performance measures. (Doc. 2769 at 48) Mr. McWilliams is in charge of prison operations. (Doc. 2724 at 167) Dr. Robertson works as a physician monitor in ADC's Monitoring Bureau. (Doc. 2671 at 87) Mr. Upton is a member of the Plaintiff class. (Doc. 2671 at 60)

At the conclusion of testimony, Defendants informed the Court that they were re-reviewing the OSC Lists. (Doc. 2782 at 136-139) The parties agreed that Defendants would provide the persons most knowledgeable about the procedure used to compile the OSC Lists. (Doc. 2782 at 148-149) Because counsel did not timely inform the Court about witness availability, Defendants filed declarations instead. (Docs. 2807 at 92-93; 2808; 2809)

LEGAL STANDARD FOR CIVIL CONTEMPT

The Parties' Stipulation empowered the Court to enforce it "through all remedies provided by law" with two exceptions not relevant here. (Doc. 1185 ¶ 36) Thus the Court's remedial power necessarily includes civil contempt proceedings. *See* 18 U.S.C. § 401(3) ("A court of the United States shall have power to punish by fine or imprisonment, or both, at its discretion, such contempt of its authority, and none other, as [. . .] [d]isobedience or resistance to its lawful writ, process, order, rule, decree, or command."); *Spallone v. United States*, 493 U.S. 265, 276 (1990) ("[C]ourts have inherent power to enforce compliance with their lawful orders through civil contempt") (quotation marks and citation omitted).

Before finding civil contempt, a court must determine by clear and convincing evidence that: (1) a valid court order exists that is "specific and definite" (*Balla v. Idaho State Bd. of Corr.*, 869 F.2d 461, 465 (9th Cir. 1989)); (2) the party had knowledge of the order, and notice of and an opportunity to be heard about the alleged noncompliance (*Int'l Union, United Mine Workers of Am. v. Bagwell*, 512 U.S. 821, 827 (1994); *United States v. Ayres*, 166 F.3d 991, 995 (9th Cir. 1999)); and (3) the party failed to take "*all* reasonable steps to comply with the order." *Kelly v. Wengler*, 822 F.3d 1085, 1096 (9th Cir. 2016) (emphasis in original).

Civil contempt "need not be willful, and there is no good faith exception to the requirement of obedience to a court order." *In Re Dual-Deck Video Cassette Recorder Antitrust Litig. v. Motion Picture Ass'n of Am.*, 10 F.3d 693, 695 (9th Cir. 1993) (internal quotation marks and citation omitted). Should a party seek to defend against a contempt

finding by arguing inability to comply, it must show "categorically and in detail" why it is unable to comply. *N.L.R.B. v. Trans Ocean Export Packing, Inc.*, 473 F.2d 612, 616 (9th Cir. 1973).

FINDINGS OF FACT

To show that they had taken all reasonable measures, Defendants presented testimony about their engagement with the State's prisoner health care provider Corizon and their efforts with Performance Measure 35, the only Performance Measure on the OSC List that ADC has not delegated to Corizon.

ADC's Oversight of Corizon

Written Demands

(1) Defendants have chosen to contract with a third-party to provide Plaintiffs with heath care and awarded that contract to Corizon in 2013. (Doc. 2770 at 61-62, Ex. 99, 103)

(2) Since the OSC Order was issued, ADC sent at least six letters to Corizon about its lack of compliance. (Doc. 2770 at 181-182, 199-201; Exs. 18, 30, 35, 36, 87, 193)

(3) As a result of the OSC Order, ADC's Monitoring Bureau reclassified one staff position from clerical duties to a liaison position. (Doc. 2770 at 155) In addition, ADC sent several letters to Corizon demanding performance. (Doc. 2770 at 108, 114; Exs. 20, 30, 31, 33, 97)

(4) In February or March 2018, ADC began requiring Corizon to provide additional details about staffing efforts because "additional staff were required to fill a current gap." (Doc. 2770 at 112, 208:12-13) Director Ryan testified that he thought Corizon might have flown in additional health care staff but he did not know how many people, what positions, what prison complexes were impacted, when they arrived, how long they stayed, or if they were still here. (Doc. 2769 at 72-73)

(5) Deputy Director Pratt testified that he believed Corizon did bring in staff to assist in Arizona but he did not know how many people came. (Doc. 2770 at 208-209)

Corizon did not provide him with any specifics about flying in additional staff. (Doc. 2769 at 158) Mr. Pratt believes that up to a dozen nurses may have come but he does not know when they arrived and there was no testimony about how long they stayed and no written communication about any staffing increases. (Doc. 2770 at 209-210) Corizon may add five additional monitors but have not yet done so. (Doc. 2770 at 153-154)

Meetings with Defendant Ryan and Defendant Pratt

(6) In November 2017, Defendants Ryan and Pratt began to meet every other week with Corizon leadership to discuss performance measures, staffing, and compliance with the OSC Order. (Doc. 2770 at 112, 130, 179; Doc. 2769 at 22, 35, 39) In these meetings, ADC had asked Corizon to increase the use of telemedicine because Corizon did not regularly use telemedicine; however, ADC has not made a written demand to Corizon to do so. (Doc. 2671 at 208; Doc. 2769 at 95, 160-163; Doc. 2770 at 49-51, 23-26; Ex. 160) In these meetings, ADC had also asked Corizon to fill the staff positions that were required by the then-current contract but had not asked Corizon to add more staff. (Doc. 2769 at 95)

(7) In November 2017, Corizon informed ADC that it was "prepared with detailed analyses of the root causes of non compliance." (Doc. 33) This analysis consists of flow charts that identify potential fail points for different performance measures. (Doc. 2770 at 113-114, 133, 147-148; 152-153, 223-224; Doc. 2781 at 72-73; Exs. 52-74) There is no evidence that these flow charts address or analyze facility-specific fail points. Further, there is no evidence that these flow charts were based on past performance at Arizona prisons.

(8) Defendant Ryan had conversations with Corizon's CEO "almost on a weekly basis." (Doc. 2769 at 35) But not until January 31, 2018, did Defendants Ryan and Pratt have an ad hoc meeting with Corizon leadership and ADC operations staff about the OSC Order issued in October.

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Meetings with Regional and Site Staff

(9) In November or December 2017, ADC began to conduct daily meetings at each facility to discuss facility-level issues such as inter-facility transportations, missed medical appointments, staffing issues, and nursing lines. (Doc. 2781 at 9-10, 36) These meetings are attended by the warden, facility health administrator, ADC monitor, transportation sergeant, and deputy warden of operations. (Doc. 2781 at 9)

(10) ADC Wardens are expected to have daily meetings with their prison's health administrator to solve problems. (Doc. 2769 at 44) Corizon conducts monthly meetings at each prison to discuss corrective actions plans. These meetings have been expanded to include ADC Monitoring Bureau staff and ADC's outside counsel. (Doc. 2770 at 84, 113, 133-134) Corizon posted training materials for its field staff but there were no classes for staff. (Doc. 2770 at 138-147; Exs. 41-51)

(11) ADC regional operations staff meets every other week with the Corizon team to discuss the performance measures in the OSC Order and staffing levels. (Doc. 2770 at 112; Doc. 2769 at 35-36) Specific performance measures are discussed at this meeting. (Doc. 2770 at 129) As a result of the OSC Order, ADC expanded its weekly meeting with Corizon to include more people. (Doc. 2770 at 112, 128, 129)

Mortality Reviews

(12) ADC conducts mortality reviews for each inmate who dies in custody. (Doc. 2671 at 95-100) Starting in February or March 2018, an individual from Corizon's Continuous Quality Improvement ("CQI") team started to call into ADC's mortality reviews. (Doc. 2671 at 131:15-16; Doc. 2770 at 7, 28-29) The ADC Mortality Review team has made recommendations to Corizon's CQI representative and those recommendations have received "a mixed response" and have not generated a solution for expediting specialty consults. (Doc. 2770 at 8:25, 9)

(13) These mortality reviews consistently show a failure to properly document the medical care provided to inmates and a failure in written and verbal communication among the health care staff. (Doc. 2671 at 137-138) Of the 18 mortality reviews

submitted into evidence during the OSC hearing, ADC checked "yes" 6 times to the question: "Could the patient's death have been prevented or delayed by more timely intervention." (Exs. 30, 35, 36, 37, 40, 47) ADC checked "yes" 8 times to the question: "Is it likely that the patient's death was caused by or affected in a negative manner by health care personnel." (Exs. 30, 33, 35, 36, 37, 40, 46, 47)

Escalation List

(14) In the summer of 2017, Dr. Robertson was speaking to Dr. FallHowe, Corizon's Western Regional Director, almost daily about obtaining specialty care for specific patients because their consults were languishing and prisoners were not being seen on a timely basis. (Doc. 2671 at 146-147) Dr. Robertson felt "that Utilization Management was being arbitrary." (Doc. 2671 at 147:15-16) Subsequently, Dr. FallHowe "and her team decided to have meetings on every one of the[] cancer patients in the Tucson complex." (Doc. 2671 at 147:16-18)

(15) By August 2017, Tucson's Assistant Facility Health Administrator had started circulating a weekly email update to ADC and Corizon staff about high acuity inmates at Tucson with cancer. (Doc. 2671 at 143-144, 148; Ex. 84) These emails were "to make sure the patients that were high acuity that needed care got the care." (Doc. 2671 at 143:21-22) There was a regular meeting about the patients on this email list. (Doc. 2671 at 143-144) There is no evidence in the record whether a similar system was employed to track high acuity patients in other facilities. (Doc. 2671 at 143, 144)

(16) Around December 2017, the meeting about high acuity Tucson cancer patients evolved into a weekly, system-wide meeting between ADC and Corizon staff to discuss high acuity patients who did not seem to be obtaining care ("Escalation Meeting"). (Doc. 2671 at 144, 148-150; Doc. 2770 at 31)

(17) The agenda for the weekly Escalation Meeting is a spreadsheet listing individual patients who have come to the attention of Dr. Robertson ("Escalation List"). (Doc. 2671 at 144, 150-153, 156; Ex. 95 at 2) There are no formal criteria to include someone on the Escalation List. (Doc. 2770 at 13-15, 38) Sometimes an individual in

ADC will advocate for an individual. (Doc. 2671 at 206-207; Ex. 158) Sometimes family members write a letter to Dr. Robertson and he will contact Corizon to bring attention to that individual's case. (Doc. 2770 at 11) The University of Arizona's Cancer Center has contacted Dr. Robertson about an individual who needs expedited care. (Doc. 2770 at 38) Corizon line staff have also contacted Dr. Robertson to complain about delays in specialty care. (Doc. 2770 at 42)

(18) Dr. Robertson testified that when Class Counsel writes to ADC's counsel about individuals, those individuals are added to the Escalation List. (Doc. 2671 at 151) However, it appears that as late as July 2017, Dr. Robertson had not been informed of these letters. (Doc. 2671 at 171)

(19) Dr. Robertson asks the ADC field monitors to track the care provided to the inmates on the Escalation List. (Doc. 2770 at 11-12) Defendants Pratt and Ryan also get involved in individual patient care. (Doc. 2770 at 135-138)

(20) Corizon's Utilization Management ("UM") Team manages the Escalation List and circulates it ahead of the weekly calls. (Doc. 2770 at 35) Dr. Robertson believes that the UM team participates in the weekly meeting but it could be "their clerks or somebody." (Doc. 2671 at 157:5)

(21) Dr. Robertson testified that the system of weekly meetings about the Escalation List is "working" to obtain care for individual inmates but acknowledged that if the system worked as it should then high acuity patients would receive appropriate care as a matter of course and there would be no need for the Escalation List. (Doc. 2671 at 154:19; Doc. 2770 at 40-41)

(22) Dr. Robertson believes Corizon's site and regional medical directors have become more responsive to his calls about individuals. (Doc. 2770 at 32) As of August 2017, Dr. Robertson has noticed an improvement in that "morphine is given on the yards if it's needed. And nursing notes are much more thorough." (Doc. 2671 at 115:2-3)

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(23) There is no version of the Escalation List for chronic care patients or patients of a slightly lower acuity to ensure that they receive care before they become high acuity patients. (Doc. 2770 at 39)

Carrots and Sticks: Fines, Sanctions, and Incentives

(24) Originally, the ADC contract with Corizon was for three years. This Contract included an offset for failing to meet staffing requirements. (Doc. 2770 at 75-77, 121) ADC has assessed this staffing offset penalty every month of the Corizon contract which, at the time of the hearing, had totaled $3,800,000. (Doc. 2770 at 77; Exs. 7, 9, 13, 14, 15, 103, 205)

(25) In May 2015, ADC amended its contract with Corizon to extend the contract to a fourth year, or from March 2016 to March 2017 ("Amendment 10"). (Ex. 201) Amendment 10 increased the amount paid to Corizon to $11.60 per inmate per day. (Ex. 201.3 at ¶ 8)

(26) Amendment 10 included a sanctions provision whereby ADC would sanction Corizon $5,000 for each performance measure at each prison that did not satisfy the Stipulation's requirements but the total for this sanction was capped at $90,000 per month. (Doc. 2770 at 93, 98, 183-184; Doc. 2769 at 55-56; Ex. 201.3 at ¶ 6) Director Ryan testified that it was "a smart business decision." (Doc. 2769 at 70) Deputy Director Pratt also testified that this cap "was an appropriate business decision" and that he thought it was "reasonable" but acknowledged that the $90,000 per month was only "a small percentage" for Corizon. (Doc. 2770 at 197-198) Director Ryan testified that the cap was "part of the negotiation process" and thought that the sanction was likely to have a significant effect on Corizon's behavior. (Doc. 2769 at 57-58)

(27) In Amendment 10, Corizon agreed to extend the contract to a fifth year "if ADC requests 4.0% CPI increases in its annual budget request for contract Years 4 and 5." (Ex. 201.1 at ¶ 2) While negotiating Amendment 10, Corizon indicated that it would cancel the contract if it did not receive the 4.0% increase. (Doc. 2769 at 18) Mr. Pratt testified that this increase was a business decision and reflected increased health care

costs. (Doc. 2781 at 52-53) At the time of Amendment 10, Director Ryan was not satisfied with Corizon's performance. (Doc. 2769 at 50, 60)

(28) Amendment 10 includes a revised indemnity provision. (Doc. 2769 at 114; Ex. 201.1-201.2 at ¶ 4) Deputy Director Pratt and Director Ryan understand this indemnity language to mean that the State would look to Corizon for any monies assessed for contempt from the Court. (Doc. 2770 at 205; Doc. 2769 at 74-75) Director Ryan believes that this was appropriate because Corizon is "the entity or organization [responsible] for the delivery of health care to the inmate population" while ADC "was overseeing Corizon in terms of its accountability in the delivery of health care to the inmate population." (Doc. 2769 at 21)

(29) In September 2015, ADC sent Corizon a letter detailing sanctions for failure to perform between April 1 and June 30, 2015. (Ex. 12)

(30) In June 2016, Director Ryan was not satisfied with Corizon's performance but nevertheless extended Corizon's contract to a fifth year, March 2017 to March 2018, because ADC had received approval for the retroactive application of the 4% increase described in Amendment 10 ("Amendment 11"). (Doc. 2769 at 59-60; Exs. 18, 20, 202) Amendment 11 increased the inmate health care per diem from $11.60 to $12.06. (Doc. 2770 at 183, 185; Ex. 202)

(31) In June 2016, ADC sent Corizon a letter detailing sanctions for failure to perform in April 2016. (Ex. 18) In July 2016, ADC sent Corizon a letter detailing sanctions for failure to perform in May 2016. (Doc. 2769 at 64-65; Ex. 20)

(32) In June 2017, ADC again amended its contract with Corizon to extend the contract from March 2018 through June 2018 and increased Corizon's payment to $12.54 per prisoner per day ("Amendment 13"). (Doc. 2770 at 185-186; Ex. 202) Between March 2016 and June 2017, Corizon paid ADC a total of $1,440,000 in sanctions but would have paid $7,350,000 without the cap. (Doc. 2770 at 199; Ex. 206) Between July and October 2017, the cap on sanctions meant that Corizon paid $1,260,000 less than it would have paid without the cap. (Doc. 2770 at 202) From March 2016 to October

2017, ADC could have offset $6.8 million against Corizon's payment but for the negotiated cap. (Doc. 2770 at 203)

(33) In September 2017, ADC made a business decision to amend its contract with Corizon to remove the previous cap on performance-based sanctions and to add performance-based incentives ("Amendment 14"). (Doc. 2770 at 73-74, 122-123, 125, 126; Doc. 2769 at 23-24; Ex. 205) Amendment 14 does not specify that Corizon has to spend the incentive payments on anything specific. (Doc. 2770 at 196; Doc. 2769 at 70) This amendment was made in anticipation of the Court's OSC Order. (Doc. 2770 at 124-125; Doc. 2769 at 24, 27)

(34) During the first four months of Amendment 14, ADC has paid Corizon $2,550,000 in incentive payments. (Doc. 2770 at 189-90; Doc. 2769 at 92). The incentive payments are capped at $3,500,000. (Doc. 2770 at 127) The incentive payments will be paid in the first part of FY 2018 and then there will be no further funds available to Corizon. (Doc. 2770 at 194-195; Doc. 2769 at 106) Corizon's CEO asked Director Ryan to consider providing Corizon with additional incentive funds and Director Ryan told him that there would not be any. (Doc. 2769 at 108-109)

(35) Director Ryan testified that Amendment 14's incentive money came either from a contingency fund or from vacancy savings accrued from vacant Correctional Officer positions. (Doc. 2769 at 27, 92-93) After his testimony, Defendants submitted a declaration correcting this testimony and stating that the incentive funds came only from funds appropriated for health care. (Doc. 2716)

(36) The disparity between the sanctions and the incentive payments in Amendment 14 was "the negotiated business decision that [ADC] made to try and compel and encourage Corizon to achieve much better performance." (Doc. 2769 at 104:22-24) Director Ryan thinks this decision "was, and still is, a good idea." (Doc. 2769 at 106:9-10)

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(37) Director Ryan believes that Amendment 14 worked to increase compliance because the CGAR numbers increased shortly after ADC and Corizon executed Amendment 14. (Doc. 2769 at 24)

(38) For FY2014 to FY2017, ADC assessed $2,071,000 in sanctions against Corizon for Corizon's failure to comply with its contract with the State for the delivery of health care. (Doc. 2770 at 189) Through January 2018 of FY2018, ADC had assessed $945,000 in sanctions against Corizon. (Doc. 2770 at 189)

(39) Director Ryan testified that Corizon paid ADC's outside counsel's fees and the annual fee to Plaintiffs' counsel that is required by the Stipulation. (Doc. 2769 at 51-53) On re-direct, he testified that he did not know. (Doc. 2769 at 112)

(40) Mr. Pratt assumes that the Amendments' various increases in the inmate health care per diem are used by Corizon to compensate for the increased cost of doing business. (Doc. 2770 at 188-189) But there is no contractual requirement that Corizon use money to increase salaries for health care staff or to hire more staff. (Doc. 2769 at 160) Mr. Pratt understands that Corizon operated at a loss in Arizona during the previous two quarters. (Doc. 2781 at 55)

(41) Mr. Pratt has not been satisfied with Corizon's performance. (Doc. 2770 at 181-185) Mr. Pratt has thought that if ADC pushes Corizon too hard, Corizon will terminate its contract. (Doc. 2781 at 78)

Performance Measure 35

(42) PM 35 states "All inmate medications (KOP [keep on person] and DOT [direct observation therapy]) will be transferred with and provided to the inmate or otherwise provided at the receiving prison without interruption." (Doc. 1185-1 at 10)

(43) Compliance with PM 35 is "a true partnership" between ADC and Corizon and requires ADC to follow its own rules. (Doc. 2770 at 162:9-11; Doc. 2769 at 42) ADC transfers 30,000 inmates every year between complexes. (Doc. 2769 at 174)

(44) ADC began collaborating with Corizon on PM 35 in June 2017 because compliance with PM 35 was "a failed process." (Doc. 2769 at 172; Doc. 2770 at 161,

163:18) As a result of that collaboration, during the summer of 2017, ADC conducted a series of meetings and developed an outline of a process to transfer medication with an inmate. (Doc. 2769 at 178; Ex. 1) As part of this process, ADC and Corizon developed a flowchart with possible fail points. (Doc. 2770 at 163-164; Ex. 78)

(45) There was no evidence presented to the Court indicating that ADC understood the fail points at specific prisons.

(46) ADC began to develop DI-361 in August 2017 and adopted it on October 31, 2017. (Doc. 2781 at 28; Ex. 78, 98) DI-361 was submitted to the Court shortly thereafter. (Ex. 2) DI-361 was distributed to ADC employees with an email address. (Doc. 2769 at 191) For ADC employees without an email address, ADC generally distributes new Director's Instructions through electronic briefing boards and through discussions at briefings. (Doc. 2769 at 191-192) There is no evidence that this process was, in fact, completed for DI-326.

(47) If an inmate arrives at the new complex and his medications are not available, DI-361 dictates that Corizon will "obtain the medications from the back-up pharmacy." (Ex. 2 at ¶3.5) There have been instances when a local pharmacy was used to obtain medications for a transferring inmate. (Doc. 2769 at 186)

(48) In March 2018, Mr. Pratt wrote to Roland Maldonado, Corizon's Vice President of Operations for Arizona, about Corizon's controlled substance audits and stated that the quarterly controlled substance findings "have been a great concern for years as related to non-adherence to the stated policies." (Ex. 96; Doc. 2769 at 154) ADC has not asked Corizon to stop relying on an out-of-state pharmacy to provide medications to prisoners but it has asked Corizon to increase the stock of pharmaceuticals maintained on site. (Doc. 2769 at 96) Mr. Ryan does not know if this request was made in writing. (Doc. 2769 at 96) Mr. Ryan understands that Corizon is not willing to relocate a pharmacy into Arizona. (Doc. 2769 at 127)

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Real Time Monitoring

(49) ADC cannot monitor health care in real time. (Doc. 2781 at 60) Two weeks after the Court issued its October 2017 OSC Order, ADC leadership asked Corizon leadership to institute real-time data tracking for the performance measures covered by the OSC Order. (Doc. 2769 at 28; Ex. 31) Deputy Director Pratt understood that Corizon would implement such a program in part to find fail points. (Doc. 2770 at 211)

(50) In early November 2017, Mr. Pratt exchanged emails with Corizon's EVP/CAO about real-time reporting on the performance measures covered by the OSC Order. (Doc. 2781 at 58-60; Exs. 105, 106)

(51) In response, Corizon's interim CEO and chair of their Board wrote a letter to Director Ryan that stated Corizon would "not implement any daily real-time monitoring data program." (Doc. 2770 at 211:2-3; Doc. 2769 at 31-32; Ex. 33) Ryan and Pratt co-signed a response letter demanding that Corizon hire additional staff to monitor the OSC Order performance measures. (Doc. 2769 at 34-35; Doc. 2769 at 150; Ex. 34) Mr. Pratt thinks that, as part of complying with the OSC Order, Corizon brought in three or four people to assist with real time data collection. (Doc. 2769 at 150; Doc. 2781 at 81)

(52) In January 2018, Ryan and Pratt co-signed a letter to Mr. Maldonado that concluded there had been 2,481 incidents covered by the OSC Order in December 2017. (Doc. 2769 at 37-38; Ex. 37) In February 2018, they sent a clarification letter stating that they had recalculated the number of incidents to be 668. (Doc. 2769 at 38-39; Ex. 39)

(53) In March 2018, the week before the hearing in this matter, Ryan and Pratt co-signed a letter to Mr. Maldonado about real time reporting. (Doc. 2769 at 82; Ex. 97) This letter noted that, for January 2018, Corizon had compiled the number of incidents and concluded that there were 891 incidents of non-compliance for the PMs covered by the OSC Order. (Ex. 97.002)

(54) In March 2018, Corizon informed ADC that it had implemented real-time reports for some performance measures. Neither Mr. Ryan nor Mr. Pratt know or could

remember which performance measures have real-time reports. (Doc. 2770 at 211; Doc. 2769 at 82-83)

(55) There is still no real-time monitoring program for all performance measures. (Doc 2704 at 3:25-26; Doc. 2770 at 108, 210; Ex. 31.002)

(56) In March 2018, ADC made its first written demand to Corizon for a written description of its "efforts taken over the last five months to document Corizon's commitment to comply with the [OSC Order's] performance measures and to fill vacant positions on your rosters." (Doc. 2769 at 85)

(57) Pentaho, a Corizon-owned program, can run reports from eOMIS, Corizon's electronic medical records program. (Doc. 2769 at 147-148) ADC does not have access to Pentaho and has to ask Corizon for any specific Pentaho reports. (Doc. 2769 at 148-149)

(58) ADC had, and has, "serious concerns" with using Pentaho to generate lists of incidents for the OSC Order. (Doc. 2769 at 156; Ex. 38, 97) ADC worked with Corizon to run different Pentaho reports for the OSC Order in an attempt to increase the accuracy of the reports. (Doc. 2769 at 155-156) ADC demanded "significant improvement" in Corizon's next report. (Doc. 2769 at 157:21; Ex. 97) ADC did not disclose its concerns to the Court or to Plaintiffs about the December 2017 real time data until Mr. Pratt's cross-examination as a part of the OSC hearing. (Doc. 2769 at 156-157; Doc. 2781 at 81-82; Ex. 97)

(59) Plaintiffs alleged that ADC had missed 420 instances of non-compliance in the December 2017 OSC List. ADC reviewed Plaintiffs allegations and added 238 names to the December 2017 OSC List. (Doc. 2690 at 21; Doc. 2781 at 62, 68; Docs. 2745, 2755) Plaintiffs made no similar allegation about the January 2018 or February 2018 OSC List.

CONCLUSIONS OF LAW

(a) Defendants' contract with Corizon does not obviate their non-delegable duty to provide Plaintiffs with health care under state law. Ariz. Rev. Stat. §§ 31-

201.01(D); 41-1604(B)(1)(d) (the director may delegate functions or duties "that the director believes can be competently, efficiently and properly performed"); *Starr v. Baca*, 652 F.3d 1202, 1208 (9th Cir. 2011) (relying on fact that the defendant sheriff was required by state statute to take charge of county jails and was answerable for prisoner's safekeeping). (Doc. 2781 at 89:11) Similarly, Defendants' contract with Corizon does not modify their position as obligors on the Stipulation.

(b) Defendants' management of Corizon does not indicate that they have any real ability to spur Corizon's compliance with the Stipulation. The Demand Letters evince ADC's frustrations with Corizon, frustrations that are similar to the frustration that the Court has expressed to Defendants. Specifically, ADC's communication with Corizon demonstrates a concern about the quality of internal audits, about staffing levels, and about performance.

(c) Obtaining care for high acuity patients depends on committed individuals advocating for the care that the State has already paid Corizon to provide. Notwithstanding Defendants' use of the Escalation List, Defendants are not entitled to congratulations for developing an extraordinary method, which identifies a subset of high acuity patients, in order to ensure that they receive the care that all high acuity inmates are entitled to receive under the Stipulation. To be clear, these high acuity patients made it to the Escalation List because they had not received the health care to which all inmates are entitled. If the system worked as it should, there would be no need for this Escalation List.

(d) Instead, Defendants' "good business decision" was to provide incentive payments to a contractor who had already committed to the State to provide that very service and had repeatedly and consistently failed to meet that obligation. The wisdom of a business decision that so rewards a failing contractor escapes the Court but is, for these purposes, irrelevant.

(e) Of the performance measures covered by the OSC Order, only PM 35 involves ADC operations. When undertaking a remediation plan for PM 35, ADC did

not review operations at each prison to determine why PM 35 was, or was not, working. ADC did not begin working on a procedure to address PM 35, DI-361, until after the Court first announced it was contemplating the OSC. This is no evidence before the Court to show that ADC understands why DI-361 did not create compliance in Eyman or Lewis in December 2017, why DI-361 did not create compliance in Florence or Lewis in January 2018, or why Tucson attained compliance in August 2017 without DI-361.

(f) The OSC Order has not resulted in ADC's compliance with the Stipulation, which requires that every single inmate receive the benefit of each Performance Measure. The Stipulation requires 100% compliance with each of its Performance Measures. As this Court has repeatedly stated, the Stipulation's 85% threshold is simply a triggering point for the Court's intervention. And since the OSC Order, the following PM/Locations have remained below the Stipulation's 85% threshold:

- Performance Measure 35 at Eyman in December 2017;
- Performance Measure 35 at Florence in January 2018;
- Performance Measure 35 at Lewis in December 2017 and January 2018;
- Performance Measure 39 at Lewis in January 2018 and March 2018;
- Performance Measure 44 at Eyman in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 46 at Eyman in December 2017 and February 2018;
- Performance Measure 47 at Eyman in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 47 Florence in January 2018 and March 2018;
- Performance Measure 47 Lewis in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 47 Phoenix in December 2017, January 2018, and February 2018;
- Performance Measure 47 Tucson in January 2018 and February 2018;
- Performance Measure 50 at Florence in December 2017 and January 2018;

- Performance Measure 51 at Eyman in January 2017;
- Performance Measure 51 at Florence in December 2018;
- Performance Measure 52 at Florence in December 2017, January 2018, February 2018, and March 2018;
- Performance Measure 54 at Eyman in December 2017;
- Performance Measure 66 at Florence in February 2018 and March 2018; and
- Performance Measure 66 at Tucson in March 2018.

(Docs. 2373, 2801-1)

(g) Defendants did not introduce any evidence to the Court about specific efforts to bring PMs 39, 44, 47, 50, 51, 52, 54, or 66 into compliance. With respect to PM 35, the testimony Defendants presented was generic in nature and not geared toward the specific issues precluding compliance at each facility. This failure alone supports the conclusion that Defendants have not taken "all reasonable steps to comply with the [OSC] order." *Kelly v. Wengler*, 822 F.3d 1085, 1096 (9th Cir. 2016).

(h) Because ADC remains noncompliant with these portions of the Stipulation, the Court concludes that civil contempt sanctions against Defendants are warranted here to address Plaintiffs' "injuries resulting from [ADC's] noncompliance." *Shuffler v. Heritage Bank*, 720 F.2d 1141, 1147 (9th Cir. 1983) (citing *Gompers v. Bucks Stove & Range Co.*, 221 U.S. 418, 448-49 (1911)).

(i) The evidence shows that the mere threat of monetary sanctions was not sufficient to generate ADC's compliance with the Stipulation. More importantly, the evidence presented to the Court indicates that wide-spread and systemic failures remain. In one recent example, Defendants had no information about what could be done to improve compliance for PM 50 at Tucson and failed to even attempt to provide a corrective action plan at the May 2018 Status Conference. (Doc. 2810). In another example, instead of presenting a corrective action plan aimed at trying something new, Defendants informed the Court at the June status hearing that they will continue to use their previous plan even though the CGARs reflect that the previous plan has not

obtained consistent compliance for PM 39 at Lewis. (Doc. 2874-1 at 81) That Defendants should exhibit such nonchalance about addressing on-going failures to comply with the Stipulation—even as the sword of sanctions loomed above them—is considerable evidence that a contempt order and monetary sanctions are necessary.

(j) The inescapable conclusion is that Defendants are missing the mark after four years of trying to get it right. Their repeated failed attempts, and too-late efforts, to take their obligation seriously demonstrate a half-hearted commitment that must be braced. The evidence suggests that the States' recalcitrance flows from its fear of losing its contracted healthcare. But even if true, such fear is not a factor that can properly be considered in determining what steps the State must take to meet the health care needs of its inmates. If a private contractor is pushed to the door because it cannot meet the State's obligations, then so be it. Such a result would flow directly from the state's decision to privatize health care to save money. That goal of privatization cannot be achieved at the expense of the health and safety of the sick and acutely ill inmates. Indeed, Arizona for most of its history, and many states, do not privatize their healthcare services. The Court must place a clear and focused light on what is happening here: the State turned to a private contractor which has been unable to meet the prisoner's health care needs. Rather than push its contractor to meet those needs, the State has instead paid them more and rewarded them with financial incentives while limiting the financial penalties for non-compliance. Accordingly, it appears the Court must do what Defendants will not: compel compliance with the Stipulation.

CIVIL SANCTIONS

The OSC Order was valid, specific, and definite. Defendants had knowledge of the OSC Order and an extended opportunity to be heard about their non-compliance. As detailed herein, the Court has concluded that Defendants did not take all reasonable steps to comply with the Court's order. As a result, and as previewed in the OSC Order, Defendants shall pay a financial penalty of $1,000 per failed instance for the

PM/Locations in the OSC Order that fell below the Stipulation's threshold of 85%. The information provided to the Court by Defendants showed 1,445 such violations:

December 2017 (Docs. 2600, 2747, 2815)		
PM/Location	*CGAR %*	*# of Instances*
PM 35 at Eyman	74	26
PM 35 at Lewis	84	26
PM 44 at Eyman	11	9
PM 46 at Eyman	84	161
PM 47 at Eyman	54	17
PM 47 at Lewis	53	11
PM 47 at Phoenix	50	1
PM 50 at Florence	60	34
PM 51 at Florence	80	21
PM 52 at Florence	65	26
PM 52 at Eyman	57	23
PM 54 at Eyman	60	542
	Subtotal	**897**

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January 2018 (Doc. 2650, 2664, 2675, 2815)		
PM/Location	*CGAR %*	*# of Instances*
PM 35 at Florence	82	13
PM 35 at Lewis	70	44
PM 39 at Lewis	81	5
PM 44 at Eyman	56	4
PM 47 at Eyman	75	9
PM 47 at Florence	82	8
PM 47 at Lewis	36	7
PM 47 at Phoenix	83	1
PM 47 at Tucson	62	9
PM 50 at Florence	77	35
PM 51 at Eyman	68	17
PM 52 at Florence	69	21
PM 52 at Eyman	60	34
	Subtotal	**207**

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February 2018 (Doc. 2786-2)		
PM/Location	*CGAR %*	*# of Instances*
PM 44 at Eyman	43	4
PM 46 at Eyman	82	157
PM 47 at Eyman	61	20
PM 47 at Lewis	61	11
PM 47 at Phoenix	67	1
PM 47 at Perryville	83	3
PM 47 at Tucson	64	5
PM 52 at Eyman	58	60
PM 52 at Florence	67	60
PM 66 at Florence	70	20
	Subtotal	**341**

The Court will impose these sanctions and collect these funds with the understanding that they will be used to further compliance with the healthcare requirements of the Stipulation. To that end, the parties will submit proposals for use of the funds and the Court will distribute the monies after considering their proposals.

IT IS THEREFORE ORDERED that Defendants are held in civil contempt for failure to comply with the Stipulation as detailed in the Court's Order to Show Cause.

IT IS FURTHER ORDERED that Defendants shall pay $1,445,000 for their December 2017, January 2018, and February 2018 violations of the Court's Order to Show Cause. Within 14 days, Defendants must remit payment to the Clerk of Court in the amount of $1,445,000.

IT IS FURTHER ORDERED that the Clerk of Court must enter judgment against Defendants reflecting contempt fines for December 2017, January 2018, and

February 2018 totaling $1,445,000. This total is due and payable into the Registry of the Court, to be kept in the Registry until further order of the Court. This judgment shall bear interest at the federal statutory rate until satisfied.

IT IS FURTHER ORDERED that Defendants shall continue to file monthly reports reflecting every instance of noncompliance for PMs at facilities under the October 10, 2017 Order to Show Cause that are at less than 85% compliance.

IT IS FURTHER ORDERED that, within 30 days of the date of this Order, the parties shall submit their respective proposals regarding the best use of these funds.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

Defendants have moved to terminate their monitoring of most of the performance measures covered by the Stipulation. (Doc. 2251) Plaintiffs raise several categories of objections and also concede that termination is appropriate in some instances. (Doc. 2344, 2819)

Defendants' motion to terminate is the first of its kind in this case and raises several questions about how to interpret the Stipulation's termination provision contained in paragraph 10(b):

> The measurement and reporting process for performance measures, as described in Paragraph 9, will determine (1) whether ADC has complied with particular performance measures at particular complexes, (2) whether the health care provisions of this Stipulation may terminate as to particular performance measures at particular complexes, as set forth in the following sub-paragraphs.
>
> b. **Termination of the duty to measure and report on a particular performance measure:** ADC's duty to measure and report on a particular performance measure, as described in Paragraph 9, terminates if:

> i. The particular performance measure that applies to a specific complex is in compliance, as defined in sub-paragraph A of this Paragraph, for eighteen months out of a twenty-four month period; and
>
> ii. The particular performance measure has not been out of compliance, as defined in sub-paragraph A of this Paragraph, for three or more consecutive months within the past 18-month period.

(Doc. 1185 at 4-5) Several predicate questions remain unanswered by this text and so the Court must answer these questions before determining which performance measures at which locations can exit the Stipulation.

Burden of Proof

Defendants argue that paragraph 10(b) of the Stipulation provides for an automatic exit and that Plaintiffs have the burden of proving that a performance measure/location should remain covered by the Stipulation. (Docs. 2251, 2407) The Court disagrees; the relevant text is silent as to the termination's mechanism and any burden of proof. Reading the Stipulation as a whole, the Court concludes that Defendants may move to terminate if they contend they have the qualifying months, but the Court's oversight function requires the Court to rule on termination based on all of the information before the Court at the time of the ruling.

The Court notes that this interpretation of the Stipulation is consistent with the Court's statutory obligation under the Prison Litigation Reform Act which states that "prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation." 18 U.S.C. § 3626(b)(3). To satisfy this requirement, the Court must know the current conditions of health care and must know that the CGAR data is accurate and reliable.

Which 24 months

Paragraph 10(b)(i) requires compliance for 18 months out of a 24 month period. By definition, after 25 months of monitoring, there is a choice about which 24 month period applies to this sub-paragraph. The Stipulation does not specify which 24 months

period applies and so this requirement could cover the first 24 months, the most recent 24 months, or something in between.

Paragraph 10(b)(ii) requires a look-back to "the past 18-month period." Reading these two sub-paragraphs together, and in conjunction with 18 U.S.C. § 3626(b)(3), the Court concludes that the proper way to evaluate this requirement is—generally[1]—to look back 24 months from the month the motion is filed.

Final Procedures

Several times, the parties have agreed to modify how the CGAR data is collected and, when agreement could not be reached, the Court has had to order specific reporting procedures ("Final Procedure"). Nearly 18 months ago, and consistent with binding precedent, the Court informed Defendants that they did not have to recalculate CGAR data but could not rely on CGAR data calculated under discredited methods. (Doc. 1951) *Pauma Band of Luiseno Mission Indians of Pauma & Yuima Reservation v. California*, 813 F.3d 1155, 1165 (9th Cir. 2015) ("Once a court has interpreted an ambiguous contract provision that is and has always been the correct interpretation from its formation.") Put another way, the 24-month period required by Paragraph 10(b) begins from the first month of data collected under a Final Procedure and so a performance measure is only eligible for termination under the Stipulation if there are 24 months of accurate and reliable data as measured by a Final Procedure.

Defendant Pratt testified that, with one possible exception, CGARs have not been recalculated under Court-ordered methodologies. (Doc. 2770 at 192-193) The more recent implementation of Final Procedures means that none of the performance measures subject to a remediation plan are eligible to exit the Stipulation and so the Court need not address the currently-hypothetical relationship between a remediation plan and termination.

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[1] As detailed herein, this lookback period may be longer in a specific instance depending on, for example, N/A results or changes in data collection.

"N/A" and Termination of Inapplicable Performance Measures

At a status conference with the parties, the Court stated that "common sense arguments" about N/A results would be accepted. This statement was in the context of counsel's discussion about measuring Pap smears at prisons that only house men. (Doc. 1956 at 67-70)

The Court informed the parties that months with "N/A" results would not count either for or against termination. This means that the lookback period would be extended to capture 24 months of data. For example, PM 14 at Winslow had five N/A results in January 2016, May 2016, October 2016, December 2016, and January 2017. (Doc. 2251-1 at 42) This means that a look back period that begins in June 2017 must extend back another five months to February 2015.[2]

The Court notes that there are several performance measures where the CGARs are inexplicably littered with N/A results. Instead of providing an affidavit or another form of competent and admissible evidence, counsel for Defendants has stated various hypothetical possibilities to explain away the N/A results. (Doc. 2407 at 10-13, 18:7) This is insufficient and is an argument that the Court will not entertain. (Doc. 1956 at 70:9-10)

Defendants have not explicitly moved to terminate monitoring of "common sense" categories but simply informed the Court that they have "no duty" to monitor these performance measures. *See, generally*, Doc. 2251-1. Defendants' posture aside, the Court will terminate monitoring for PM/locations that it understands are inapplicable.[3]

First, the performance measures that apply to infirmaries do not need to be monitored at prisons without an infirmary. The Court understands that the only complexes with infirmaries are Florence, Lewis, Perryville, and Tucson. (Doc. 2251-1 at

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[2] This also means that, monitoring methodology aside, PM 14 at Winslow cannot exit the Stipulation because the 18 month lookback extends to August 2015 and includes four consecutive months of non-compliance from August 2015 to November 2015.

[3] If Defendants change their operations in a way that impacts this ruling such that, for example, women are at other facilities or the location of intake units is changed, the Court may proceed accordingly.

¶¶ 225, 231, 235, 243, 251) Accordingly, the Court will terminate monitoring of infirmary-related performance measures—PM 63, 64, 65, 68, and 70—at prisons without infirmaries, namely Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma.[4]

Second, performance measures that apply only to women—PM 57, 58, 60, 61, and 74—do not need to be monitored at prisons that only house men. However, Defendant Pratt avowed that one performance measure involving post-natal care (PM74) applies in Perryville and Phoenix. (Doc. 2251-1 at ¶ 261) However, he also avowed that performance measures involving pre-natal care (PM 57 and PM 58) and Pap smears (PM 60) only apply in Perryville. (Doc. 2251-1 at ¶¶ 204, 208, 217) This inconsistency about the women prisoners in Phoenix may have a straightforward explanation but Phoenix cannot exit these women-only performance measures based on the information currently before the Court. Accordingly, the Court will deny without prejudice Defendants' motion to terminate monitoring PM 57, 58, 60, 61, and 74 at Phoenix.

Finally, the Court agrees that performance measures that apply to intake procedures do not need to be monitored at prisons where no intake occurs. Accordingly, the Court will terminate monitoring PM 33, 34, 62, 75, and 76 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma.

Specific Issues. Plaintiffs argue that Defendants' motion should be denied for PM 40 at Tucson. (Doc. 2344 at 41:8) Because Defendants did not move for termination of PM 40 at Tucson, this issue is moot. (Doc. 2251 at 6:5-6; Doc. 2251-1 at 18)

Defendants argue that they are entitled to terminate PM 42 at Lewis. (Doc. 2251 at 6:9, Doc. 2407 at 18:16-20) However, Defendant Pratt's declaration did not include any reference to PM 42 at Lewis. (Doc. 2251 at 19:1-14) Thus, separate from any data collection or monitoring methodology issues, PM 42 at Lewis is not eligible for termination.

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[4] The Court notes that Defendants' Motion does not address PM 66. *Compare* Doc. 2251 at 7:11-12 *with* Doc. 2251-1 at ¶¶238-39.

Plaintiffs' Stipulations. Plaintiffs have agreed to terminate monitoring of PM 7, 38, 56, and 71. (Doc. 2819) The Court will do so.

The Validity, Reliability, and Accuracy of the CGAR Data[5]

Defendants collect and report the CGAR data that determines whether they are in compliance with the Stipulation's performance measures. Thus, the CGAR data that is the foundation for the operation of the Stipulation is entirely within Defendants' control. For the past several years, Plaintiffs have raised various challenges to the collection and verification of that data. In response, and as detailed on the record, the Court has invested a significant amount of time understanding the data collection process and the implications of Defendants' different data reporting methods. The Court had addressed various minutiae of this process in an on-going attempt to obtain valid, reliable, and accurate CGAR data. At this point, the inescapable conclusion is there are profound and systemic concerns with the monitoring process at every stage of the process.

eOMIS. eOMIS is the electronic medical record system that Corizon providers use to document their care to inmates. ADC's Monitoring Bureau, in turn, relies on eOMIS records to calculate the CGARs. Therefore, the integrity of eOMIS is crucial.

The evidence before the Court is that eOMIS is not an accurate reflection of the care provided because providers can back-date entries in eOMIS and do not have to document that a late entry is late. In other words, "the health care staff at Corizon are able to go into eOMIS and change and manipulate the dates of requests to an earlier date." (Doc. 2671 at 166; Ex. 190)

The Court heard testimony from Cecilia Edwards, a credible witness and a Corizon employee, that she was instructed to cancel consults because Corizon had not yet obtained additional information, such as charts from outside providers or testing, or

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[5] This Order will only discuss the problems with the CGAR data and will not detail the related and concerning information presented to the Court such as exhibits where the date and day did not match (Doc. 2329 at 38, 104-105,166, 241-242, 277), testimony that Corizon does not pay its outside providers (Doc. 2244 at 93-97; Doc. 2876 at 40-42, 58), and Defendants apparently incorrect allegations that one of the oncology providers had filed for bankruptcy without any prior notification (Doc. 2635).

because there was no specialist available to see the patient. (Doc. 2876 at 18-19) Utilization Management instructed Edwards to cancel and then resubmit the consult request when the additional information was available. (Doc. 2876 at 18, 113, 126) This was done to avoid violating the Stipulation's timelines. (Doc 2876 at 128) She understood that she could wait but also that waiting would create non-compliance: this is a decision made by providers. (Doc. 2876 at 18) She was instructed to cancel a pending consult for these reasons an average of five times a month. (Doc. 2876 at 19) For ENT care, she has not cancelled consults and instead left them in place. (Doc. 2876 at 43-44)

Other examples of potential systemic weaknesses exist. Corizon does not provide all new providers with their own username/password immediately and so providers share. (Doc. 2670 at 29-31; Ex. 4) This means that an entry in eOMIS may be attributed to the wrong provider.

The Court recently heard from multiple witnesses about changes and limitations in eOMIS. Approximately four times last year, eOMIS "[went] down" and was sometimes inoperable all day. When that happens, providers had to "write the full note on a piece of paper and hang on to it until eOMIS is back up and running and then [providers] have to spend time inputting that information." (Doc. 2690 at 74-75) When eOMIS is down, there is no backup for the "extremely important" information in eOMIS such as progress notes or written orders. (Tr. 6-12-18 at 68) There is no evidence that Corizon has implemented any kind of eOMIS back-up or that busy providers do, in fact, input the paper information when eOMIS is working again.

Plaintiffs have raised other concerns about eOMIS documentation. For example, Plaintiffs noted nearly two dozen instances where IPC encounters started at precisely the start of the hour. (Doc. 2426-1 at 20-21) Also, during recent testimony, the Court heard that a new drop-down menu was going to be added to eOMIS. (Doc. 2895 at 215) Lisa McNeal, an ADC employee, testified that she had learned at a meeting that "a non-formulary button had kind of disappeared within eOMIS." (Doc. 2895 at 184:1) Finally, the Court learned that Corizon does not want providers to schedule consults 6 months

ahead of time but there is no tickler system for reminding providers to schedule consults, and there is no system to ensure that consults are scheduled even if there is provider turnover. (Doc. 2895 at 80-84)

Simply put, the credible evidence before the Court indicates that eOMIS allows providers to create dishonest and untraceable entries in an inmate's medical record, that Corizon has manipulated categories of records to comply with the Stipulation's time frames, and that Corizon has not ensured the integrity of its electronic medical records system.

Number of Records Reviewed. The Monitoring Bureau picks a seemingly arbitrary number of records to review for each Performance Measure. Although the Court understands that using more than 10 records could lead to more accurate information—the larger the pool reviewed, the more information gleaned—there is no apparent rhyme or reason to the number of records ADC reviews. These decisions can be dispositive to a finding of non-compliance.

For example: in January 2018's CGAR report, PM 51 at Florence listed 49 of 56 records as compliant. (Doc. 2711 at 112-113) Thus, according to the CGAR report, there were at least 7 instances of non-compliance. The first list submitted for the Order to Show Cause hearing ("OSC List") had 5 instances of non-compliance for PM 51/Florence in January 2018 and the amended list had 12 instances where each instance was a different inmate. (Doc. 2815-2 at 15) Adding the 12 instances of non-compliance from the final OSC list and the 49 instances of compliance from the CGAR report, it appears that there was a pool of 61 instances that the Monitoring Bureau could have included in the CGAR.[6] If all 61 instances had been included, this performance measure would not have met the Stipulation's threshold of 85%: 49/61=80%. But because only 56 records were included, the performance measure was documented on the CGAR report as compliant: 49/56=88%.

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[6] There could be many more than 61 records for PM 51 at Florence in January 2018.

Escalation Cases vs CGAR Report. The Court expected that recent testimony would buttress the integrity of the CGAR reports. The opposite occurred.

For example, on Friday, July 28, 2017, Karen Padron, a Program Evaluation Specialist in the ADC Monitoring Bureau, emailed Dr. Robertson about Inmate 40 at Phoenix:

> I am working on PM 50-52 and ran across this consult that was cancelled by the regional medical director and wondered if you were aware and that nothing has been pursued since 4/20. . . . Thought you might want to be aware that this IM appears to not be getting an evaluation he needs in order to be appropriately treated.

(Ex. 85) Ms. Padron's email indicates that Inmate 40's care was not compliant with the Stipulation and that his records were part of her review for that months' CGAR. On Monday, July 31, 2017, Ms. Padron entered the June 2017 CGARs for PM 50, PM 51, and PM 52 in Phoenix. She reviewed 5 records for PM 50, 9 records for PM 51, and 11 records for PM 52. Inmate 40 is not included in the CGARs for PM 50, PM 51, or PM 52. (Doc. 2247 at 264-265) Because of the Stipulation's monitoring requirements of reviewing at least 10 records, and the fact that Ms. Padron reviewed fewer for PM 50 and 51, the Court concludes that Ms. Padron should have reviewed the entire universe of possible records for PM 50 and PM 51 in Phoenix for the June 2017 CGARs.[7] (Doc. 1185-1 at 26) Thus, it is inexplicable that Ms. Padron reviewed Inmate 40's records on a Friday and then did not include him on Monday's report. The system is not working when an individual Monitor flags someone for not receiving timely care and then doesn't include that person in the CGAR analysis.

A different email indicates different concerns. On Monday, August 7, 2017, Marlena Bedoya, a Monitor for ASP-Tucson, emailed Dr. Robertson and several others about Inmate 23:

> I think I found another Cancer. I came across this chart while auditing and saw his Cancer diagnosis, went into the latest consult – and found these

[7] Inmate 40 does not appear in the July 2018 CGARs for PM 50, 51, or 52. (Doc. 2333)

> comments. I just don't understand why they continue to state "need more info" if he has ongoing cancer. . . .

Ms. Bedoya then detailed portions of Inmate 23's July 2017 medical record. As part of the response emails, Vanessa Headstream told Ms. Bedoya, "When you find oddities or areas of concern in any i/m [inmate] record, please alert both Dr. Robertson and myself to them. Each case is added to my tracking and f/u caseload." (Ex. 154)

For the July 2017 CGARs, Ms. Bedoya documented Inmate 23 as compliant in several CGARs, including performance measures for access to care (PM 40, 41, 43, 44) and specialty care (PM 50, 51, 52). (Doc. 2333 at 332-333, 337-339) In other words, a conscientiousness individual was so concerned that she escalated his records to a supervisor but the established system did not catch any concerns with his care. Again, something is not working when an individual Monitor flags someone for receiving insufficient care and then still marks that inmate as compliant with the CGARs.

This lacuna indicates that the Monitoring Guide was written, or is being used, in a way that documents compliance even when appropriate care is not being provided to inmates.

Monitoring Guide. The Monitoring Bureau uses a document called the "Monitoring Guide" to determine whether the eOMIS records are compliant with the Stipulation. The Court has repeatedly attempted to understand the monitoring process and specific issues therein. (Doc. 1915 at 3) These investments have had limited returns. For example, the Court attempted to understand the CGARs for PM 85 and 86 and Defendants' explanation did not clarify the matter. (Doc. 2587)

Defendants' Filings. Other submissions by Defendants are inexplicably inconsistent. For example, when Defendants first submitted their March 2018 charts, PM 35 at Florence was listed at 82% and, in an amended filing, it was listed at 88%. (Doc. 2801-1 at 61; 2803-1 at 2) Subsequently, Defendants filed their monthly CGAR report for March 2018 which listed PM 35 at Florence at 86.27%. (Doc. 2836 at 107-108) This means that this PM/location was modified at least twice—first up to 88% and then down

to 86%—with no explanation and no paper trail. This lack of audit integrity causes the Court to question the audit process overall.

Evidentiary Hearing. The Court recently concluded an extensive evidentiary hearing into allegations that Corizon had instructed a provider on ways to "beat the monitor." The evidence presented to the Court was also enough to raise questions about the integrity of the state's CGAR system.

In one example, Ms. Edwards testified that Defendants—in an apparently unilateral decision—changed optometry from the "appointments" category to the "consults" category. (Doc. 2876 at 11-12) By making this change, Defendants moved optometry care from a shorter timeframe under the Stipulation to a longer one and gave themselves additional time to provide the same care. (Doc. 2876 at 11-12)

As part of this change from appointments to consults, Corizon cancelled all pending appointments and initiated consult requests. (Doc. 2876 at 12-13) The consult requests did not accurately capture the previous appointment request date. In other words, Corizon re-categorized a category of care in a way that allowed them to take additional time to provide the care and that did not permit an accurate assessment of whether or not there had been compliance with the relevant performance measure. (Doc. 2867 at 15)

Examples like this indicate that Defendants and their contractor are at times more interested in obtaining compliance with the Stipulation by playing a shell game than by providing care to the Plaintiff Class.

Expert Review. Although the Stipulation is focused on aggregate numbers, compliance can be a life-or-death matter for inmates. (Doc. 2876 at 59-66) In one example, in November 2017, Matilde Smith, the Eyman Assistant Facility Health Administrator, told her supervisor that "[i]n the last month and a half we have sent out 3 Inmates who were on the [chronic care] Backlog at Cook unit to local ER with life threatening issues which correlate with their chronic conditions, 1 of which expired at hospital." (Ex. 213)

Because the stakes could not be higher, the Court cannot release Performance Measures from the Stipulation without confirmation that a compliant CGAR is a valid, reliable, and accurate indicator that Defendants have provided Class Members the care required by the Stipulation. Each of the examples above, when taken together, demonstrates that the Court cannot be confident that the CGARs demonstrate compliance with the Stipulation. To provide confidence, the Court will retain a Rule 706 expert, paid for by Defendants, who will review the entire monitoring process. This review shall include the issues noted above and shall include, but is not limited to, a review of eOMIS, the Monitoring Guide as written and as applied including the sampling process and the number of records reviewed, the ADC/Corizon challenge process, and the metadata/trail of any subsequent modifications. If the expert concludes that any of the CGARs are not, in fact, valid, reliable, or accurate, the expert shall develop remedial measures that will permit the collection and submission of valid, reliable, and accurate CGARs.

Although the Court has determined that an expert is necessary to evaluate the efficacy and reliability of the Monitoring Guide and its procedures, the Court also recognizes that committed and conscientious overseers exist within the system. Nevertheless, sufficient questions have been raised about the audit system's integrity to warrant this expert review. As the Court has explained previously, the state and its contractor have incentives to under report noncompliance. This fact does not mean such conduct is ineluctable—indeed the many months or reported failures to meet the Performance Measures suggest otherwise —however the potential bias of not wanting to report one's errors and the evidence of structural weaknesses in the monitoring program demand a high level of audit integrity.

IT IS THEREFORE ORDERED granting in part and denying in part Defendants Motion to Terminate Monitoring (Doc. 2251). The following performance measures at the following locations will be terminated for the reasons described above:

- PM 7 at all 10 facilities;
- PM 33 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;

- PM 34 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;
- PM 38 at all 10 facilities;
- PM 56 at all 10 facilities;
- PM 57 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 58 at at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 60 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 61 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 62 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma;
- PM 63 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 64 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 65 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 68 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 70 at Douglas, Eyman, Phoenix, Safford, Winslow, and Yuma;
- PM 71 at all 10 facilities;
- PM 74 at Douglas, Eyman, Florence, Lewis, Safford, Tucson, Winslow, and Yuma;
- PM 75 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma; and
- PM 76 at Douglas, Florence, Lewis, Safford, Winslow, and Yuma.

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IT IS FURTHER ORDERED that, within 30 days of the date of this Order, the parties shall each submit the names of two proposed experts who can conduct a review of the monitoring process, along with their CVs and confirmation of their availability. Thereafter, the Court will pursue a selection process that may include interviewing a finalist.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

WO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

A Health Needs Request (HNR) form is the mechanism by which Arizona Department of Corrections (ADOC) inmates request medical treatment, dental care, mental health treatment, prescription refills, or report symptoms to the health care providers. ADOC's longstanding practice required housing units to have a repository for inmates to submit HNRs—HNR Boxes—from which health care staff would collect, review, log, triage, and act upon accordingly. At least a dozen of the Stipulation's performance measures require Defendants to act within certain time frames and it is the submission of an HNR which starts the clock for assessing compliance with them.[1] For example, PM 37 requires an RN to see a sick call inmate within 24 hours after receiving an HNR (or earlier if a more urgent need is present).

In a significant shift, the parties informed the Court in May 2017 that HNR Boxes would be removed from multiple units because those units had adopted the "open clinic

[1] Specifically, Performance Measures 5, 7, 36, 37, 39, 40, 41, 42, 47, 98, 102, and 103. (Doc. 1185-1)

process." As explained by the Defendants, the open clinic process is similar to the urgent care model in the community and requires inmates to go to the health unit at designated hours to see a nurse. As implemented by the Defendants, the open clinic procedures only allow the inmate to submit the HNR when visiting with the nurse in person (Doc. 2365 at 5).

Because the way HNRs are submitted and evaluated is critical to assuring meaningful compliance with multiple areas of the Stipulation, the Court held a four-day hearing to assess whether the new HNR submission process frustrated the ability to assess compliance with the Stipulation's Performance Measures. The Court heard testimony from multiple inmate witnesses, ADOC staff, and Corizon staff (Docs. 2124, 2186, 2233, 2318).

Witness testimony at the hearing confirmed that HNRs are now only tracked when an inmate sees a health care provider (Doc. 2148, June 14, 2017 Hr'g Tr. at 94:15-95:21; Doc. 2328, September 13, 2017 Hr'g Tr. at 143:13-25). The testimony indicated that ADOC does not have any mechanism to track inmates who attempted to attend an open clinic and does not log HNRs when inmates arrived at the open clinic (Doc. 2148, June 14, 2017 Hr'g Tr. at 94:15-95:21).

The testimony presented in Court indicated that not all inmates are able to attend an open clinic, wait to be seen, and submit an HNR without difficulty. Specifically, witnesses testified that some inmates were unable to attend the open clinic during the designated hours (Doc. 2208, July 14, 2017 Hr'g Tr. at 85:1-5, 132:3-4, 134:20-135:12, 137:19-138:3; Doc. 2243, August 9, 2017 Hr'g Tr. at 12:2-6, 13:13-14, 15-2:4). Other inmates were too ill or disabled to get to and wait at the open clinic (Doc. 2208, July 14, 2017 Hr'g Tr. at 67:2-12, 67:25-68, 69:9-71:6). Finally, some inmates were required to wait outside in temperatures exceeding 100 degrees while waiting to see nursing staff (Doc. 2208, July 14, 2017 Hr'g Tr. at 18:18-21, 20:25-21:4, 34:4-5, 34:11-35:5, 52:6-20, 83:13-15, 94:20-95:1).[2]

[2] This ruling does not pass judgment on the open clinic process itself which, as

This shift flatly contradicts Defendants' avowal to the Court on January 18, 2017, wherein they maintained that multiple HNR submission methods "ensure that inmates are able to submit HNRs in multiple ways to request and receive routine medical care" (Doc. 1873 at 3). And indeed, certain health care monitor staff testified that only accepting HNRs upon seeing a nurse at the open clinic erects a barrier for inmates to access care (Doc. 2244, August 8, 2017 Hr'g Ex. 27 at 2) ("I said this was in direct contradiction to what I was told today, which is that [HNR Boxes] are never going away because it is an access to care issue."). Finally, Mr. Pratt acknowledged that he did not believe it was necessary to completely remove the HNR boxes (Doc. 2244, August 8, 2017 Hr'g Tr. at 54:19-24).

Based on the evidence presented during the four-day hearing and the parties' briefing, it is clear that the open clinic process means that the only HNRs logged for measuring compliance with the Stipulation are the HNRs submitted by inmates who were able to see a nurse in person. In other words, there is no trace of an inmate's HNR until s/he is seen by a nurse, at which point the HNR is submitted. The Court concludes that the modified open clinic HNR process may impermissibly constrict the numbers of HNRs submitted for measurement and so it cannot replace the HNR Boxes for purposes of measuring compliance with the Stipulation. Because the parties identified the HNR boxes as the triggering event with some of the performance measures, this practice cannot be abandoned without proof that it would have no effect on the measurement of Defendants' compliance with the Stipulation. Not only have Defendants failed to meet this burden of proof but the Court is satisfied that it is likely that some class members would not be able to brave the gauntlet of making it to a nurse at the open clinic.

Defendants raise several arguments in defense of the open clinic process. None of them are well taken. First, Defendants maintain that the Court is powerless to address their decision because the Stipulation does not mandate a particular method for inmates

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the witnesses noted, has positive attributes. This ruling also does not address how ADOC collects and logs HNRs during the open clinic process.

to submit HNRs (Doc. 2416 at 3-4). But, as Plaintiffs point out, when the parties negotiated the Stipulation, there was no indication that the HNR Box system—where inmates could submit HNRs in a collection box at any time of the day or to have another inmate submit it on their behalf if they were unable—would change (Doc. 2458 at 3).[3]

Moreover, Defendants' contention that the Court cannot evaluate their fundamental change in health care delivery to determine whether it complies with the letter and spirit of the Stipulation is meritless. As with innumerable disputes regarding monitoring compliance with the Performance Measures, the Court is well within its discretion to address Defendants' removal of the HNR boxes in order to ensure that compliance is assessed meaningfully.

Similarly unavailing is Defendants' contention that this issue is not yet ripe for resolution—it has been over one year since this decision was reported to the Court and the parties have litigated the issue to conclusion.

Based upon the testimony and evidence before it, the Court finds that the removal of the HNR boxes is inconsistent with the Stipulation's requirements.

IT IS THEREFORE ORDERED that within 30 days of this Order, Defendants shall:

(1) Defendants shall reinstall HNR boxes in all housing units where they were removed. The Court will not require the HNR boxes to be replaced in the same locations but will require the same number in each unit as before and expects that any change in location will not create a barrier for any particular group of inmates (i.e., if an HNR box was previously accessible to wheelchair-bound inmates then a comparably accessible box must be placed in the same unit);

(2) Defendants shall resume the previous process for collecting and logging the submitted HNRs. Defendants may also continue the open clinic procedures for accepting HNRs;

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[3] The parties negotiated the Stipulation understanding that other procedural changes, such as the adoption of electronic medical records, were imminent.

(3) Defendants shall notify the affected inmates in writing announcing the reversion to the prior HNR submission process; and

(4) Defendants shall provide competent and admissible evidence to the Court that this return to the *status quo ante* has occurred.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

WO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

The Court's expert, Advisory Group, has made its final presentation to the Court and submitted a final report. Plaintiffs have asked the Court to issue an order that Defendants file a plan to implement these recommendations. (Doc. 2880) Good cause appearing,

IT IS THEREFORE ORDERED that, within 30 days of the date of this Order, Defendants shall file their plan to implement the recommendations contained in the final Advisory Group report.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge

WO

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Victor Antonio Parsons, et al.,

Plaintiffs,

v.

Charles L. Ryan, et al.,

Defendants.

No. CV-12-0601-PHX-DKD

ORDER

After more than three years, it is clear to the Court that Defendants are unable or unwilling to meet several of the Stipulation's requirements. Defendants have submitted, and the Court has adopted, multiple remediation plans. (Docs. 1619, 2030) Defendants have revised and re-revised these remediation plans and yet, pockets of non-compliance persist. For example, PM 42 at Eyman has been non-compliant since April 2017 and Defendants have stopped proposing substantive revisions to their remediation plan. (Docs. 2801-1 at 83-85; 2807 at 68) Similarly, PM 39 at Lewis has been non-compliant for eight of the last 12 months and Defendants most recent plan is that they "will continue to utilize the same corrective action plan as set forth in the [previous] update." (Doc. 2874-1 at 79-80)

For other performance measure/locations, Defendants have not even attempted a substantive remedial measure and have simply informed the Court that a new hire will solve the problem. For example, PM 50 at Tucson has been non-compliant for 11 of the last 13 months. Defendants informed the Court on May 9, 2018, that "A new clinical

coordinator has been hired and is currently in the process of on-boarding. Effects of this action should be reflected in the May audit." (Doc. 2803-1 at 5) At the Status Hearing, Counsel could not address basic issues and had no information about how hiring one new person could constitute a remediation plan or would solve the previous year's non-compliance. (Doc. 2807 at 165-166) Accordingly, the Court ordered a remediation plan. (Doc. 2810) In response, Defendants responded with an explanation of the hiring history of the clinical coordinator position. (Doc. 2858-1 at 2) However, when Defendants had the position filled, PM 50/Tucson was non-compliant so it is unclear to the Court, and Defendants do not explain, why refilling the position will solve the underlying problem(s) and create compliance.

In another example, PM 19 at Lewis has been non-compliant for at least 13 consecutive months. Defendants submitted a corrective action plan on May 9, 2018, that stated "A new DON [Director of Nursing] started March 12 and, upon arrival, began addressing medication administration issues. . . . Due to the large number of staff that will need to be trained on the new plan, full plan development and implementation will not be accomplished until July 2018." (Doc. 2801-1 at 39) This means that for the previous year, Defendants did not attempt to create a solution.

The Court further notes that the show cause hearing did not result in full compliance with the subset of PM/locations targeted by the OSC. Moreover, the OSC only covered some of the failing PM/locations and, in the year since the OSC was first raised, other PM/locations have been consistently non-compliant. For example, PM 42 at Florence has been non-compliant for 12 of the last 13 months, PM 42 at Lewis has been non-compliant for 8 of the last 10 months, PM 44 at Florence has been non-compliant for the last three months, PM 52 at Tucson has been non-compliant for 8 of the last 10 months, and PM 67 has been non-compliant for 10 of the last 12 months. (Doc. 2801-1 at 86, 88, 93, 162, 183) It appears that Peter has, in fact, been robbed to pay Paul.

Defendants have professed that they welcome ideas from Plaintiffs. (Doc. 2071 at 137-138) To the extent that this knowledge-sharing has occurred, it has not produced

compliance. Based on Defendants' representations to the Court and the monthly CGAR reports, it appears that Defendants do not have additional ideas or resources that they can rely upon to obtain compliance with the Stipulation. As a result, the Court has determined that it is not efficacious to require Defendants to submit yet another revised remediation plan. (Doc. 1185 at ¶ 36)

"The ongoing, intractable nature of this litigation affords the district court considerable discretion in fashioning relief." *Armstrong v. Brown*, 768 F.3d 975, 986 (9th Cir. 2014). Accordingly, as part of the Court's remedial authority under the Stipulation (Doc. 1185 ¶ 36), the Court will require Defendants to hire outside experts who can perform the analysis necessary to understand why deficiencies persist and to opine as to the policies and procedures necessary to compel compliance with the Stipulation.[1] Put another way, the Court expects that the experts will review existing policies and procedures, create a remediation plan based on their expertise, and that Defendants will then adopt the expert's remediation plan. The Court expects that, because the problematic performance measures cover different categories of care, different experts may be necessary to create remediation plans that are targeted to the varying needs and difficulties at different prisons. Specifically, the Court expects expert opinions on the following six categories:

- Pharmacy: PM 15 at Lewis; PM 19 at Lewis.
- Intersystem Transfers: PM 35 at Lewis.
- Access to Care: PM 39 at Lewis; PM 40 at Eyman; PM 42 at Eyman, Florence, Lewis; PM 44 at Eyman, Florence, Lewis.
- Diagnostic Services: PM 46 at Eyman; PM 47 at Eyman, Lewis, Phoenix, Tucson.
- Specialty Care: PM 49 at Tucson; PM 50 at Florence, Tucson; PM 51 at Florence; PM 52 at Eyman, Florence, Tucson.

[1] Because of Defendants' inability to hire and retain providers, the Court has ordered an outside consultant, Advisory Group, to opine on the hiring and retention of providers. Advisory Group presented its findings in open court on June 13, 2018. (Doc. 2880) The Court expects the additional expert(s) would opine on what Defendants' employees should do and/or how they should do it.

- Chronic Care: PM 54 at Eyman; PM 55 at Eyman.
- Infirmary Care: PM 66 at Florence; PM 67 at Lewis, Tucson.

IT IS THEREFORE ORDERED that, within 30 days of the date of this Order, Plaintiffs and Defendants shall each submit a list of two proposed experts for each of the following categories of care delineated by the Stipulation: Pharmacy, Intersystem Transfers, Access to Care, Diagnostic Services, Specialty Care, and Chronic Care. For each proposed expert, the parties shall submit a current CV/resume and confirm that s/he is available to serve as an outside expert to Defendants. The Court will then conduct its selection process.

Dated this 22nd day of June, 2018.

David K. Duncan
United States Magistrate Judge