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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Fred Graves, Isaac Popoca, on their own behalf and on behalf of a class of all pretrial detainees in the Maricopa County Jails,

Plaintiffs,

v.

Paul Penzone, Sheriff of Maricopa County; Bill Gates, Steve Gallardo, Denny Barney, Steve Chucri, and Clint L. Hickman, Maricopa County Supervisors,

Defendants.

No. CV-77-00479-PHX-NVW

ORDER

TABLE OF CONTENTS

- I. Prison Litigation Reform Act..... 1
- II. Background 2
- III. Plaintiffs’ Motion for Evidentiary Hearing (Doc. 2380) 14
- IV. Plaintiffs’ Motion to Enforce the Revised Fourth Amended Judgment (Doc. 2373) 16
 - A. 2014 Findings, Conclusions, and Orders..... 19
 - B. 2015 Evidence 27
- V. Compliance with the Revised Fourth Amended Judgment..... 34
 - A. Subparagraph 5(a)(1): A registered nurse will perform the receiving screening for each pretrial detainee processed in the 4th Avenue jail intake center. 36
 - B. Subparagraph 5(a)(2): If the receiving screening indicates a pretrial detainee is suffering from a serious acute or chronic health condition, a physician,

1 physician assistant, or nurse practitioner will conduct a face-to-face
2 examination of the pretrial detainee within 24 hours after the receiving
3 screening..... 36

4 C. Subparagraph 5(a)(3): If the receiving screening indicates a pretrial detainee
5 has symptoms of tuberculosis, the pretrial detainee immediately will be placed
6 in an Airborne Infection Isolation Room and evaluated promptly for
7 tuberculosis..... 37

8 D. Subparagraph 5(a)(4): If the receiving screening indicates a pretrial detainee is
9 known to have HIV infection or is at risk for HIV infection with unknown
10 status, a chest x-ray of the pretrial detainee will be performed and the results
11 reviewed by a physician, physician assistant, or nurse practitioner before the
12 pretrial detainee is placed in a housing unit. 38

13 E. Subparagraph 5(a)(5): If a pretrial detainee has a positive mental health
14 screening or does not respond to all of the mental health screening questions,
15 the detainee will be assessed by mental health staff while the pretrial detainee
16 is in the intake center. The mental health staff will identify the urgency with
17 which the pretrial detainee must be seen by a mental health provider, *i.e.*, a
18 psychiatrist, psychiatric nurse practitioner, or physician assistant..... 39

19 F. Subparagraph 5(a)(6): If the receiving screening indicates a pretrial detainee is
20 at risk for suicide, a psychiatrist, psychiatric nurse practitioner, or physician
21 assistant will conduct a face-to-face assessment of the pretrial detainee within
22 24 hours after the receiving screening..... 40

23 G. Subparagraph 5(a)(7): Pretrial detainees will be tested for tuberculosis within
24 14 days after the receiving screening unless they have been tested with
25 negative results within the past year..... 41

26 H. Subparagraph 5(a)(8): Pretrial detainees with serious acute and chronic
27 medical conditions will be evaluated face-to-face by a medical provider and
28 will receive an initial health assessment within 24 hours after the receiving
screening..... 42

I. Subparagraph 5(a)(9): A medical provider will develop plans for treatment
and monitoring for pretrial detainees with serious medical conditions. 43

J. Subparagraph 5(a)(10): All medical Health Needs Requests will be triaged
within 24 hours of their submission. 44

K. Subparagraph 5(a)(11): Each 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..... 44

L. Subparagraph 5(a)(12): 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

1	study must be performed, <i>e.g.</i> , within 24 hours, 72 hours, or 7–10 days, and the	
2	urgency with which the results of the test or study must be returned. The test	
3	or study will be performed within the timeframe ordered by a physician,	
4	physician assistant, or nurse practitioner.....	45
5	M. Subparagraph 5(a)(13): Pretrial detainees identified during the receiving	
6	screening as being at risk of serious harm from alcohol or drug withdrawal will	
7	be assessed by a registered nurse twice a day for at least seven days regardless	
8	of whether they are assigned to a housing unit designated for withdrawing	
9	inmates or their classification status. The nurse will document each	
10	assessment and identify the urgency with which the pretrial detainee should be	
11	seen by a physician, physician assistant, or nurse practitioner. If a pretrial	
12	detainee is not seen face-to-face by a physician, physician assistant, or nurse	
13	practitioner within the timeframe recommended by the nurse, the reason will	
14	be documented in the pretrial detainee’s medical record.	46
15	N. Subparagraph 5(a)(14): All mental health Health Needs Requests stating or	
16	indicating a clinical symptom will be triaged face-to-face within 48 hours of	
17	their submission.	46
18	O. Subparagraph 5(a)(15): Upon referral by detention, intake, medical, or mental	
19	health staff, pretrial detainees who display active symptoms of mental illness	
20	or otherwise demonstrate an emergent mental health need will be seen face-to-	
21	face by a mental health provider within 24 hours of the referral.	47
22	P. Subparagraph 5(a)(16): Mental health providers will assess pretrial detainees	
23	in an area outside of their cells that affords sound privacy except when there	
24	are legitimate safety, security, and treatment reasons for not doing so.	49
25	Q. Subparagraph 5(a)(17): Defendants will adopt and implement written criteria	
26	for placing pretrial detainees in each level of mental health care, including	
27	subunits within the Mental Health Unit.	51
28	R. Subparagraph 5(a)(18): 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.	52
	S. Subparagraph 5(a)(19): Pretrial detainees discharged from the Mental Health	
	Unit will be assessed by mental health staff within 48 hours after discharge.....	54
	T. Subparagraph 5(a)(20): MCSO will consult with CHS mental health staff	
	before placing a seriously mentally ill pretrial detainee in any type of	
	segregated confinement.	54
	U. Subparagraph 5(a)(21): 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.....	55

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V. 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. 56

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. 56

W. Subparagraph 5(a)(24): Defendants will adopt and implement a written policy regarding the use of discipline for behavior resulting from serious mental illness. 58

Subparagraph 5(a)(25): Defendants will 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. 58

Subparagraph 5(a)(26): Defendants will adopt and implement a written policy requiring that mental health staff be consulted regarding discipline of any seriously mentally ill pretrial detainee. 58

X. Subparagraph 5(a)(27): A potentially suicidal pretrial detainee will not be placed in isolation without constant supervision. 58

Y. Subparagraph 5(a)(28): 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.” 59

Z. Subparagraph 5(a)(29): 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. 59

AA. Subparagraph 5(a)(30): 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. 60

BB. Subparagraph 5(a)(31): 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. 61

1 Before the Court are the following:

2 (1) Defendants’ Report of Data Collected and Summarized (Doc. 2333) regarding
3 Defendants’ compliance with Paragraph 5 of the Revised Fourth Amended Judgment,
4 Defendants’ supplemental report (Doc. 2336), Plaintiffs’ response (Doc. 2372), and
5 Defendants’ reply (Doc. 2378);

6 (2) Plaintiffs’ Motion to Enforce Fourth Amended Judgment and for Additional
7 Relief (Doc. 2373), Defendants’ response (Doc. 2376) and Plaintiffs’ reply (Doc. 2379);
8 and

9 (3) Plaintiffs’ Motion for Evidentiary Hearing (Doc. 2380), Defendants’ response
10 (Doc. 2384), and Plaintiffs’ reply (Doc. 2389).

11 Collectively, Defendants’ compliance reports and Plaintiffs’ motions dispute whether the
12 Revised Fourth Amended Judgment should be terminated, whether additional prospective
13 relief under the Prison Litigation Reform Act is required, and whether another
14 evidentiary hearing is required to decide those issues. On February 15, 2017, oral
15 argument was heard regarding the pending motions and Defendants’ proof of compliance
16 with the Revised Fourth Amended Judgment.

17 **I. PRISON LITIGATION REFORM ACT**

18 Congress enacted the Prison Litigation Reform Act (“PLRA”), 18 U.S.C. § 3626
19 and 42 U.S.C. § 1997, to prevent federal courts from micromanaging prisons by consent
20 decrees. *Gilmore v. California*, 220 F.3d 987, 996 (9th Cir. 2000). The PLRA requires
21 that prospective relief regarding prison conditions “extend no further than necessary to
22 correct the violation of the Federal right of a particular plaintiff or plaintiffs.” 18 U.S.C.
23 § 3626(a)(1). Relief must be narrowly drawn, extend no further than necessary to correct
24 the violation, and be the least intrusive means necessary to correct the violation. *Id.*
25 Further, courts must “give substantial weight to any adverse impact on public safety or
26 the operation of a criminal justice system caused by the relief.” *Id.*

27 A party seeking to terminate prospective relief under § 3626(b) bears the burden
28 of proof. *Gilmore*, 220 F.3d at 1007; *Graves v. Arpaio*, 623 F.3d 1043, 1048 (9th Cir.

1 2010) (per curiam). “Prospective relief shall not terminate if the court makes written
2 findings based upon the record that prospective relief remains necessary to correct a
3 current and ongoing violation of the Federal right, extends no further than necessary to
4 correct the violation of the Federal right, and that the prospective relief is narrowly drawn
5 and the least intrusive means to correct the violation.” 18 U.S.C. § 3626(b)(3). If
6 prospective relief remains necessary to correct a current and ongoing violation, the
7 district court’s authority to modify the existing prospective relief includes authority to
8 expand or diminish the existing relief. *See Pierce v. Orange County*, 526 F.3d 1190,
9 1204 n.13 (9th Cir. 2008).

10 To make the findings required to terminate prospective relief, the Court must take
11 evidence on current jail conditions, at least with respect to those conditions Plaintiffs do
12 not concede comply with constitutional requirements. *See Gilmore*, 220 F.3d at 1010.
13 Evidence of “current and ongoing” violations must reflect conditions “as of the time
14 termination is sought.” *Id.*; *accord Pierce*, 526 F.3d at 1205.

15 **II. BACKGROUND**

16 The issues presented for decision can be fully understood only in the context of
17 this case’s lengthy history, particularly the past eight years during which all parties have
18 made substantial efforts to improve jail conditions with significant court involvement.
19 *See* David Marcus, *Finding the Civil Trial’s Democratic Future After Its Demise*, 15 Nev.
20 L.J. 1523, 1530–46 (2015). Pretrial detainees held in the Maricopa County Jail brought
21 this class action in 1977 against the Maricopa County Sheriff and the Maricopa County
22 Board of Supervisors seeking injunctive relief for alleged violations of their civil rights.
23 On March 27, 1981, the parties entered into a consent decree that addressed and regulated
24 aspects of the County jail operations as they applied to pretrial detainees.

25 On January 10, 1995, upon stipulation of the parties, the 1981 consent decree was
26 superseded by the Amended Judgment. The stipulated Amended Judgment expressly did
27 not represent a judicial determination of any constitutionally mandated standards
28 applicable to the Maricopa County Jail. The 116-paragraph Amended Judgment included

1 specific requirements regarding population and housing limitations; dayroom access;
2 access to reading materials; access to religious services; mail; telephone privileges;
3 clothes and towels; sanitation, safety, hygiene, and toilet facilities; access to law library;
4 medical, dental and psychiatric care; intake areas; mechanical restraints and segregation;
5 recreation time outside; inmate classification; visitation; food; staff members, training,
6 and screening; facilities for the handicapped; disciplinary policy and procedures; inmate
7 grievance policy and procedures; reports and record keeping; and security override.

8 The Amended Judgment included the following provisions:

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

17 57. All pretrial detainees confined in the jails shall have access to
18 medical services and facilities which conform to the standards designated
19 as “essential” by the National Commission on Correctional Health Care
20 (“NCCCHC”) Standards for Health Services in Jails, as amended from time
21 to time. When necessary, pretrial detainees confined in jail facilities which
22 lack such services shall be transferred to another jail or other location
23 where such services or health care facilities can be provided or shall
24 otherwise be provided with appropriate alternative on-site medical services.

25

26 61. Defendants shall ensure that the pretrial detainees’
27 prescription medications are provided without interruption where medically
28 prescribed by correctional medical staff.

(Doc. 705 at 12–13.)

29 In November 2003, Defendants renewed a prior motion to terminate the Amended
30 Judgment, an evidentiary hearing was initiated, and the parties engaged in further
31 discovery, but the motion was not decided. On April 3, 2008, the case was assigned to

1 the undersigned judge. On April 25, 2008, Defendants' motion to terminate the
2 Amended Judgment was set for evidentiary hearing commencing August 12, 2008.

3 Although evidence of "current and ongoing" violations usually must reflect
4 conditions as of the time termination is sought, Defendants had been seeking termination
5 for nearly five years. Therefore, it was necessary to determine the period for which
6 evidence would be considered relevant to current conditions. The Court initially ordered
7 the parties to plan for discovery and trial regarding jail conditions during the period of
8 July 1, 2007, through June 30, 2008. Subsequently, upon request of the parties, the
9 relevant evidentiary period for evaluating current conditions was reduced to July 1, 2007,
10 through May 31, 2008, to facilitate providing information to expert witnesses before their
11 tours and inspections of jail facilities.

12 In August and September 2008, a thirteen-day evidentiary hearing was held to
13 decide whether prospective relief in the Amended Judgment should be continued,
14 modified, or terminated. On October 22, 2008, the Court made detailed findings of fact
15 and conclusions of law and entered the Second Amended Judgment. Certain provisions
16 of the Amended Judgment were found to remain necessary to correct a current and
17 ongoing violation of a federal right, to extend no further than necessary to correct the
18 violation of the federal right, to be narrowly drawn, and to be the least intrusive means to
19 correct the violation. Other provisions were modified or vacated based on the evidence
20 presented. The provisions remaining in effect, as originally written or as modified, were
21 restated in the Second Amended Judgment.

22 The sixteen-paragraph Second Amended Judgment included requirements for the
23 number of detainees per cell, court holding cell capacities, maximum housing
24 temperature for detainees who take prescribed psychotropic medications, provision of
25 cleaning supplies, toilet and wash basin facilities in intake areas and court holding cells,
26 length of stay in intake areas, outdoor recreation, nutrition, recordkeeping, and visual
27 observation of intake areas, court holding cells, the Lower Buckeye jail psychiatric unit,
28

1 and segregation units. Paragraph 6 of the Second Amended Judgment continued
2 Paragraph 56 of the Amended Judgment, regarding receiving screenings, without
3 modification. Paragraph 8 of the Second Amended Judgment continued Paragraph 61 of
4 the Amended Judgment, regarding continuity of prescription medications, without
5 modification.

6 With respect to Paragraph 57 of the Amended Judgment, regarding access to
7 medical services and facilities, the Court found that “pretrial detainees have a
8 constitutional right to access to adequate health care, but there is no constitutional
9 requirement that the adequacy of health care be defined by the NCCHC.” (Doc. 1634 at
10 43, ¶ 180.) The Court further found:

11 182. Paragraph 57 of the Amended Judgment does not exceed the
12 constitutional minimum to the extent it requires Defendants to ensure
13 pretrial detainees’ ready access to care to meet their serious medical, dental,
14 and mental health needs, which means that in a timely manner, a pretrial
15 detainee can be seen by a clinician, receive a professional clinical
16 judgment, and receive care that is ordered.

17

18 211. Some of the seriously mentally ill pretrial detainees are
19 housed in the psychiatric unit at the Lower Buckeye jail, and the most
20 seriously mentally ill of those are housed in cells that do not permit
21 psychiatrists and pretrial detainees to have visual contact while
22 communicating or to have private therapeutic communications. Mental
23 health staff frequently provide cell-side treatment without privacy in other
24 housing units as well. In some cases, this detriment to therapeutic
25 treatment is necessary to preserve the safety and security of staff and
26 pretrial detainees; in some cases, it is not.

27 212. Many of the pretrial detainees housed at the Lower Buckeye
28 jail psychiatric unit need hospital level psychiatric care.

213. The psychiatric unit at the Lower Buckeye jail does not
provide hospital level psychiatric care.

214. Many of the pretrial detainees housed at the Lower Buckeye
jail psychiatric unit are maintained in segregation lockdown with little or no
meaningful therapeutic treatment, which results in needless suffering and
deterioration.

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2 216. Regarding paragraph 57 of the Amended Judgment,
3 Defendants do not ensure that pretrial detainees receive access to adequate
4 medical and mental health care because Correctional Health Services does
5 not provide timely in-person assessment of the urgency of their need for
6 treatment, is not able to readily retrieve information from pretrial detainees’
7 medical and mental health records and housing records, and does not
8 identify and appropriately treat many pretrial detainees with serious mental
9 illness.

10 (*Id.* at 43, 46–47.) Therefore, Paragraph 57 of the Amended Judgment was renumbered
11 as Paragraph 7 of the Second Amended Judgment and modified to state:

12 7. All pretrial detainees confined in the jails shall have ready
13 access to care to meet their serious medical and mental health needs. When
14 necessary, pretrial detainees confined in jail facilities which lack such
15 services shall be transferred to another jail or other location where such
16 services or health care facilities can be provided or shall otherwise be
17 provided with appropriate alternative on-site medical services.

18 (*Doc.* 1635 at 2–3.)

19 In addition to making detailed findings and entering the Second Amended
20 Judgment on October 22, 2008, the Court ordered the parties to confer immediately
21 regarding prompt compliance and to submit status reports. A status conference was held
22 on December 5, 2008. On January 9, 2009, a hearing was held regarding Defendants’
23 progress toward compliance with the nonmedical portions of the Second Amended
24 Judgment. On January 28, 2009, upon stipulation of the parties, the Court appointed a
25 medical expert and a mental health expert to serve as independent evaluators of
26 Defendants’ compliance with the medical and mental health provisions of the Second
27 Amended Judgment. In June 2009, the Court began receiving quarterly reports from the
28 experts. By April 2010, the Court concluded that “significant areas of failure to comply
with the Second Amended Judgment’s medical and mental health requirements remain”
and ordered the parties to jointly “develop a proposed procedure for achieving and
demonstrating Defendants’ complete compliance with the Second Amended Judgment.”

(*Doc.* 1880 at 3–4.) In the April 7, 2010 Order, the Court stated: “The Court’s purpose is

1 to set a procedure by which full compliance with the Second Amended Judgment is either
2 confirmed or specific implementing remedies are ordered and complied with by the end
3 of this calendar year.” (*Id.* at 4.)

4 On July 30, 2010, the parties filed a joint report stating each party’s position
5 regarding the status of Defendants’ compliance with the medical and mental health
6 portions of the Second Amended Judgment. The parties agreed to a procedure for
7 achieving compliance with the Second Amended Judgment regarding the medical and
8 mental health issues that remained disputed. The independent evaluators would
9 determine whether Defendants were in full compliance with the Second Amended
10 Judgment, and if Defendants were found not to be in full compliance with any provision,
11 the evaluators would submit detailed proposed remedies and timetables for remedial
12 action to bring Defendants into full compliance. If neither party objected to an
13 evaluator’s finding and remedial recommendation, the finding and remedy would be
14 adopted as an order of the Court. The Court would resolve any objections after hearing
15 evidence on the relevant issues. But this procedure never was implemented.

16 In January 2011, the parties reported Defendants’ disagreement with two of the
17 independent evaluators’ recommendations, but in June 2011 the parties jointly reported
18 that an evidentiary hearing regarding medical and mental health remedies was no longer
19 necessary. On June 7, 2011, Defendants filed a motion to terminate the nonmedical
20 provisions of the Second Amended Judgment. An evidentiary hearing on the motion was
21 set, and the parties conducted extensive discovery. However, on October 12, 2011, the
22 parties stipulated that certain nonmedical provisions should be terminated and others
23 should remain in effect without an evidentiary hearing. The stipulation stated that
24 Defendants would renew the motion to terminate the remaining nonmedical provisions
25 after April 1, 2012, and that Plaintiffs would not contest the renewed motion if
26 Defendants successfully accomplished certain goals for the period November 1, 2011,
27 through March 1, 2012.

28

1 On April 24, 2012, Defendants moved to terminate the remaining nonmedical
2 provisions of the Second Amended Judgment, and Plaintiffs did not oppose the motion.
3 On May 24, 2012, Defendants' motion was granted, and those provisions of the Second
4 Amended Judgment that remained in effect were restated in the Third Amended
5 Judgment. The remaining substantive provisions were:

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

12 3. All pretrial detainees confined in the jails shall have ready
13 access to care to meet their serious medical and mental health needs. When
14 necessary, pretrial detainees confined in jail facilities which lack such
15 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.

16 4. Defendants shall ensure that the pretrial detainees'
17 prescription medications are provided without interruption where medically
18 prescribed by correctional medical staff.

19 (Doc. 2094.) Thus, the Third Amended Judgment of 2012 essentially consisted only of
20 Paragraphs 56, 57, and 61 of the Amended Judgment of 1995.

21 In October 2012, the independent evaluators visited the jails, conducted
22 interviews, and reviewed medical records. In January 2013, the evaluators reported that
23 Defendants had made significant progress toward compliance with the Third Amended
24 Judgment, and the evaluators provided specific recommendations for achieving
25 substantial compliance. In June 2013, Defendants filed a status report describing their
26 efforts to address the evaluators' concerns and identified certain recommendations with
27 which they disagreed. In response, Plaintiffs identified recommendations for which
28 Defendants had not shown evidence of compliance and also challenged the accuracy of

1 some of Defendants' assertions about their compliance with the evaluators'
2 recommendations.

3 On August 9, 2013, Defendants moved to terminate the Third Amended Judgment.
4 The Court ordered that for evidence to be relevant to the motion, it must tend to show
5 whether any current and ongoing constitutional violation existed on August 9, 2013. In
6 addition to filing briefs and statements of facts with supporting exhibits, the parties
7 presented evidence and argument for six days in February and March 2014.

8 On September 30, 2014, the Court made detailed findings of fact and conclusions
9 of law regarding whether and to what extent prospective relief in the Third Amended
10 Judgment should be terminated. In many instances, Defendants demonstrated they had
11 recently adopted or revised policies and procedures designed to correct deficiencies
12 identified by the independent evaluators and/or Plaintiffs, but they were unable to
13 produce evidence that the revised policies and procedures had been fully and consistently
14 implemented or that the identified systemic deficiencies had been corrected. For
15 example, an expanded electronic integrated health screen for the receiving screening at
16 intake was implemented on August 5, 2013, only four days before Defendants filed their
17 motion to terminate. Defendants also developed a new electronic health records system,
18 but it was not fully implemented until September 2013, after the relevant evidentiary
19 period. The Court found:

20 238. An electronic health records system is not itself
21 constitutionally required, but managing the health records, housing
22 locations, [Health Needs Requests], prescriptions, appointment scheduling,
23 and necessary follow up for thousands of pretrial detainees to ensure ready
access to health care and continuity of medications likely would be
impossible without one.

24 (Doc. 2283 at 58.) Because Defendants did not prove compliance with any of the three
25 substantive paragraphs of the Third Amended Judgment, *i.e.*, sufficient screening at
26 intake, ready access to care for serious medical and mental health needs, and continuity
27 of prescription medications, the Court found that the prospective relief ordered in those
28

1 three paragraphs remained necessary to correct current and ongoing constitutional
2 violations.

3 Also on September 30, 2014, after six years of reviewing evidence, expert opinion,
4 and legal argument regarding conditions in the Maricopa County Jail, and after allowing
5 both parties opportunity to propose remedies to correct constitutional deficiencies, the
6 Court ordered remedies that did not exactly track constitutional standards but were
7 practical, concrete measures necessary to correct constitutional violations. Defendants
8 were ordered to, within 60 days, adopt new policies or amend existing policies regarding
9 31 specific requirements for providing medical and mental health care, implement the
10 policies within 150 days, collect and summarize compliance data for a period of 180 days
11 after implementation of the policies, and report documentation showing completion of
12 each stage. The Court stated, "If Defendants comply with this Order and its deadlines,
13 within one year they will demonstrate that prospective relief no longer remains necessary
14 to correct any current and ongoing violation of Plaintiffs' constitutional rights, and Court-
15 ordered relief may be terminated before the PLRA permits another motion to terminate."
16 (Doc. 2283 at 5960.)

17 Therefore, Paragraphs 2, 3, and 4 of the Fourth Amended Judgment continue the
18 prospective relief in the Third Amended Judgment, and Paragraph 5 of the Fourth
19 Amended Judgment defines specifically how Defendants will prove their compliance
20 with Paragraphs 2, 3, and 4. Paragraph 5(a) identifies the 31 specific requirements for
21 providing medical and mental health care that are expected to become institutionalized
22 through appropriate policies, staffing, training, and monitoring.

23 On October 14, 2014, Plaintiffs moved for reconsideration of five remedial
24 provisions of the Fourth Amended Judgment. On December 10, 2014, the Court granted
25 Plaintiffs' motion in part, amended one of the 31 subparagraphs of Paragraph 5(a) of the
26 Fourth Amended Judgment, and entered the Revised Fourth Amended Judgment.

1 In January 2015, the Court clarified that Plaintiffs' counsel were permitted to tour
2 the jail facilities, speak with pretrial detainees and staff, review records on-site, and
3 review copies of records off-site upon reasonable request. It further stated that the
4 Revised Fourth Amended Judgment "requires Defendants to meet a series of deadlines
5 and anticipates that Plaintiffs will promptly bring to the Court's attention any perceived
6 lack of compliance with each requirement." (Doc. 2309.) On September 14, 2015, the
7 Court further explained Plaintiffs' role:

8 [T]he time for monitoring Defendants' compliance actions required by the
9 Revised Fourth Amended Judgment began in December 2014 when
10 Defendants filed their newly adopted or revised policies. It continued
11 through the 180-day period when Defendants were required to demonstrate
12 their implementation of those policies. Plaintiffs' counsel has had
13 opportunity to conduct on-site tours and interviews as well as off-site
14 record reviews to confirm that Defendants are in fact doing what they say
15 they are doing. Data collection for 180 days enabled Defendants to monitor
16 implementation, make any needed corrections, and satisfy their burden of
17 proof. Defendants' September 15, 2015 report will be a summary of the
18 compliance data, which Plaintiffs may challenge. But Plaintiffs do not
19 need additional counsel to begin investigation of potential constitutional
20 violations after the report is filed. **To be clear, this litigation is now
21 strictly limited to whether Defendants have satisfied the requirements
22 of Paragraph 5 of the Revised Fourth Amended Judgment. Plaintiffs'
23 class counsel has no authority to investigate any potential
24 constitutional violations outside of Paragraph 5.**

25 (Doc. 2331, emphasis added.) Also on September 14, 2015, the Court clarified that
26 Defendants were to collect and summarize data showing the extent of their compliance
27 and to report to the Court only a summary of their evidence showing compliance related
28 to each of the 31 subparagraphs of Paragraph 5(a) of the Revised Fourth Amended
Judgment.

On September 15, 2015, Defendants filed a report of the data they had collected
and summarized pursuant to the Revised Fourth Amended Judgment. On September 16,
2015, the Court ordered Defendants to file a supplemental report regarding seven
subparagraphs of Paragraph 5(a), explaining why the reported compliance rates should be

1 considered sufficient to establish proof of compliance. On September 25, 2015,
2 Defendants filed a supplemental report. On October 15, 2015, the Court granted
3 Plaintiffs' request that they be permitted to file their response to Defendants' compliance
4 reports by January 15, 2016. The Court further ordered that Plaintiffs' response address
5 only whether Defendants had demonstrated compliance with Paragraph 5 of the Revised
6 Fourth Amended Judgment related to each of the 31 subparagraphs of Paragraph 5(a):

7 The Revised Fourth Amended Judgment required Defendants to
8 collect and summarize data for a period of 180 days that showed the extent
9 to which Defendants were complying with the Revised Fourth Amended
10 Judgment and to file a report of the data collected and summarized on
11 September 15, 2015. (Doc. 2299.) The Court clarified that Defendants'
12 report should address the 31 subparagraphs of Paragraph 5(a) of the
13 Revised Fourth Amended Judgment, explaining what and how data was
14 collected to determine compliance and what level of compliance was found.
15 (Doc. 2332.)

16

17 Plaintiffs' response to Defendants' compliance reports will be
18 limited to addressing whether Defendants have demonstrated compliance
19 with the 31 subparagraphs of Paragraph 5(a) of the Revised Fourth
20 Amended Judgment. The time has expired for Plaintiffs to object to the
21 policies and procedures adopted or amended to comply with the Revised
22 Fourth Amended Judgment and the actions taken to implement each of the
23 policies (*e.g.*, hiring staff, training, modifying facilities), which Defendants
24 reported December 16, 2014, and March 16, 2015, respectively. **Only two
25 issues remain to be decided: (1) whether Defendants' compliance
26 reports accurately portray the extent to which the relevant policies and
27 procedures have been implemented and (2) whether the reported levels
28 of compliance demonstrate that the remedies ordered by the Revised
Fourth Amended Judgment have been sufficiently implemented to
resolve the systemic deficiencies previously found by the Court.** (*See*
Findings of Fact and Conclusions of Law (Doc. 2283).)

(Doc. 2344, emphasis added.) Plaintiffs moved for reconsideration of that order,
requesting opportunity for Plaintiffs and their experts to review individual medical
records off-site and to conduct a site visit at the jail to review medical records.

1 The Court granted Plaintiffs’ motion for reconsideration to the extent that
2 Plaintiffs’ counsel and their medical experts were permitted to review individual medical
3 records on-site within certain limitations, Defendants were permitted to produce paper
4 copies of some of the requested records, and Plaintiffs’ time to respond to Defendants’
5 compliance reports was extended to February 26, 2016. The Court further ordered that
6 Plaintiffs’ records review would focus on the accuracy of Defendants’ compliance reports
7 and the significance of any lack of compliance. The Court explained:

8 To clarify, at this stage of the litigation, the question is not whether the
9 remedies ordered have in fact resolved the previously found systemic
10 deficiencies, but whether the remedies have been implemented consistently
11 enough. What is “enough” is context-specific. **The Court has already**
12 **determined that adequate compliance with the specific standards**
13 **previously stated will meet minimum constitutional standards.** The
14 Court will not go behind those determinations in the current proceedings,
15 and **Plaintiffs will not be granted discovery to attempt to argue and**
16 **prove some other measure of constitutional requirements.** This case
has always been about systemic failures amounting to constitutional
violations. Proof of some individual failures does not establish systemic
constitutional failures, and discovery regarding mere individual failures is
not warranted.

17

18 In its September 30, 2014 Findings of Fact and Conclusions of Law,
19 the Court explained that because Defendants had not shown they had
20 resolved certain systemic deficiencies after six years, it was necessary for
21 the Court to craft remedies to correct constitutional violations. (Doc. 2283
22 at 6.) After giving Plaintiffs and Defendants opportunity to propose and
23 debate specific remedies, the Court ordered “remedies that do not exactly
24 track constitutional standards but that are practical measures necessary to
25 correct constitutional violations.” (*Id.* at 59.) Each remedy was
intentionally written to provide a clear standard by which compliance could
be decided even though the Eighth and Fourteenth Amendments do not
demand a particular action. **Therefore, the Court will evaluate**
Defendants’ compliance with the 31 subparagraphs of Paragraph 5(a)
of the Revised Fourth Amended Judgment exactly as they are written.

26

27 However, Plaintiffs are not required to accept as true Defendants’
28 assertions about their compliance. They are entitled to examine how data

1 were collected, whether the reported data were relevant to the ordered
2 remedy, and whether the data show sufficient compliance.

3 (Doc. 2352, emphasis added.)

4 After several delays in providing Plaintiffs with copies of requested medical
5 records, Plaintiffs' time to respond to Defendants' compliance reports was extended to
6 April 1, 2016. In addition to filing a response, Plaintiffs also filed a motion requesting
7 the Court to order additional specific relief regarding Paragraph 3 of the Revised Fourth
8 Amended Judgment. Subsequently, Plaintiffs moved for an evidentiary hearing to
9 resolve factual disputes related to Paragraph 5 and their motion to enforce Paragraph 3.

10 **III. PLAINTIFFS' MOTION FOR EVIDENTIARY HEARING (DOC. 2380)**

11 Plaintiffs request that the Court set an evidentiary hearing "to resolve factual
12 disputes between the parties as to Defendants' compliance with the general orders and the
13 thirty-one implementing remedies of the [Revised] Fourth Amended Judgment, as well as
14 the existence of current and ongoing constitutional violations in the provision of medical
15 and mental health care at the Jail." (*Id.* at 12.) Plaintiffs also request that the Court
16 "order its own mental health expert, Kathryn Burns, M.D., to report to the Court on
17 Defendants' current compliance with the mental health remedies." (*Id.*)

18 As previously explained, Paragraph 5 of the Revised Fourth Amended Judgment
19 specifies what Defendants must prove to show compliance with the general orders of
20 Paragraphs 2, 3, and 4. After finding that Defendants had not proved that the prospective
21 relief ordered in Paragraphs 2, 3, and 4 of the Third Amended Complaint no longer
22 remained necessary to correct a current and ongoing violation of pretrial detainees'
23 constitutional rights, and after considering remedies proposed by the parties, the Court
24 identified 31 requirements that Defendants must satisfy to prove they had corrected the
25 remaining constitutional deficiencies. To increase the likelihood that Defendants would
26 continue compliance after court monitoring ends, in Paragraph 5 of the Revised Fourth
27 Amended Judgment the Court ordered Defendants to adopt or revise policies regarding
28 the 31 requirements, file the new or revised policies on the public record, and fully

1 implement each of the policies, including hiring additional staff, providing training, and
2 making facility modifications, as needed. The Court ordered Defendants to report actions
3 taken to implement each of the policies and then to collect data showing consistent
4 implementation of those policies for 180 days. Plaintiffs were expected to monitor each
5 step of this process, were provided the raw data as well as summary reports, and were
6 allowed to review records with their experts. But they were not allowed to investigate
7 potential constitutional violations outside of Paragraph 5 of the Revised Fourth Amended
8 Judgment because the time for doing so had passed.

9 Plaintiffs contend that *Rouser v. White*, 825 F.3d 1076 (9th Cir. 2016), requires the
10 Court to hold an evidentiary hearing before considering termination of the Revised
11 Fourth Amended Judgment. Relying on *Jeff D. v. Otter*, 643 F.3d 278 (9th Cir. 2011),
12 *Rouser* treated the consent decree as a contract and held that the district court should not
13 have vacated the consent decree without finding (1) the goals of the consent decree had
14 been adequately met and (2) defendants had substantially complied with each of the
15 decree's terms for a substantial period before terminating the decree. *Rouser*, 825 F.3d at
16 1081. In *Rouser*, the district court vacated the consent decree four months after finding
17 that defendants had not complied with certain provisions, despite receiving no evidence
18 of compliance and making no findings of compliance. The Ninth Circuit acknowledged
19 that heightened deference applies to a district court's decisions where it has been
20 overseeing complex institutional reform for a long period of time, but found special
21 deference was not warranted where the district court had managed the institutional reform
22 litigation for only two of the case's twenty years. *Id.* at 1080–81. Neither *Rouser* nor
23 *Otter* mandates a further evidentiary hearing in the present case.

24 The task before the Court is not to determine whether goals of a consent decree,
25 *i.e.*, a contract between the parties, have been satisfied. The Second Amended Judgment
26 and the Third Amended Judgment were not consent decrees. They ordered prospective
27 relief based on detailed evidentiary findings and only after the Court concluded the
28

1 specific relief extended no further than necessary to correct the violation of the federal
2 right, it was narrowly drawn, and it was the least intrusive means to correct the violation.
3 The Revised Fourth Amended Judgment also is not a consent decree. After multiple
4 rounds of evidentiary hearings and detailed findings of fact and conclusions of law, it
5 became plain that in order for Defendants to bear their burden of proof, the prospective
6 relief must include concrete, demonstrable requirements that would show the correction
7 of constitutional violations was systemic and consistent, *i.e.*, institutionalized. Thus,
8 specific constitutional deficiencies were identified, and specific remedies tailored to
9 address those deficiencies were ordered in the Revised Fourth Amended Judgment. Now
10 the Court must determine whether Defendants fully implemented the ordered remedies
11 during the 180-day period beginning March 2, 2015. As a result, Plaintiffs' request for
12 an evidentiary hearing and their request that the Court order Dr. Burns to report on
13 current compliance with mental health remedies are untimely.

14 The parties have been provided multiple opportunities to submit evidence
15 regarding Defendants' compliance with the Revised Fourth Amended Judgment.
16 Therefore, Plaintiffs' motion for a further evidentiary hearing will be denied.

17 **IV. PLAINTIFFS' MOTION TO ENFORCE THE REVISED FOURTH**
18 **AMENDED JUDGMENT (DOC. 2373)**

19 Plaintiffs' Motion to Enforce the Revised Fourth Amended Judgment essentially
20 asks the Court to reconsider its 2014 findings and conclusions regarding termination of
21 the Third Amended Judgment. Plaintiffs claim that Defendants are in violation of
22 Paragraph 3 of the Revised Fourth Amended Judgment, which states:

23 3. All pretrial detainees confined in the jails shall have ready
24 access to care to meet their serious medical and mental health needs. When
25 necessary, pretrial detainees confined in jail facilities which lack such
26 services shall be transferred to another jail or other location where such
27 services or health care facilities can be provided or shall otherwise be
28 provided with appropriate alternative on-site medical services.

1 (Doc. 2094.) Paragraph 3 requires that pretrial detainees be “transferred to another jail or
2 other location,” when necessary. It does not order Defendants to transfer detainees to a
3 facility outside of the Maricopa County Jail except to the extent necessary to provide
4 “ready access to care to meet their serious medical and mental health needs.”

5 Paragraph 5 of the Fourth Amended Judgment defines specifically how
6 Defendants will prove their compliance with Paragraph 3. It does not require Defendants
7 to ensure placement of seriously mentally ill detainees in any facility outside of the
8 Maricopa County Jail. It does not require hospitalization of seriously mentally ill
9 detainees. Nor does it require Maricopa County to designate a facility outside of the Jail
10 for its program to provide competency restoration treatment or seek court-ordered
11 treatment and/or civil commitment on an expedited basis. Rather, with respect to mental
12 health care, Paragraph 5 requires:

- 13 • If a pretrial detainee has a positive mental health screening or does not respond to
14 all of the mental health screening questions, the detainee will be assessed by
15 mental health staff while the pretrial detainee is in the intake center. The mental
16 health staff will identify the urgency with which the pretrial detainee must be seen
17 by a mental health provider, *i.e.*, a psychiatrist, psychiatric nurse practitioner, or
18 physician assistant.
- 19 • All mental health Health Needs Requests stating or indicating a clinical symptom
20 will be triaged face-to-face within 48 hours of their submission.
- 21 • Pretrial detainees with a mental health condition identified as urgent by detention,
22 intake, medical, or mental health staff will be seen face-to-face by a mental health
23 provider within 24 hours of the identification.
- 24 • Defendants will adopt and implement written criteria for placing pretrial detainees
25 in each level of mental health care, including subunits within the Mental Health
26 Unit.

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- 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.
- Pretrial detainees discharged from the Mental Health Unit will be assessed by mental health staff within 48 hours after discharge.
- 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.
- 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.

Plaintiffs contend that the Maricopa County Jail does not provide inpatient or hospital-level psychiatric care and Defendants fail to transfer detainees who need such services to outside psychiatric hospitals. Defendants assert that pretrial detainees receive more care and monitoring in the Mental Health Unit than they would in a psychiatric hospital. Neither Plaintiffs nor Defendants define the term “inpatient” care or provide objective standards for determining what constitutes “inpatient” or “hospital-level” psychiatric care. In 2014, the Court found that the Mental Health Unit was not a licensed inpatient psychiatric hospital, but it did not determine whether it provided inpatient psychiatric care or the equivalent of hospital-level psychiatric care.

Rather than seeking enforcement of the Revised Fourth Amended Judgment, Plaintiffs actually seek new injunctive relief to resolve longstanding problems outside the scope of this action. Plaintiffs ask the Court to order Defendants to ensure that patients are timely transferred to the Arizona State Hospital or, alternatively, order Defendants to “better utilize the county-operated Desert Vista psychiatric facility or form contracts with

1 other psychiatric facilities that can provide appropriate care.”¹ In addition, Plaintiffs seek
2 an order that Defendants identify and transfer patients in need of inpatient care to Desert
3 Vista or other facilities not only for court-ordered evaluations, but also for longer periods
4 of treatment.

5 Plaintiffs assert that a substantial proportion of those who need psychiatric
6 hospitalization are in Maricopa County’s Restoration to Competency (“RTC”) program.
7 Plaintiffs contend that Defendants should transfer all detainees deemed incompetent to
8 proceed in their criminal cases to outside psychiatric facilities for treatment to restore
9 them to competency. Plaintiffs also contend that many detainees who refuse treatment
10 have been denied access to adequate care because Defendants generally do not seek
11 court-ordered treatment for detainees in the RTC program. Plaintiffs contend that the
12 evidence that some detainees were civilly committed after restoration attempts failed and
13 criminal charges were dismissed demonstrates that those detainees needed court-ordered
14 treatment and/or psychiatric hospitalization before conclusion of the RTC program.
15 Plaintiffs’ arguments, couched as a motion to enforce the Revised Fourth Amended
16 Judgment, seek remedies that were not ordered in Paragraph 5 of the Revised Fourth
17 Amended Judgment.

18 **A. 2014 Findings, Conclusions, and Orders**

19 Plaintiffs contend that problems with Defendants’ provision of inpatient care are
20 longstanding and were documented as early as 2009. They rely substantially on the
21 Eleventh Report of Kathryn A. Burns (Doc. 22-15-1) based on her May 2013 site visit,
22 Dr. Burns’ prior reports, and Dr. Burns’ March 5, 2014 trial testimony (Doc. 2248)—all
23 of which was considered by the Court in 2014. In 2014, the parties briefed, produced
24 evidence, and argued how the Maricopa County Jail should provide adequate and timely
25 assessment, placement, and treatment of seriously mentally ill pretrial detainees.

26
27 ¹ The Desert Vista psychiatric facility is not operated by Defendants. It is
28 operated by the Maricopa Integrated Health System, which is a health care district
governed by the Maricopa County Special Health Care District Board.

1 On January 13, 2014, before hearing evidence regarding termination of the Third
2 Amended Judgment, the Court ordered Plaintiffs to file “a statement concisely identifying
3 specifically what actions, in Plaintiffs’ opinion, Defendants must take to correct any and
4 all current and ongoing systemic constitutional violations within the scope of the Third
5 Amended Judgment and deadlines by which Defendants reasonably can and should
6 complete all of the corrective actions.” (Doc. 2194.) Plaintiffs proposed the following:

7 Defendants shall ensure that prisoners² are timely transferred to a
8 psychiatric facility when they cannot be adequately treated at the Jail, and
9 that there is continuity of care for prisoners returning to the Jail after
10 psychiatric hospitalization.

11 *Within 90 days*, Defendants shall revise their policies and procedures to
12 ensure the following:

13 Defendants transfer to a psychiatric facility all prisoners who require an
14 inpatient level of care, and those who otherwise cannot be adequately
15 treated at the Jail, even if previous efforts have failed. They address all
16 efforts they have made and plan to make in monthly treatment team
17 meetings, and document their ongoing and planned efforts in these
18 prisoners’ treatment plans.

19 *Within 180 days*, Defendants shall develop a memorandum of
20 understanding with a psychiatric facility or facilities for the admission of
21 prisoners in need of psychiatric hospitalization who cannot be adequately
22 treated at the Jail. The memorandum establishes admission and discharge
23 criteria for prisoners in need of acute stabilization, and for prisoners in need
24 of chronic mental health care.

25 *Within 180 days*, Defendants shall have implemented the provisions
26 described above.

27 (Doc. 2210-1 at 16.) Plaintiffs’ proposed relief did not provide objective standards or
28 definitions for timeliness, adequacy of treatment available at the Jail, and inpatient level
of care. Moreover, it required Defendants to *ensure* placement of pretrial detainees in
outside psychiatric facilities without regard to the detainees’ constitutional and statutory

² Despite Plaintiffs’ use of the term “prisoner,” this case involves only pretrial
detainees. The Maricopa County Jail houses both pretrial detainees and sentenced
inmates, but the majority of the Jail population consists of pretrial detainees.

1 rights regarding refusing treatment, establishing incompetency as a defense to criminal
2 charges, and avoiding involuntary civil commitment.

3 On February 14, 2014, Plaintiffs filed the Eleventh Report of Kathryn A. Burns,
4 M.D., M.P.H., on Correctional Health Services Compliance with Third Amended
5 Judgment. (Doc. 2215.) Dr. Burns reported that she had visited the Jail on May 8–10,
6 2013, reviewed a sample of medical records, and reviewed with Dr. Dawn Noggle,
7 Maricopa County Correctional Health Services Mental Health Director, the status of all
8 of the recommendations Dr. Burns had made in February 2011. Dr. Burns summarized
9 the status of her 2011 recommendations. Among other things, she reported that the
10 absolute number of petitions for hospitalization had increased, but information regarding
11 the timeliness of the hospitalization process was not available. Dr. Burns noted, “Chart
12 reviews and site visits have consistently demonstrated delays in access to psychiatric
13 inpatient care, particularly for RTC inmates in the [Mental Health Unit].” (Doc. 2215-1
14 at 9.) Dr. Burns reported that Defendants were unable to use the Maricopa County
15 Integrated Health System (*i.e.*, Desert Vista) and:

16 Arrangements have been made to use Arizona State Hospital for inmates in
17 RTC that need acute care although this procedure has not yet been utilized.
18 [Correctional Health Services] reports expediting the [court-ordered
19 evaluation and court-ordered treatment] process and triaging for evaluators
20 those inmates that clinically appear not able to be restored. (This leads to
an earlier evaluation, subsequent finding of incompetence and access to the
hospital by way of civil commitment.)

21 (*Id.*)

22 On September 30, 2014, the Court found, among other things:

23 158. The most seriously mentally ill inmates and those determined
24 to be at risk of harming themselves or others are housed in the Mental
Health Unit at the Lower Buckeye jail.

25 159. All of the cells in the Mental Health Unit are single cells.

26 160. The Mental Health Unit is not a licensed inpatient psychiatric
27 hospital.
28

1 161. Pretrial detainees who need inpatient psychiatric care may be
2 placed in the Mental Health Unit while CHS³ staff attempts to get them
3 admitted to the state psychiatric hospital. Although Defendants cannot
4 control whether pretrial detainees who need inpatient psychiatric care will
5 be admitted to the state psychiatric hospital, Defendants are responsible for
6 identifying those detainees and making reasonable efforts to obtain their
7 admission to the state psychiatric hospital.

8 162. The Mental Health Unit includes subunits for different levels
9 of care, including acute, sub-acute, and stepdown treatment subunits. A
10 stepdown placement is interim housing where treatment can continue until
11 the inmate is sufficiently stable to move to general population housing.

12 163. Group programs are provided in the treatment subunits of the
13 Mental Health Unit.

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15 166. One subunit of the Mental Health Unit houses inmates
16 classified at a security level greater than general population regardless of
17 their level of acuity.

18 167. In May and June 2010, therapeutic cubicle spaces were built
19 in two subunits of the Mental Health Unit in which mental health providers
20 can conduct group therapy sessions with high security or mixed
21 classification pretrial detainees.

22 168. Evaluating a pretrial detainee's mental health condition,
23 developing or modifying the pretrial detainee's treatment plan, and
24 deciding when a pretrial detainee should be placed in or discharged from a
25 specific facility to obtain appropriate mental health care must be performed
26 by a mental health provider after the provider has assessed the pretrial
27 detainee face-to-face in space that at least provides sound privacy.

28 169. Many pretrial detainees with serious mental health needs do
not remain in the Jail long enough to receive a full psychiatric evaluation,
but every pretrial detainee with a mental health condition identified as
urgent by detention, intake, medical, or mental health staff can and must be
seen face-to-face by a mental health provider within 24 hours of
identification.

169. Although there are criteria for placement in each level of
mental health care, including subunits within the Mental Health Unit,
Defendants have not shown that the placement criteria are clearly
articulated in writing and consistently and timely applied.

³ CHS means Correctional Health Services.

1 171. Defendants have not shown that a mental health provider
2 determines the placement of each pretrial detainee needing mental health
3 care after the provider has performed a face-to-face assessment, especially
4 for admission into and discharge from the Mental Health Unit.

5 (Doc. 2283 at 48–50.) The Court concluded that the prospective relief ordered in
6 Paragraph 3 of the Third Amended Judgment remained necessary to correct a current and
7 ongoing violation of the federal right and ordered remedies that were “practical measures
8 necessary to correct constitutional violations.” (Doc. 2283 at 59.)

9 Although the Court found that the Mental Health Unit is not a licensed inpatient
10 psychiatric hospital, the Court stated that pretrial detainees who need inpatient psychiatric
11 care may be placed in the Mental Health Unit while staff attempts to get them admitted to
12 the state psychiatric hospital. The Court acknowledged that Defendants cannot control
13 whether pretrial detainees who need inpatient psychiatric care will be admitted to the
14 state psychiatric hospital, but expected Defendants to make reasonable efforts to place
15 detainees needing inpatient psychiatric care in the state psychiatric hospital.

16 The Revised Fourth Amended Judgment required Defendants to adopt policies and
17 procedures or amend existing policies and procedures to more clearly articulate
18 placement criteria and assess detainees before and after placement:

19 (17) Defendants will adopt and implement written criteria for
20 placing pretrial detainees in each level of mental health care, including
21 subunits within the Mental Health Unit.

22 (18) A mental health provider will determine the placement of
23 each seriously mentally ill pretrial detainee after performing a face-to-face
24 assessment, including upon admission into, transfer within, and discharge
25 from the Mental Health Unit.

26 (19) Pretrial detainees discharged from the Mental Health Unit
27 will be assessed by mental health staff within 48 hours after discharge.

28 (Doc. 2299 at 5, ¶ 5(a).) The Revised Fourth Amended Judgment further required
Defendants to file a copy of each policy adopted or revised to comply with Paragraph
5(a), fully implement each of the policies, file a summary of actions taken to implement
each of the policies, collect and summarize data for a period of 180 days that shows the

1 extent of Defendants’ compliance, and file a report of the compliance data collected and
2 summarized. (*Id.* at 6-7, ¶ 5(b)–(f).)

3 The Revised Fourth Amended Judgment does not require Defendants to *ensure*
4 placement of certain detainees in the state psychiatric hospital or in an outside facility for
5 long-term psychiatric care. Defendants are responsible for identifying pretrial detainees
6 who need psychiatric services that cannot be provided within the Maricopa County Jail
7 and making reasonable efforts to transfer them to outside facilities, but they cannot
8 ensure the outcome of their efforts. Moreover, Defendants cannot override pretrial
9 detainees’ constitutional and statutory rights to refuse involuntary treatment and/or civil
10 commitment and to have criminal charges dismissed for lack of competence to stand trial.

11 Because court-ordered treatment and involuntary commitment may result in a
12 serious deprivation of liberty, statutory requirements must be strictly complied with.
13 *Matter of Commitment of Alleged Mentally Disordered Pers.*, 181 Ariz. 290, 293, 889
14 P.2d 1088, 1091 (1995). In Arizona, mental health proceedings are adversarial, and the
15 proposed patient is provided counsel and an evidentiary hearing. A.R.S. §§ 36-536(A),
16 36-539. Arizona law establishes procedures for obtaining a court-ordered evaluation of a
17 person “alleged to be, as a result of a mental disorder, a danger to self or to others or a
18 person with a persistent or acute disability or a grave disability and who is unwilling or
19 unable to undergo a voluntary evaluation.” A.R.S. § 36-520 *et seq.* An application for
20 court-ordered evaluation must be submitted to the screening agency, which will conduct a
21 prepetition screening. If the screening agency determines there is reasonable cause to
22 believe that “the proposed patient is, as a result of mental disorder, a danger to self or to
23 others or has a persistent or acute disability or a grave disability and that the proposed
24 patient is unable or unwilling to voluntarily receive evaluation or is likely to present a
25 danger to self or to others, has a grave disability or will further deteriorate before
26 receiving a voluntary evaluation,” the agency will file a petition for court-ordered
27 evaluation. A.R.S. § 36-521(D). An application for emergency admission for evaluation
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1 may be made if the applicant “believes on the basis of personal observation that the
2 person is, as a result of a mental disorder, a danger to self or others, and that during the
3 time necessary to complete the prepetition screening procedures set forth in §§ 36-520
4 and 36-521 the person is likely without immediate hospitalization to suffer serious
5 physical harm or serious illness or is likely to inflict serious physical harm upon another
6 person.” A.R.S. § 36-524.

7 A pretrial detainee may be transferred from the Maricopa County Jail to an outside
8 facility for mental health treatment only upon a court-ordered conditional release. A
9 petition for involuntary mental health court-ordered treatment must be accompanied by:

10 the affidavits of the two physicians who participated in the evaluation and
11 by the affidavit of the applicant for the evaluation, if any. The affidavits of
12 the physicians shall describe in detail the behavior that indicates that the
13 person, as a result of mental disorder, is a danger to self or to others, has a
14 persistent or acute disability or a grave disability and shall be based on the
15 physician’s observations of the patient and the physician’s study of
16 information about the patient. A summary of the facts that support the
allegations of the petition shall be included. The affidavit shall also include
any of the results of the physical examination of the patient if relevant to
the patient’s psychiatric condition.

17 A.R.S. § 36-533(B). The Arizona state hospital or the department of health services is
18 not required to provide civil commitment treatment that exceeds the maximum funded
19 capacity. A.R.S. §§ 36-503.03, 36-206(D). If the Arizona state hospital reaches its
20 funded capacity in civil commitment treatment programs, it must establish a waiting list
21 for admission based on the date of the court order.

22 The Revised Fourth Amended Judgment also does not require the Maricopa
23 County Board of Supervisors to change its designation of the Maricopa County Jail as its
24 program to provide competency restoration treatment. Under Arizona law, “[a] person
25 shall not be tried, convicted, sentenced or punished for an offense if the court determines
26 that the person is incompetent to stand trial.” A.R.S. § 13-4502(A). If a court determines
27 that reasonable grounds exist for a competency examination, the court shall appoint two
28 or more mental health experts to examine the defendant, issue a report, and, if necessary,

1 testify regarding the defendant's competency. A.R.S. § 13-4505(A). Within thirty days
2 after the report is submitted, the court shall hold an evidentiary hearing to determine the
3 defendant's competency to stand trial. A.R.S. § 13-4510(A). "If the court initially finds
4 that the defendant is incompetent to stand trial, the court shall order treatment for the
5 restoration of competency unless there is clear and convincing evidence that the
6 defendant will not be restored to competency within fifteen months. The court may
7 extend the restoration treatment by six months if the court determines that the defendant
8 is making progress toward the goal of restoration." A.R.S. § 13-4510(C).

9 A court may order a defendant to undergo out of custody competency restoration
10 treatment, but if it determines that confinement is necessary for treatment, the court must
11 commit the defendant to the competency restoration treatment program designated by the
12 county board of supervisors. A.R.S. § 13-4512(A). A county competency restoration
13 treatment program may provide treatment to a defendant in the county jail, including
14 inpatient treatment, or it may obtain court orders to transport the defendant to other
15 providers, including the Arizona state hospital, for inpatient, in custody competency
16 restoration treatment. A.R.S. § 13-4512(C). The court shall select the least restrictive
17 treatment alternative after considering whether confinement is necessary for treatment,
18 the likelihood that the defendant is a threat to public safety, the defendant's participation
19 and cooperation during an outpatient examination, and the defendant's willingness to
20 submit to outpatient competency restoration treatment as a condition of pretrial release, if
21 the defendant is eligible for pretrial release. A.R.S. § 13-4512(D). The court's order for
22 competency restoration treatment must state whether the defendant is incompetent to
23 refuse treatment, including medication, and is subject to involuntary treatment. A.R.S.
24 § 13-4512(E).

25 The Maricopa County Board of Supervisors designated the Maricopa County Jail
26 as its program to provide competency restoration treatment based on multiple factors,
27 including that using the Arizona state hospital to provide such treatment resulted in
28

1 delays in the criminal justice process and longer incarceration for pretrial detainees. All
2 but one of the other counties in Arizona have their RTC programs within their jails. The
3 Revised Fourth Amended Judgment does not affect the Maricopa County Board of
4 Supervisors' designation of the Maricopa County Jail as its RTC program.

5 Providing constitutionally adequate mental health care for pretrial detainees
6 confined in the Maricopa County Jail presents important, complex, and challenging
7 issues. Plaintiffs' motion brings attention to public policy concerns regarding who
8 should provide and how to provide appropriate mental health care for the chronically and
9 seriously mentally ill, avoid repetitive incarceration, and balance individual freedom with
10 safety concerns. But this class action on behalf of pretrial detainees confined in the
11 Maricopa County Jail addresses only confinement conditions within Defendants' control.

12 As the Court previously stated:

13 The Maricopa County Jail must make reasonable efforts to prevent a
14 pretrial detainee's confinement from causing the detainee serious medical
15 or mental health injury. It also must make reasonable efforts to avoid
16 depriving the detainee from obtaining or continuing necessary medical or
17 mental health care the detainee would have obtained or continued outside of
18 the Jail. But the Jail is not the County's public health care provider.
19 Several hundred pretrial detainees enter the Jail daily, approximately half
20 need some form of health care, and nearly 40% are released within 24
21 hours. Only 35% stay longer than 7 days; only 25% stay longer than 14
22 days. With a high-volume, short-stay inmate population, the Jail cannot
23 cure serious systemic inadequacies in public medical and mental health care
24 in Maricopa County and the State of Arizona.

25 (Doc. 2283 at 4.) To the extent that Plaintiffs advocate on behalf of the seriously
26 mentally ill residents of Maricopa County generally and seek to increase the availability
27 of inpatient psychiatric care and to accelerate procedures resulting in civil commitment,
28 they must do it in a different lawsuit.

B. 2015 Evidence

29 Defendants contend that differentiated subunits with the Mental Health Unit
30 currently provide adequate treatment for most seriously mentally ill pretrial detainees.

1 They assert that the Maricopa County Jail’s Mental Health Unit provides inpatient care,
2 and the Mental Health Unit currently has seven full-time psychiatric providers and
3 coverage 365 days per year by at least two psychiatric providers, which is more coverage
4 than is provided by the Arizona State Hospital. Defendants assert that all new admission
5 patients are seen within 24 hours, acute patients are seen daily, nursing staff make daily
6 rounds, and group and individual services are provided according to patient need and
7 acuity. Defendants assert that patients remain in the acute units only for the time they are
8 acutely agitated or at risk. Defendants have requested that some pretrial detainees be
9 transferred to psychiatric facilities outside of the Jail, but the transfers usually are not
10 accepted until after detainees have been found incompetent and unrestorable and they
11 have been civilly committed.

12 Plaintiffs contend that the Mental Health Unit does not provide inpatient care
13 because in 2014 the Court found that the Mental Health Unit was not “a licensed
14 inpatient psychiatric hospital.” However, the question here is not whether the Mental
15 Health Unit is licensed or can be labeled “inpatient” or “hospital-level”—it is whether
16 Defendants are providing constitutionally adequate treatment for seriously mentally ill
17 pretrial detainees.

18 Plaintiffs rely on the Declaration of Pablo Stewart (Doc. 2372-3), dated April 1,
19 2016, to support their contention that Defendants are not currently providing psychiatric
20 hospitalization for pretrial detainees who need such care. Dr. Stewart stated that it is his
21 opinion now, as it was in 2013, “that the Jail does not have a reliable system in place to
22 ensure the timely transfer of seriously ill prisoners to an inpatient psychiatric facility.”
23 (Doc. 2372-3 at 127, ¶ 348.) He further opined that “The problems are particularly acute
24 with regard to RTC patients in need of hospitalization.” (*Id.*) Dr. Stewart found that
25 from March through August 2015, there were 235 inmates in the Jail’s RTC program, and
26 they were “the most seriously mentally ill prisoners in the Jail’s population.” (*Id.* at 125,
27 ¶ 343.) He observed that many of the inmates in the RTC program refuse treatment and
28

1 will not be approved for involuntary treatment, and he opined that the delays in treatment
2 harm recovery. From his review of the records of 47 selected patients, Dr. Stewart
3 concluded that 34 of those patients were “in need of a higher level of care” and “were not
4 receiving adequate treatment at the Jail.” (*Id.* at 128, ¶ 349.) He further stated, “While
5 many of these men and women are eventually hospitalized, that only happens after they
6 are deemed incompetent, their criminal charges are dismissed and they are civilly
7 committed.” (*Id.*)

8 Dr. Stewart opined:

9 In my own recent record reviews, I found numerous prisoners in need of
10 acute stabilization who were not petitioned for a COT Order, or whose
11 COT petitions were unnecessarily delayed. I also found prisoners whose
12 COT Orders were not timely renewed or were not fully utilized to address
13 their non-compliance with treatment. Nor was there a reliable process in
14 place to transfer to an inpatient facility those prisoners in need of that care
15 who could otherwise not be adequately treated at the Jail. Many of these
16 prisoners spend months locked alone in their cells for up to 24 hours daily,
17 with no significant treatment offered to them other than medications. They
18 include prisoners who refuse treatment and are actively psychotic. Their
19 living conditions, coupled with the lack of appropriate care, results in their
20 unnecessarily suffering. It is also my opinion that prisoners returning from
21 the hospital are at risk of deteriorating once back at the Jail. I attribute this
22 risk of deterioration to the conditions at the Jail coupled with the inadequate
23 treatment they are likely to receive.

24 (*Id.* at 125, ¶ 343.)⁴

25 Because delay in treatment risks serious harm, Dr. Stewart opined that Defendants
26 should seek court orders for involuntary treatment more quickly—that is, before a patient
27 is found incompetent and unrestorable, before criminal charges are dismissed. But Dr.
28 Stewart did not explain what “higher level of care” a psychiatric hospital would provide
if a court will not order involuntary treatment for an RTC pretrial detainee and the
detainee continues to refuse treatment. Dr. Stewart opined that pretrial detainees were

⁴ “COT” refers to “court-ordered treatment.”

1 subjected to additional and needless suffering during completion of the RTC process, but
2 he did not explain how their suffering would be reduced by psychiatric hospitalization.

3 Dr. Stewart's general conclusions are based on his observations and opinions
4 regarding 47 patients whose medical records he reviewed⁵ and, in some cases, met with
5 in person. Of those, Dr. Stewart identified 34 patients who, in his opinion, had not
6 received adequate treatment at the Jail. Most of the 34 patients were in the RTC
7 program. Dr. Stewart opined that some of the patients should have been involuntarily
8 medicated, either with a court order or on an emergency basis, and that many of them
9 should have been hospitalized before court determination of incompetence and
10 restorability. Many did receive court-ordered treatment and/or were hospitalized, but not
11 as quickly as Dr. Stewart deemed appropriate. In a few cases, Defendants sought transfer
12 to Desert Vista, but Desert Vista would accept patients only after civil commitment, not
13 on conditional release. Dr. Stewart also opined that placement of mentally ill detainees in
14 single cells exacerbated their psychiatric impairment. In some instances, Dr. Stewart
15 disagreed with the type or dosage of medication prescribed, the placement within the Jail,
16 and transitions between placements. Generally, his criticism of the treatment provided
17 was that it had not been effective for these seriously mentally ill patients.

18 Treatment solutions for these patients are not simple. Even after being civilly
19 committed to a psychiatric hospital, many patients are released, booked again, and
20 returned to the Jail. For example, patient CB was identified by the community provider
21 as Seriously Mentally Ill but was not currently being treated. He was homeless, engaged
22 in chronic substance abuse, and had multiple prior bookings. He was psychotic,
23 uncooperative, and at times agitated and verbally abusive. He refused medication. Dr.
24 Stewart opined that Jail staff should have petitioned for court-ordered treatment
25 immediately when he was booked in August 2014. Instead, he was placed in a single cell
26 where he did not present a danger to others and was monitored for danger to self until he

27 ⁵ The 47 patients Plaintiffs selected for Dr. Stewart to review were not randomly
28 selected.

1 was found incompetent and unrestorable and was civilly committed on May 28, 2015.
2 On June 4, 2015, patient CB was released to Desert Vista hospital. On June 29, 2015, he
3 was booked again and placed in segregation. Despite continuing on medications from
4 Desert Vista, he showed signs of deterioration.

5 Similarly, patient DY was booked January 29, 2015, and on July 21, 2015, found
6 to be incompetent and unrestorable and was civilly committed. On August 11, 2015,
7 after treatment at Desert Vista, patient DY was booked again. Although there was a court
8 order for involuntary treatment, it did not authorize involuntary medication at the Jail
9 because the Jail is not a licensed inpatient psychiatric facility. Dr. Stewart opined that
10 Defendants should have attempted to get a court order for outpatient treatment. He
11 further opined that patient DY should not have been placed in segregation, despite
12 previous incidents in which he assaulted a cellmate, because it likely exacerbated his
13 mental illness. Dr. Noggle stated that patient DY did not display any contraindications to
14 segregation and he was monitored for any negative effects of segregation.

15 Patient DC was placed in the Mental Health Unit when he was screened at intake
16 on March 27, 2015. He was transitioned from the acute subunit to step-down units.
17 Patient DC's charges were dropped, and he was released on April 1, 2015. Jail staff
18 arranged for a community clinic navigator to pick up patient DC at the jail upon release.
19 Patient DC was booked again on May 9, 2015, screened, and placed at the Mental Health
20 Unit. Again, he was transitioned from the acute subunit to step-down units. Patient DC
21 was placed in the RTC program on July 8, 2015. On September 8, 2015, he was deemed
22 incompetent and unrestorable, and he was civilly committed. He remained in the Mental
23 Health Unit until he was released to Desert Vista hospital on September 21, 2015. Dr.
24 Stewart disagreed with the dosage of medication prescribed for patient DC and opined
25 that he was prescribed a variety of medications that produced little to no positive clinical
26 effects. Dr. Noggle stated that notes in Patient DC's medical record documented
27 sporadic unstable behavior, hypomanic symptoms, but no psychiatric distress.

28

1 Patient VW was placed in the Mental Health Unit when he was screened at intake
2 and was housed in step-down subunits from February 25, 2015, to May 29, 2015, during
3 which he was seen by a psychiatric provider nine times. Although patient VW refused
4 psychiatric medication, he exhibited stable behavior and was an active participant in
5 socialization groups and one-on-one sessions. He was transferred to general population
6 and followed by mental health staff. On May 7, 2015, he began the RTC program. On
7 June 18, 2015, patient VW was transferred back to the Mental Health Unit because he
8 threatened to harm his cellmate and custody staff and he was responding to internal
9 stimuli. Subsequently, he consented to psychiatric medication. Patient VW was found
10 incompetent on July 10, 2015, and accepted into Desert Vista hospital.

11 Patient PW was booked on January 29, 2015, and assessed as stable for general
12 population. He initially declined psychiatric services, but later agreed to a trial of
13 psychiatric medication. He subsequently refused the medication because of its side
14 effects. He began the RTC program on May 11, 2015, was found incompetent on June
15 25, 2015, and was released to Desert Vista on July 13, 2015. Dr. Stewart cites this case
16 as another example of an overtly psychotic patient who, in Dr. Stewart's opinion, should
17 have been hospitalized much sooner.

18 Patient AD was initially placed on suicide watch and then was transferred to a
19 segregation unit at the Estrella jail. After a suicide attempt, she was transferred to the
20 Mental Health Unit and then transferred back to the segregation unit. Eight months after
21 booking, Dr. Stewart met with patient AD and described her as very psychotic, hearing
22 voices, calm, and sitting quietly in the recreation yard. Dr. Stewart opined that patient
23 AD was not receiving adequate care because she required close monitoring to avoid self-
24 harm and that placement in segregation exacerbated her mental illness. Dr. Noggle stated
25 that medical records documented patient AD was monitored by mental health staff and
26 her psychiatric provider, and there were no incidents of self-harm noted around the time
27 that Dr. Stewart met with patient AD.

28

1 Patient RG was booked on October 7, 2012, and consistently refused medications
2 since then. On December 9, 2014, he was placed in the Special Management Unit
3 because of his custody classification.⁶ In February 2015 he made nonsensical statements,
4 yelled profanities, and appeared psychotic. In April 2015 he again yelled profanities and
5 kicked the door. Dr. Stewart concluded patient RG was extremely psychotic and
6 agitated, living in unsanitary conditions in his cell, not eating adequately, and at serious
7 risk of harming others. Dr. Stewart opined that keeping patient RG in the Special
8 Management Unit exacerbated his illness and patient RG should be immediately
9 transferred to an inpatient psychiatric facility for acute medication stabilization. Dr.
10 Noggle said that patient RG was assessed for acute needs frequently and offered
11 medication, but he continuously refused medication. Because he was housed in a single
12 cell, he was unable to hurt others. Although patient RG's cell was messy, he was not an
13 acute danger to himself or others in that environment, and he was eating, drinking, and
14 sleeping.

15 These examples and the other patient records reviewed by Dr. Stewart demonstrate
16 that there are seriously mentally ill persons in Maricopa County who are not engaged in
17 treatment, or are not being successfully treated, by community mental health providers.
18 Some are charged with crimes, confined in the Maricopa County Jail, and quickly
19 identified as seriously mentally ill. Their constitutional and statutory rights to refuse
20 treatment, be provided counsel and hearing before civil commitment, and have criminal
21 charges dismissed for lack of competence cannot be disregarded. Dr. Stewart prefers that
22 the restoration to competency process be completed at a psychiatric facility outside the
23 Jail, but he did not explain how the time without treatment can be reduced without
24 compromising detainees' rights to establish lack of competence to stand trial. Further,
25 Dr. Stewart did not opine regarding the likelihood that treatment for the chronically

26 ⁶ Inmates classified as closed-custody are those who pose a serious threat to life,
27 property, staff, other inmates, or to the orderly operation of the jail and may be locked in
28 their cells for up to 23 hours daily.

1 seriously mental ill would be effective even if treatment begins at intake, especially if
2 they have not engaged in or been compliant with treatment offered by community
3 providers. Finally, the Jail mental health staff cannot force outside psychiatric facilities
4 to accept pretrial detainees for whom criminal charges have not been dismissed, and state
5 and county mental health care statutes and policies are not within the scope of this
6 lawsuit.

7 In summary, the Court previously considered the issues, evidence, and expert
8 opinions Plaintiffs present in their Motion to Enforce the Revised Fourth Amended
9 Judgment. Upon reconsideration, the 2014 evidence, supplemented by 2015 evidence,
10 does not show that prospective relief in addition to that ordered in Paragraph 5 of the
11 Revised Fourth Amended Judgment is constitutionally required. Defendants must
12 provide differentiated levels of mental health care ranging from outpatient to acute units
13 and must assess, place, monitor, and transition pretrial detainees appropriately. When
14 clinically necessary, Defendants must make reasonable efforts to obtain court-ordered
15 evaluations, treatment, and transfer to outside facilities. Defendants cannot ensure the
16 results of their efforts.

17 Therefore, Plaintiffs' Motion to Enforce the Revised Fourth Amended Judgment
18 and for Additional Relief (Doc. 2373) will be denied.

19 **V. COMPLIANCE WITH THE REVISED FOURTH AMENDED JUDGMENT**

20 Paragraph 5(a) of the Revised Fourth Amended Judgment required Defendants to
21 adopt policies and procedures or amend existing policies and procedures to establish
22 requirements stated in 31 subparagraphs. Paragraph 5(b) required Defendants to file with
23 the Court a copy of each policy adopted or amended to comply with Paragraph 5(a) and
24 identify the specific policy provisions that demonstrated compliance. Paragraph 5(c)
25 required Defendants to fully implement each of the policies, including hiring additional
26 staff, providing training, and making facility modifications, as needed. Paragraph 5(d)
27 required Defendants to file with the Court a summary of actions taken to implement each
28

1 of the policies. Paragraph 5(e) required Defendants to collect and summarize data for a
2 period of 180 days beginning March 2, 2015. Paragraph 5(f) required Defendants to file
3 with the Court a report of the data collected and summarized. Defendants timely
4 completed the requirements of Paragraphs 5(a), (b), (c), (d), (e), and (f). However,
5 satisfaction of reporting requirements does not establish that Defendants have
6 demonstrated compliance with the Revised Fourth Amended Judgment.

7 As previously stated:

8 Only two issues remain to be decided: (1) whether Defendants' compliance
9 reports accurately portray the extent to which the relevant policies and
10 procedures have been implemented and (2) whether the reported levels of
11 compliance demonstrate that the remedies ordered by the Revised Fourth
Amended Judgment have been sufficiently implemented to resolve the
systemic deficiencies previously found by the Court.

12 (Doc. 2344.) Whether a certain level of compliance demonstrates that a remedy has been
13 "sufficiently implemented" is context-specific. (Doc. 2352.)

14 The day after Defendants filed their initial summary compliance report, the Court
15 ordered Defendants to file a supplemental report explaining why the reported compliance
16 rates for each of subparagraphs 5(a)(6), (8), (15), (18), (20), (29), and (31) were sufficient
17 to establish proof of compliance, including any factors to be considered in interpreting
18 them. In addition to filing the summary reports, Defendants provided Plaintiffs the raw
19 data collected and permitted Plaintiffs' counsel and experts to conduct site visits and
20 record reviews.

21 Plaintiffs' response to Defendants' compliance reports includes expert opinions
22 regarding medical care, mental health care, and jail policies and procedures. Plaintiffs'
23 medical experts, Robert L. Cohen, M.D., and Madeleine LaMarre, MN, FNP-BC,
24 reviewed 49 health records, selected from patients who were known to have serious
25 medical needs based on predetermined criteria. On multiple occasions, Plaintiffs' mental
26 health expert, Pablo Stewart, M.D., toured Maricopa County Jail facilities, reviewed
27 reports, selected medical records, and other materials. Plaintiffs submitted the expert
28

1 opinion of Eldon Vail, a former correctional administrator, regarding use of force
2 practices and policies, disciplinary policies and practices, and segregation placement of
3 mentally ill inmates. Defendants responded to Plaintiffs' expert opinions with
4 declarations by Dawn Noggle, Ph.D., the Maricopa County Correctional Health Services
5 Mental Health Director, and Jeffrey Alvarez, M.D., the Medical Director of Maricopa
6 County Correctional Health Services.

7 **A. Subparagraph 5(a)(1): A registered nurse will perform the receiving**
8 **screening for each pretrial detainee processed in the 4th Avenue jail**
9 **intake center.**

10 Defendants reported compliance rates of 99.98% for March 2015 and 100% for
11 April through August 2015. Plaintiffs' medical experts found that a registered nurse
12 performed the receiving screening for each pretrial detainee in 48 of 49 records reviewed,
13 which is 98%.

14 The Court finds that Defendants have sufficiently implemented the remedy
15 described in subparagraph 5(a)(1).

16 **B. Subparagraph 5(a)(2): If the receiving screening indicates a pretrial**
17 **detainee is suffering from a serious acute or chronic health condition, a**
18 **physician, physician assistant, or nurse practitioner will conduct a**
19 **face-to-face examination of the pretrial detainee within 24 hours after**
20 **the receiving screening.**

21 Subparagraph 5(a)(2) relies on an extensive receiving screening process coupled
22 with the clinical judgment of a registered nurse to identify those who require prompt in-
23 person assessment by a medical provider⁷ to avoid exacerbation of serious conditions and
24 needless suffering. Defendants reported the following monthly compliance rates for
25 March through August 2015: 89%, 84%, 83%, 88%, 92%, and 87%.

26 Plaintiffs' experts reviewed the records of 48 patients who had been identified as
27 having a serious acute or chronic health condition by the time of the records review and
28

⁷ As used in the Revised Fourth Amended Judgment, the term "medical provider"
refers only to physicians, physician assistants, and nurse practitioners. (Doc. 2283 at 27,
¶ 18.)

1 opined that only 29 of the 48 patients had been seen by a medical provider within 24
2 hours of the receiving screening. Most, if not all, of the remaining 19 were not included
3 in Defendants' compliance data. However, at intake, some of the 19 patients who
4 Plaintiffs contend should have been seen by a provider within 24 hours did not report
5 relevant medical history or symptoms and did not display relevant symptoms. Those
6 patients were not identified at intake as suffering from a serious acute or chronic health
7 condition and therefore were not included in Defendants' compliance data. Some of the
8 19 patients were sentenced inmates, not pretrial detainees, and therefore properly not
9 included in Defendants' compliance data. Some of the 19 patients were seen at a hospital
10 for assessment and clearance immediately before intake and therefore were not seen
11 again by a provider at the Jail within 24 hours of intake.

12 Some of Plaintiffs' references to specific patients are factually inconsistent with
13 Defendants' records. Individual discrepancies do not need to be resolved to determine
14 whether Defendants are consistently implementing their policy to provide face-to-face
15 examinations of certain pretrial detainees identified during the receiving screening within
16 24 hours after the receiving screening.

17 The Court finds that Defendants have sufficiently implemented the remedy
18 described in subparagraph 5(a)(2).

19 **C. Subparagraph 5(a)(3): If the receiving screening indicates a pretrial**
20 **detainee has symptoms of tuberculosis, the pretrial detainee**
21 **immediately will be placed in an Airborne Infection Isolation Room**
22 **and evaluated promptly for tuberculosis.**

23 Defendants reported monthly compliance rates of 100% for March through August
24 2015. Among the 49 records Plaintiffs' medical experts reviewed, no patient reported
25 symptoms of tuberculosis. Therefore, they were unable to evaluate the accuracy of
26 Defendants' reported compliance rates.

27 The Court finds that Defendants have sufficiently implemented the remedy
28 described in subparagraph 5(a)(3).

1 **D. Subparagraph 5(a)(4): If the receiving screening indicates a pretrial**
2 **detainee is known to have HIV infection or is at risk for HIV infection**
3 **with unknown status, a chest x-ray of the pretrial detainee will be**
4 **performed and the results reviewed by a physician, physician assistant,**
5 **or nurse practitioner before the pretrial detainee is placed in a housing**
6 **unit.**

7 Subparagraph 5(a)(4) is intended to identify any pretrial detainees who have
8 tuberculosis among those with HIV or at risk for HIV infection. Plaintiffs' experts
9 dispute Defendants' criteria for "at risk for HIV infection," contending that all pretrial
10 detainees with a history of injectable drug use and unknown HIV status must receive a
11 chest x-ray. Dr. Alvarez opined that is unreasonable to segregate patients and expose
12 them to a chest x-ray based solely on a history of injectable drug use if they show no
13 symptoms of HIV or tuberculosis. The Revised Fourth Amended Judgment does not
14 require Defendants to define "at risk for HIV infection" to include all pretrial detainees
15 with a history of injectable drug use and unknown HIV status.

16 Defendants reported the following monthly compliance rates for March through
17 August 2015: 85%, 100%, 97%, 100%, 100%, and 100%. Plaintiffs' experts found that
18 11 of 15 patients whose records they reviewed did not receive a chest x-ray before
19 housing placement. The 11 cases primarily involved patients with a history of injectable
20 drug use and unknown HIV status and were not included in Defendants' compliance data.
21 Defendants provided an explanation for each of the nine cases that Defendants described.
22 Three of the nine patients were cleared by a hospital before they were admitted to the
23 Jail. One was housed alone and sent to the hospital two days after booking. One was
24 housed alone and received a chest x-ray three days after booking. One was admitted to
25 and housed in the infirmary; subsequently he received a chest x-ray. One had received a
26 chest x-ray less than six months before during a prior admission to the Jail and reported
27 no health information or symptoms at intake that would have warranted another chest x-
28 ray. One did not report a positive HIV status at intake; his status was determined two
 months later as the result of hospitalization. One was seen by a provider at intake and
 had no symptoms of HIV or tuberculosis.

1 The Court finds that Defendants have sufficiently implemented the remedy
2 described in subparagraph 5(a)(4).

3 **E. Subparagraph 5(a)(5): If a pretrial detainee has a positive mental**
4 **health screening or does not respond to all of the mental health**
5 **screening questions, the detainee will be assessed by mental health staff**
6 **while the pretrial detainee is in the intake center. The mental health**
7 **staff will identify the urgency with which the pretrial detainee must be**
8 **seen by a mental health provider, i.e., a psychiatrist, psychiatric nurse**
9 **practitioner, or physician assistant.**

10 Defendants reported the following monthly compliance rates for March through
11 August 2015: 43%, 57%, 82%, 85%, 93%, and 98%. Defendants explained that the
12 Mental Health Director reviewed monthly detailed reports regularly to find compliance
13 problems and retrain staff to improve compliance. Compliance rates improved
14 significantly after the first two months.

15 Subparagraph 5(a)(5) requires mental health staff to assess and triage pretrial
16 detainees with a positive mental health screening before they leave the intake center.
17 Defendants' policy directs mental health staff to assess, triage, and schedule
18 appointments with psychiatric providers within time limits based on the assessments.
19 Plaintiffs contend that Defendants failed to measure whether patients received a timely
20 provider assessment, which is not required by subparagraph 5(a)(5).

21 Plaintiffs also contend that Defendants' methodology for determining compliance
22 with subparagraph 5(a)(5) is flawed because Defendants' policy requires mental health
23 staff to assign triage codes during intake and no triage codes were documented. Rather,
24 as subparagraph 5(a)(5) requires, mental health staff indicated the urgency with which
25 pretrial detainees should be seen by a mental health provider. Dr. Noggle reported that
26 clinical decision making, not triage codes, determined the urgency with which mental
27 health appointments were scheduled.

28 Plaintiffs do not dispute that detainees with positive mental health screens were
assessed by mental health staff during intake and scheduled to be seen by mental health
providers. They contend that some patients were not seen by a provider within 24 hours

1 despite mental health staff indicating “urgent” or “emergent” for scheduling priority.
2 However, of the 47 patient files Dr. Stewart reviewed, at least 11 of the patients were
3 placed in the Mental Health Unit directly from intake. Three others were transferred to
4 the Mental Health Unit the day after booking. Dr. Stewart opined that some or all of
5 these patients should have been seen by a mental health provider within 24 hours, but
6 they were not. This alleged deficiency is better addressed by subparagraph 5(a)(18),
7 which requires that a mental health provider will determine placement of each seriously
8 mentally ill pretrial detainee after performing a face-to-face assessment, including
9 placement in the Mental Health Unit.

10 The Court finds that Defendants have sufficiently implemented the remedy
11 described in subparagraph 5(a)(5).

12 **F. Subparagraph 5(a)(6): If the receiving screening indicates a pretrial**
13 **detainee is at risk for suicide, a psychiatrist, psychiatric nurse**
14 **practitioner, or physician assistant will conduct a face-to-face**
15 **assessment of the pretrial detainee within 24 hours after the receiving**
16 **screening.**

17 Plaintiffs contend that Defendants erred by determining compliance based on
18 precisely what the Revised Fourth Amended Judgment ordered—face-to-face assessment
19 within 24 hours—and not whether pretrial detainees identified as being at risk for suicide
20 were consistently placed at the Mental Health Unit or appropriate facilities outside the
21 Jail. As previously explained, Plaintiffs’ compliance with the Revised Fourth Amended
22 Judgment is determined by their satisfaction of the literal requirements of Paragraph 5.

23 Defendants initially reported the following monthly compliance rates for March
24 through August 2015: 79%, 71%, 71%, 76%, 81%, and 81%. After the Court ordered
25 Defendants to file supplemental briefing, Defendants conducted chart audits for all
26 pretrial detainees who should have been seen within 24 hours and were not. Defendants
27 determined that the majority of those detainees had been seen by a provider within 24
28 hours, and the encounter was documented on a form other than the one included in the
electronic reporting. In most of the remaining cases, the suicide risk was not identified

1 during the receiving screening, and the time within which the detainees were seen by a
2 provider is irrelevant to subparagraph 5(a)(6). Defendants reported the following revised
3 monthly compliance rates for March through August 2015: 96.5%, 98.7%, 92.9%,
4 98.7%, 99.5%, and 98.9%.

5 Defendants' initial analysis and supplemental analysis after chart audits appear to
6 count pretrial detainees released within 24 hours as instances of compliance, instead of
7 excluding them, thereby somewhat inflating the compliance rates. Also, by adding the
8 percentage of pretrial detainees released within 24 hours to the percentage assessed by a
9 provider within 24 hours, Defendants double counted any pretrial detainees who were
10 both assessed and released within 24 hours. Nevertheless, it is not realistic that a
11 sufficient number of at-risk detainees were identified, seen by a provider, and released
12 within 24 hours to significantly affect the monthly compliance rates.

13 The Court finds that Defendants have sufficiently implemented the remedy
14 described in subparagraph 5(a)(6).

15 **G. Subparagraph 5(a)(7): Pretrial detainees will be tested for tuberculosis**
16 **within 14 days after the receiving screening unless they have been**
17 **tested with negative results within the past year.**

18 Defendants reported the following monthly compliance rates for March through
19 August 2015: 98%, 98%, 99%, 99%, 99%, and 99%. Plaintiffs' experts found
20 compliance in 39 of 46 applicable records. They identified four cases as noncompliant
21 that Defendants reported as compliant and identified two cases as noncompliant that were
22 not included in Defendants' analysis. Dr. Alvarez reviewed each of these six cases and
23 explained that one was a sentenced inmate who was hospitalized during the first 14 days
24 after intake and another was released within 24 hours. The records for the remaining four
25 cases documented that the pretrial detainees were tested for tuberculosis within 14 days
26 after the receiving screening.

27 The Court finds that Defendants have sufficiently implemented the remedy
28 described in subparagraph 5(a)(7).

1 **H. Subparagraph 5(a)(8): Pretrial detainees with serious acute and**
2 **chronic medical conditions will be evaluated face-to-face by a medical**
3 **provider and will receive an initial health assessment within 24 hours**
4 **after the receiving screening.**

5 Subparagraph 5(a)(2) requires that pretrial detainees identified during the
6 receiving screening as having serious acute and chronic medical conditions be evaluated
7 in person by a physician, physician assistant, or nurse practitioner within 24 hours after
8 the receiving screening. Subparagraph 5(a)(8) requires that pretrial detainees with
9 serious acute and chronic medical conditions be evaluated in person by a medical
10 provider, *i.e.*, a physician, physician assistant, or nurse practitioner, within 24 hours after
11 the receiving screening *and* receive an initial health assessment within 24 hours after the
12 receiving screening.

13 The physical examination portion of an initial health assessment may be
14 completed by a physician, physician assistant, nurse practitioner, or registered nurse who
15 has completed the Certified Nurse Examiner training. A physician must review health
16 assessments completed by nurse practitioners, physician assistants, and registered nurses
17 with Certified Nurse Examiner training. An initial health assessment does not constitute
18 a comprehensive assessment of serious medical conditions and treatment plan. As
19 required in subparagraph 5(a)(9), plans for treatment and monitoring of pretrial detainees
20 with serious medical conditions must be developed by a medical provider.

21 Regarding providing initial health assessments within 24 hours, Defendants
22 initially reported the following monthly compliance rates for March through August
23 2015: 89%, 83%, 83%, 87%, 89%, and 86%. In their supplemental report, Defendants
24 added to the initial compliance rates the percentage of relevant pretrial detainees who
25 were released within 24 hours, which yielded the following monthly compliance rates:
26 93%, 87%, 86%, 92%, 94%, and 96%. As previously noted, including those released
27 within 24 hours in the total somewhat inflates the compliance rates, and adding the
28 percentages double counts any pretrial detainees who both received an initial health
 assessment and were released within 24 hours.

1 Defendants explained that a frequent reason for pretrial detainees with serious
2 acute and chronic medical conditions not receiving initial health assessments within 24
3 hours after the receiving screening is that the detainees have been taken to court for initial
4 appearances. Many of those receive their initial health assessments within 24 to 30 hours
5 after the receiving screening. Defendants do not have an automated method for
6 determining the precise number for whom initial health assessments are delayed for court
7 appearances, but they reported the percentage of relevant pretrial detainees who received
8 initial health assessments within 30 hours after the receiving screening: 99.5%, 97.4%,
9 95.7%, 98.9%, 98.3%, and 99.6%. It is not apparent whether these rates include any
10 pretrial detainees who were released within 24 hours.

11 Plaintiffs dispute Defendants' compliance with subparagraph 5(a)(8) because they
12 interpreted it as requiring that initial health assessments be provided by a medical
13 provider. Plaintiffs' experts reviewed 47 applicable records and found that in 23 records
14 the pretrial detainees were evaluated face-to-face by a medical provider and received an
15 initial health assessment by a medical provider. Of the remaining 24 cases, three were
16 sentenced inmates, some did not report or display serious acute and chronic medical
17 conditions during the receiving screening, four were given a provider assessment at
18 intake and required no follow-up, and some were assessed at the hospital. One of the
19 cases identified by Plaintiffs as noncompliant was described by Dr. Alvarez as a
20 complicated patient who should have been seen by a provider at intake and was not.

21 The Court finds that Defendants have sufficiently implemented the remedy
22 described in subparagraph 5(a)(8).

23 **I. Subparagraph 5(a)(9): A medical provider will develop plans for**
24 **treatment and monitoring for pretrial detainees with serious medical**
25 **conditions.**

26 Subparagraph 5(a)(9) requires that a physician, physician assistant, or nurse
27 practitioner develop treatment and monitoring plans for pretrial detainees. This provision
28 does not require Defendants to demonstrate that within 24 hours of admission a medical

1 provider ordered medications, labs, and follow-up appointments that addressed all of the
2 patient's presenting conditions, both acute and chronic. In some cases, a medical
3 provider may determine that an acute condition should be treated and stabilized before
4 routine labs and medication are ordered for a chronic condition. Defendants reported the
5 following monthly compliance rates for March through August 2015: 98%, 98%, 98%,
6 97%, 96%, and 96%. Plaintiffs dispute those rates based upon their experts' incorrect
7 interpretation of the requirements of subparagraph 5(a)(9).

8 The Court finds that Defendants have sufficiently implemented the remedy
9 described in subparagraph 5(a)(9).

10 **J. Subparagraph 5(a)(10): All medical Health Needs Requests will be**
11 **triaged within 24 hours of their submission.**

12 Defendants reported compliance rates of 98% or 99% for each month. Plaintiffs'
13 experts reviewed 31 Health Needs Requests and found all of them were triaged within 24
14 hours of submission.

15 The Court finds that Defendants have sufficiently implemented the remedy
16 described in subparagraph 5(a)(10).

17 **K. Subparagraph 5(a)(11): Each pretrial detainee who submits a medical**
18 **Health Needs Request stating or indicating a clinical symptom will be**
19 **seen by a nurse within 48 hours of submitting the Health Needs**
20 **Request.**

21 To evaluate compliance with subparagraph 5(a)(11), Defendants determined
22 whether pretrial detainees were seen by a nurse within 36 hours of Health Needs
23 Requests being triaged, assuming that all Health Needs Requests are triaged within 12
24 hours. Because the average time from submission to triage is slightly more than three
25 hours, actual compliance rates are likely greater than those reported. Defendants reported
26 the following monthly compliance rates for March through August 2015: 84%, 84%,
27 81%, 83%, 81%, and 84%. Plaintiffs' experts' review of 33 Health Needs Requests
28 showed that 28 (85%) were seen by a nurse within 48 hours of submission.

1 The Court finds that Defendants have sufficiently implemented the remedy
2 described in subparagraph 5(a)(11).

3 **L. Subparagraph 5(a)(12): When a physician, physician assistant, or**
4 **nurse practitioner orders a lab test or radiological study, the physician,**
5 **physician assistant, or nurse practitioner will identify the urgency with**
6 **which the test or study must be performed, e.g., within 24 hours, 72**
7 **hours, or 7–10 days, and the urgency with which the results of the test**
8 **or study must be returned. The test or study will be performed within**
9 **the timeframe ordered by a physician, physician assistant, or nurse**
10 **practitioner.**

11 When the Jail's medical providers order a lab test or radiological study, they do
12 not always explicitly identify the urgency with which the test or study must be
13 performed. A provider can request that a test be performed immediately, on a specific
14 day or time, or within a time frame. When the provider does not do so, the test is
15 considered routine and timely if it is performed within the next thirty days. Defendants
16 contend that the provider implicitly identifies a test as non-urgent when the provider does
17 not identify it as urgent.

18 Because the urgency of an order for lab test or radiological study is not
19 documented in the electronic health record system, Defendants were unable to generate
20 automated reports of the timeliness with which tests were completed. Therefore, to
21 determine compliance with subparagraph 5(a)(12), Defendants reviewed a sample of lab
22 and x-ray orders for each reporting month. Orders for routine labs and/or x-rays were
23 deemed completed on time if they were completed within 30 days of the provider order.
24 Priority labs and/or x-rays were deemed completed on time if they were completed within
25 the time frame ordered by the provider. In 100% of the charts reviewed, the lab or x-ray
26 was either completed on time or the pretrial detainee was released from custody prior to
27 the deadline.

28 The Court finds that Defendants have sufficiently implemented the remedy
described in subparagraph 5(a)(12).

1 **M. Subparagraph 5(a)(13): Pretrial detainees identified during the**
2 **receiving screening as being at risk of serious harm from alcohol or**
3 **drug withdrawal will be assessed by a registered nurse twice a day for**
4 **at least seven days regardless of whether they are assigned to a housing**
5 **unit designated for withdrawing inmates or their classification status.**
6 **The nurse will document each assessment and identify the urgency**
7 **with which the pretrial detainee should be seen by a physician,**
8 **physician assistant, or nurse practitioner. If a pretrial detainee is not**
9 **seen face-to-face by a physician, physician assistant, or nurse**
10 **practitioner within the timeframe recommended by the nurse, the**
11 **reason will be documented in the pretrial detainee’s medical record.**

12 Defendants reported the average number of days in detox and the average number
13 of nursing assessments for three categories of patients over the six-month period. For
14 each category, the averages do not show that patients were assessed by a registered nurse
15 twice a day for at least seven days. Defendants explained that the averages were affected
16 by pretrial detainees being removed from withdrawal precautions based on clinical
17 evaluations. Plaintiffs’ experts found that 31 of 34 applicable records, *i.e.*, 91%, showed
18 that the patient was assessed by a registered nurse twice a day for at least seven days.

19 Defendants reported the following percentages of pretrial detainees who were seen
20 face-to-face by a medical provider within the time requested for March through August
21 2015: 88%, 94%, 87%, 89%, 95%, and 87%. Plaintiffs do not dispute this.

22 Plaintiffs agree that Defendants are in compliance with subparagraph 5(a)(13).
23 The Court finds that Defendants have sufficiently implemented the remedy described in
24 subparagraph 5(a)(13).

25 **N. Subparagraph 5(a)(14): All mental health Health Needs Requests**
26 **stating or indicating a clinical symptom will be triaged face-to-face**
27 **within 48 hours of their submission.**

28 Defendants reported compliance rates of 82% in March, 94% in April, 96% in
 May, 94% in June, 95% in July, and 94% in August based on whether pretrial detainees
 who submitted mental health Health Needs Requests stating a clinical symptom were
 seen by mental health staff within 48 hours. The monthly triage time averages for March

1 through August 2015 were 18.6 hours, 15.7 hours, 18.4 hours, 15.7 hours, 14.2 hours, and
2 15.8 hours.

3 Plaintiffs contend that the triage process requires actual assessment and the data
4 collected by Defendants indicates only whether face-to-face contact with mental health
5 staff, not whether an assessment was conducted. Subparagraph 5(a)(14) was ordered to
6 avoid situations in which written statements by pretrial detainees failed to adequately
7 communicate mental health needs, resulting in delay or denial of necessary mental health
8 care. This remedy only requires mental health staff to communicate face-to-face with
9 each pretrial detainee who submits a mental health Health Needs Request indicating a
10 clinical symptom.

11 Plaintiffs further contend that Defendants' policy SOP J-E-07 requires that
12 detainees with "urgent psychiatric need" be seen by a provider within 24 hours, but the
13 compliance data collected does not show the triage category assigned to each Health
14 Needs Request and the date of follow-up provider assessment, if any. Defendants were
15 not ordered to provide data showing compliance with Jail policies.

16 The Court finds that Defendants have sufficiently implemented the remedy
17 described in subparagraph 5(a)(14).

18 **O. Subparagraph 5(a)(15): Upon referral by detention, intake, medical,**
19 **or mental health staff, pretrial detainees who display active symptoms**
20 **of mental illness or otherwise demonstrate an emergent mental health**
21 **need will be seen face-to-face by a mental health provider within 24**
22 **hours of the referral.**

23 Defendants initially reported the following monthly compliance rates for March
24 through August 2015: 69%, 45%, 50%, 72%, 74%, and 75%. Data for March, April, and
25 May were obtained through manual chart audits. Enhancements to the electronic health
26 record system in June permitted electronic data retrieval for June, July, and August.
27 Defendants' supplemental compliance report stated that the compliance rate for May
28 should have been 67% and the initial report included pretrial detainees who had been
released within 24 hours of referrals. By counting the released pretrial detainees as

1 though they were seen within 24 hours, Defendants adjusted their compliance rates to
2 69%, 47%, 70%, 75%, 74%, and 77%.⁸

3 Defendants then conducted chart audits for June, July, and August and found that
4 many referrals included in the electronically generated reports did not involve “pretrial
5 detainees who display active symptoms of mental illness or otherwise demonstrate an
6 emergent mental health need.” The chart audits revealed additional reporting errors.
7 After corrections, Defendants reported the following monthly compliance rates for June,
8 July, and August 2015: 94%, 95%, and 96%.

9 Defendants report that detention staff members are asked to refer to mental health
10 staff anyone for whom they have a concern because detention staff members are not
11 trained to determine whether a pretrial detainee is displaying active symptoms of mental
12 illness or demonstrating an emergent mental health need. Then a mental health staff
13 member responds within three hours to assess the detainee and determine whether the
14 mental health need requires a provider assessment within 24 hours of the initial referral.

15 Plaintiffs dispute Defendants’ compliance with subparagraph 5(a)(15) primarily
16 because, in Dr. Stewart’s opinion, certain referrals were inaccurately triaged by mental
17 health staff. As explained above, Dr. Stewart reviewed the records of 47 selected
18 patients, many of whom were in the RTC program, refused treatment, and eventually
19 were hospitalized after their criminal charges were dismissed. Some were placed in the
20 Mental Health Unit. Of the 47 records Dr. Stewart reviewed, he opined that 32 were
21 relevant to subparagraph 5(a)(15). He opined that 21 of the 32 records (66%) were
22 noncompliant with subparagraph 5(a)(15). Many of the examples Dr. Stewart described
23 were seriously mentally ill patients who were being treated on an ongoing basis but were
24 not referred to a provider every time a referral was made by detention staff.

25
26 ⁸ As previously explained, released detainees should have been excluded from the
27 analysis entirely. Nevertheless, including them here does not make a significant
28 difference.

1 In addition, Dr. Stewart reviewed the electronic medical charts for 13 of 19
2 patients who were initially identified as noncompliant with subparagraph 5(a)(15) and
3 then were changed to compliant or were removed from Defendants' analysis. He opined
4 that four of the patients displayed symptoms that required a provider assessment and
5 were either not referred to a provider or not seen within 24 hours. Some of the referrals
6 that Dr. Stewart deemed to be noncompliant were not marked "urgent" and therefore not
7 included in Defendants' data analysis. For example, Dr. Stewart described a patient who
8 was referred by detention staff on two consecutive days and seen by a provider within 24
9 hours of the second referral. Defendants assert that the first referral was not marked
10 urgent, and the second one was. Some of Dr. Stewart's criticisms are based on
11 Defendants' failure to include referrals from March, April, and May 2015 in the
12 electronic health record system, which Defendants explained did not include the relevant
13 information until June.

14 The purpose of subparagraph 5(a)(15) is to give greater priority to mental health
15 referrals from detention, intake, medical, or mental health staff regarding pretrial
16 detainees who need to be seen by a mental provider within 24 hours than to mental health
17 Health Needs Requests, which often are less urgent. Dr. Stewart found instances where,
18 in his opinion, seriously mentally ill patients were not seen as frequently or as urgently as
19 he would recommend. Nevertheless, after resolving documentation and data collection
20 issues, Defendants provided evidence that they complied with the requirements of
21 subparagraph 5(a)(15) for June, July, and August 2015.

22 The Court finds that Defendants have sufficiently implemented the remedy
23 described in subparagraph 5(a)(15).

24 **P. Subparagraph 5(a)(16): Mental health providers will assess pretrial**
25 **detainees in an area outside of their cells that affords sound privacy**
26 **except when there are legitimate safety, security, and treatment**
27 **reasons for not doing so.**

28 Defendants reported the following monthly compliance rates for March through
August 2015: 89%, 100%, 99%, 89%, 99.5%, and 96%. For March, April, and May

1 2015, Defendants conducted manual chart audits of randomly selected records. For June,
2 July, and August 2015, Defendants' electronic records showed whether each psychiatric
3 assessment was conducted privately or cell-side and whether one of five reasons for
4 conducting the non-private assessment existed. The five reasons were "Safety
5 Concerns," "Security Concerns," "Treatment Reasons," "Patient Refusal," and "Patient
6 Unavailable." Defendants conducted chart audits on all patients shown as being seen
7 without sound privacy to determine whether a legitimate reason was documented.
8 Defendants counted an assessment as noncompliant only when the assessment was
9 conducted in a non-private space and none of the five reasons was entered into the record.

10 Plaintiffs contend that Defendants should have reported the total percentage of
11 non-confidential assessments and should have provided more specific information
12 regarding each non-private assessment to show that the reason selected was legitimate or
13 justified. As a practical matter, however, neither Plaintiffs' counsel nor Dr. Stewart
14 would have been able to determine whether a legitimate safety or security reason existed,
15 and they would have been only able to second-guess a mental health provider's
16 determination that "treatment reasons" existed for not conducting an assessment in a
17 private location outside of the cell. Notes that a patient was "neat, calm, and oriented" do
18 not necessarily mean that a patient should be moved from his or her cell.

19 Dr. Stewart stated that he reviewed 33 records for compliance with subparagraph
20 5(a)(16). Presumably, the 33 records were selected from the records of the 47 patients
21 selected for review by Dr. Stewart, many of whom were in the RTC program and
22 hospitalized after being declared incompetent. Dr. Stewart found 16 of the 33 records
23 noncompliant because the reason for a non-private assessment was not documented, the
24 provider's notes did not adequately support the documented reason for a non-private
25 assessment, the notes did not clearly state whether the assessment was conducted in a
26 private space, or the assessment was not included in Defendants' compliance data. The
27 33 records reviewed by Dr. Stewart is not a representative sample, and even if it were, it
28

1 is a very small sample of the mental health patients seen by providers during the six-
2 month period. Moreover, Dr. Stewart's opinion that 16 records showed noncompliance
3 does not explain how many of those 16 records he found noncompliant because he
4 disagreed with the legitimacy of the reason provided.

5 The Court finds that Defendants have sufficiently implemented the remedy
6 described in subparagraph 5(a)(16).

7 **Q. Subparagraph 5(a)(17): Defendants will adopt and implement written**
8 **criteria for placing pretrial detainees in each level of mental health**
9 **care, including subunits within the Mental Health Unit.**

10 On December 11, 2014, Defendants revised Standard Operating Procedure SOP J-
11 G-04 regarding the Jail's provision of basic mental health services. Among other things,
12 it establishes admission criteria for the Mental Health Unit, the process for admission to
13 the Mental Health Unit, initial placement upon admission to the Mental Health Unit,
14 criteria for transfer to any of four step-down psychiatric units within the Mental Health
15 Unit, procedures regarding discharge from the Mental Health Unit to general population,
16 procedures for outpatient mental health services, and documentation of level of care
17 classification. (Doc. 2304-1 at 137-147.)

18 Plaintiffs' expert, Dr. Stewart, opined that the Mental Health Unit admission
19 criteria remain too high and the discharge criteria remain too low, resulting in many
20 seriously mentally ill inmates being inappropriately placed in outpatient care. As
21 previously discussed, Dr. Stewart reviewed the records of 47 selected patients, many of
22 whom were in the RTC program. In his opinion, 29 of the 47 records demonstrated
23 delayed admission to the Mental Health Unit, premature discharge from the Mental
24 Health Unit, inadequate use of step-down units, and/or inadequate care in the outpatient
25 setting. Dr. Stewart does not specifically explain how these 29 examples show that
26 Defendants have not adopted and implemented placement criteria rather than his
27 disagreement with the clinical judgment of the Jail's mental health providers.
28

1 Subparagraph 5(a)(17) requires that Defendants adopt and implement written
2 criteria. Defendants provided Plaintiffs their revised procedure in December 2014, and
3 Plaintiffs raised no objection. Defendants filed a summary of their actions taken to
4 implement the revised procedure. However, Defendants have provided no evidence of
5 the extent to which they have actually implemented SOP J-G-04.

6 Defendants have not shown that they have sufficiently implemented the remedy
7 described in subparagraph 5(a)(17).

8 **R. Subparagraph 5(a)(18): A mental health provider will determine the**
9 **placement of each seriously mentally ill pretrial detainee after**
10 **performing a face-to-face assessment, including upon admission into,**
11 **transfer within, and discharge from the Mental Health Unit.**

12 Standard Operating Procedure SOP J-G-04 provides that inmates presenting with
13 acute or chronic mental health needs who cannot be managed in general population may
14 be housed in the Mental Health Unit. It provides criteria for admission to the Mental
15 Health Unit and establishes an admission process. But SOP J-G-04 does not expressly
16 require face-to-face assessment by a mental health provider before a pretrial detainee is
17 placed in the Mental Health Unit. A “mental health provider” includes a psychiatrist,
18 psychiatric nurse practitioner, or physician assistant. SOP J-G-04 requires that an
19 admission form be completed by the “referring Provider or Licensed Nurse (Registered
20 Nurse [RN] or Licensed Practical Nurse [LPN]) with Provider phone order.” It requires
21 that a psychiatric provider see each patient for face-to-face evaluation “by the next day
22 after admission” to the Mental Health Unit. It also requires that a psychiatric provider
23 conduct a clinical assessment to determine if it is appropriate to transfer a patient to other
24 Mental Health Unit subunits for further treatment or to general population.

25 Notwithstanding the express language of SOP J-G-04, Defendants analyzed data
26 regarding whether seriously mentally ill pretrial detainees received face-to-face
27 assessment by a mental health provider before admission into, transfer within, or
28 discharge from the Mental Health Unit. Defendants initially reported the following
monthly compliance rates for March through August 2015: 72%, 74%, 73%, 83%, 82%,

1 and 85%. These rates were calculated by adding the percentage of seriously mentally ill
2 pretrial detainees who received a face-to-face assessment prior to their admission into,
3 transfer within, or discharge from the Mental Health Unit to the percentage of pretrial
4 detainees who were released within 24 hours each month. Subparagraph 5(a)(18)
5 requires assessment *before* placement—what happens after placement is irrelevant.
6 Therefore, the monthly compliance rates should have been reported as 64%, 67%, 66%,
7 76%, 77%, and 77%.

8 Defendants’ manual audit of cases deemed noncompliant found that many
9 involved transfers to different cells, not different levels of care, within the Mental
10 Housing Unit. In other cases, a provider assessed the patient before the patient was
11 transferred, but entered the documentation after the patient was transferred. Defendants
12 explained that a provider usually will see multiple patients during his shift and enter notes
13 for all patients at the end of his shift, but the electronically generated reports are based on
14 the time the provider entered his note, not the time the patient was actually seen. Because
15 housing transfers must be completed by noon, frequently a provider sees a patient in the
16 morning and orders transfer, the patient is transferred at noon, and the provider enters his
17 note in the afternoon.

18 After correcting for these circumstances, Defendants reported monthly compliance
19 rates for June, July, and August 2015 of 92%, 87%, and 96%. Defendants did not explain
20 whether they included the percentage of pretrial detainees released within 24 hours to
21 calculate the corrected compliance rates; if so, the corrected rates should have been
22 reported as 85%, 82%, and 88%.

23 SOP J-G-04 does not require face-to-face assessment by a mental health provider
24 before a pretrial detainee, who is not placed in the Mental Health Unit, is placed in
25 outpatient care. It articulates three levels of outpatient care and states that mental health
26 staff “begin the assessment, treatment planning and re-entry planning process.”
27 Subparagraph 5(a)(18) requires that a mental health provider assess and determine the
28

1 placement of each “seriously mentally ill” pretrial detainee and does not define “seriously
2 mentally ill.” However, elsewhere, the Revised Fourth Amended Judgment requires a
3 mental health screening at intake for every pretrial detainee and, upon referral at intake or
4 at any time, a face-to-face examination by a mental health provider for any pretrial
5 detainee who displays active symptoms of mental illness or emergent mental health need.
6 Therefore, pretrial detainees may receive outpatient mental health services without a
7 face-to-face examination by a mental health provider, but only if they do not display
8 active symptoms of mental illness or emergent mental health need.

9 The Court finds that Defendants have sufficiently implemented the remedy
10 described in subparagraph 5(a)(18).

11 **S. Subparagraph 5(a)(19): Pretrial detainees discharged from the Mental**
12 **Health Unit will be assessed by mental health staff within 48 hours**
13 **after discharge.**

14 Defendants reported the following monthly compliance rates for March through
15 August 2015: 93%, 90%, 85%, 88%, 96%, and 92%. Plaintiffs contend that this
16 provision was intended “to address the problem of clinically unstable patients being
17 prematurely discharged from the [Mental Health Unit] and lingering in outpatient care
18 without being timely readmitted to the [Mental Health Unit].” Of 18 records reviewed by
19 Dr. Stewart, 3 indicated that patients were not seen within 48 hours of discharge.

20 The Court finds that Defendants have sufficiently implemented the remedy
21 described in subparagraph 5(a)(19).

22 **T. Subparagraph 5(a)(20): MCSO⁹ will consult with CHS mental health**
23 **staff before placing a seriously mentally ill pretrial detainee in any type**
24 **of segregated confinement.**

25 Defendants initially reported the following monthly compliance rates for March
26 through August 2015: 59%, 50%, 67%, 61%, 57%, and 80%. They determined
27 compliance based on whether a consultation with mental health staff occurred each time

28 ⁹ MCSO means Maricopa County Sheriff’s Office.

1 that MCSO requested an evaluation, not based on whether a consultation occurred before
2 a pretrial detainee was placed in segregation.

3 Defendants performed chart review audits for June, July, and August 2015 and
4 found reporting errors for July and August, including duplicate entries. Defendants
5 removed duplicates from cases identified as noncompliant, but did not do so for those
6 identified as compliant. The corrected compliance rates for June, July, and August 2015
7 are 61%, 80%, and 92%. Even if these rates were based on what subparagraph 5(a)(20)
8 requires, *i.e.*, consultation before placement in segregation, they do not show sufficient
9 implementation.

10 Defendants have not shown that they have sufficiently implemented the remedy
11 described in subparagraph 5(a)(20).

12 **U. Subparagraph 5(a)(21): Seriously mentally ill pretrial detainees who**
13 **are confined to single cells for 22 or more hours a day will have face-to-**
14 **face communication with mental health staff at least twice per week.**

15 Defendants reported the following monthly compliance rates for March through
16 August 2015: 88%, 98%, 98%, 99.6%, 98%, and 95%. To determine compliance,
17 Defendants generated electronic reports each month that included data for each seriously
18 mentally ill pretrial detainee who appeared to be in some type of segregation during that
19 month and then conducted a manual audit of the third week of each month to verify
20 compliance.

21 Plaintiffs contend that Defendants' measure of compliance shows only that there
22 were two contacts each week, not whether the contacts consisted of verbal interaction,
23 mental status, and observations and whether patients were given opportunity to
24 communicate health care concerns, as Defendants' procedure SOP J-E-09 requires. Of
25 the records Dr. Stewart reviewed, he identified 39 records in which a patient was housed
26 in segregation, and he looked closely at the records of mental health rounds in 13 of the
27 39. Dr. Stewart opined that Defendants failed to comply with SOP J-E-09 in each of the
28 13 cases. Dr. Stewart reported that in many of the 13 cases the staff checked off the

1 boxes for no health concerns noted and no observable change in mental health status,
2 despite other notes that indicated the patient was actively symptomatic. In his opinion,
3 the minimal contact with mental health staff during segregation rounds did not mitigate
4 the risk of mental health deterioration related to isolation. Nevertheless, Dr. Stewart's
5 review indicated that mental health staff had face-to-face communication at least twice
6 per week with each of the 13 patients.

7 The Court finds that Defendants have sufficiently implemented the remedy
8 described in subparagraph 5(a)(21).

9 **V. Subparagraph 5(a)(22): A mental health provider or professional will**
10 **be consulted before each planned use of force or involuntary treatment**
11 **on a seriously mentally ill pretrial detainee.**

12 **Subparagraph 5(a)(23): Mental health staff will be involved in the**
13 **implementation of any planned use of force or involuntary treatment**
14 **on a seriously mentally ill pretrial detainee.**

15 For subparagraphs 5(a)(22) and 5(a)(23), Defendants reported that the monthly
16 compliance rate for March through August 2015 was 100%. Defendants reported they
17 had revised procedure J-A-08 to require that MCSO consult with CHS before each
18 planned use of force or involuntary treatment on a seriously mentally ill or mental health
19 chronic care patient and to require that for any planned use of force or involuntary
20 treatment deemed necessary, mental health staff be involved in the implementation of the
21 planned use of force or involuntary treatment. Defendants generated electronic reports
22 for each month that included data for each pretrial detainee identified as a seriously
23 mentally ill or mental health chronic care patient in which the MCSO consulted with
24 CHS on a planned use of force. The electronic reports compared the date and time of a
25 request by MCSO for a consultation by mental health staff to the date and time of the
26 planned use of force. In other words, they evaluated whether mental health staff were
27 responsive to requests from MCSO. They did not evaluate whether MCSO consistently
28 requested a consultation before each planned use of force involving a pretrial detainee
identified as a seriously mentally ill or mental health chronic care patient.

1 Eldon Vail, a former correctional administrator, reviewed MCSO's policies and
2 documentation regarding planned use of force and consultation with mental health staff.
3 He opined that, unlike the related CHS policies, the MCSO use-of-force policy does not
4 require that detention staff document consultation with mental health staff. Mr. Vail
5 reviewed 33 incident summaries from March through June 2015, that appeared to be
6 planned use of force events involving seriously mentally ill detainees. He found that 14
7 of the 33 did not mention mental health consultation. When Mr. Vail reviewed records
8 for use-of-force incidents during June, July, and August 2015, he found documentation of
9 mental health staff involvement in 32 of 64 incidents. By examining the medical files for
10 the 64 inmates, Mr. Vail found documentation for 38 showing that there was some level
11 of involvement by mental health staff. Defendants disagree with Mr. Vail's
12 characterization of certain incidents as involving planned use of force and contend that
13 some of his expectations exceed the requirements of the Revised Fourth Amended
14 Judgment.

15 Dr. Stewart opined that Defendants' analysis also was flawed because it did not
16 include patients not identified as a seriously mentally ill or mental health chronic care
17 patient but who were suspected of being seriously mentally ill. Subparagraphs 5(a)(22)
18 and (23) do not require MCSO staff to determine whether a patient is "suspected" of
19 serious mental illness. Nor do subparagraphs 5(a)(22) and (23) require Defendants to be
20 able to report whether mental health consultations have occurred regarding pretrial
21 detainees who have not been designated as seriously mentally ill or mental health chronic
22 care patients.

23 Defendants have provided no evidence regarding whether MCSO staff
24 consistently seek a consultation with mental health staff before implementing a planned
25 use of force or involuntary treatment involving a seriously mentally ill pretrial detainee.
26 They have provided no evidence that mental health staff members are consistently
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1 involved in the implementation of planned use of force or involuntary treatment
2 involving a seriously mentally ill pretrial detainee.

3 The Court finds that Defendants have not shown that they have sufficiently
4 implemented the remedy described in subparagraphs 5(a)(22) and 5(a)(23).

5 **W. Subparagraph 5(a)(24): Defendants will adopt and implement a**
6 **written policy regarding the use of discipline for behavior resulting**
7 **from serious mental illness.**

8 **Subparagraph 5(a)(25): Defendants will adopt and implement a**
9 **written policy regarding the use of isolation in a disciplinary**
10 **segregation unit as a sanction against seriously mentally ill pretrial**
11 **detainees.**

12 **Subparagraph 5(a)(26): Defendants will adopt and implement a**
13 **written policy requiring that mental health staff be consulted**
14 **regarding discipline of any seriously mentally ill pretrial detainee.**

15 Defendants reported that on December 11, 2014, they revised procedures J-A-08
16 and J-E-09 to satisfy the requirements of subparagraphs 5(a)(24), 5(a)(25), 5(a)(26).
17 Defendants provided Plaintiffs their revised procedures in December 2014, and Plaintiffs
18 raised no objection. Defendants filed a summary of their actions taken to implement the
19 revised procedures. However, Defendants have provided no evidence of the extent to
20 which they have actually implemented the revised procedures.

21 The Court finds that Defendants have not shown that they have sufficiently
22 implemented the remedies described in subparagraphs 5(a)(24), 5(a)(25), 5(a)(26).

23 **X. Subparagraph 5(a)(27): A potentially suicidal pretrial detainee will**
24 **not be placed in isolation without constant supervision.**

25 Based on pretrial detainees who were “actively suicidal,” Defendants reported the
26 following monthly compliance rates for March through August 2015: 72%, 86%, 72%,
27 89%, 97%, and 95%. They did not report compliance rates for “potentially suicidal”
28 pretrial detainees.

Dr. Noggle opined that there is mental health distinction between “potentially
suicidal” and “actively suicidal.” She asserted that CHS relies on the definition provided
by the National Commission on Correctional Health Care to determine which inmates

1 may be potentially suicidal, which “allows CHS to cast a wide protective net.” But
2 Defendants have not explained why they have complied with subparagraph 5(a)(27) only
3 with respect to pretrial detainees who are “actively suicidal” and not those who are
4 “potentially suicidal.”

5 The Court finds that Defendants have not shown they have sufficiently
6 implemented the remedy described in subparagraph 5(a)(27).

7 **Y. Subparagraph 5(a)(28): A potentially suicidal pretrial detainee will be**
8 **placed into a suicide-resistant cell or safe cell only with “direct,**
9 **continuous observation until a treatment plan is determined by**
10 **medical staff.”**

11 Based on pretrial detainees who were “actively suicidal,” Defendants reported the
12 following monthly compliance rates for March through August 2015: 72%, 91%, 72%,
13 89%, 97%, and 100%. They did not report compliance rates for “potentially suicidal”
14 pretrial detainees.

15 As explained above, Dr. Noggle opined that there is mental health distinction
16 between “potentially suicidal” and “actively suicidal” and asserted that CHS relies on the
17 definition provided by the National Commission on Correctional Health Care to
18 determine which inmates may be potentially suicidal. But Defendants have not explained
19 why they have complied with subparagraph 5(a)(28) only with respect to pretrial
20 detainees who are “actively suicidal” and not those who are “potentially suicidal.”

21 The Court finds that Defendants have not shown they have sufficiently
22 implemented the remedy described in subparagraph 5(a)(28).

23 **Z. Subparagraph 5(a)(29): When a pretrial detainee is discharged from**
24 **suicide watch or a safe cell, the pretrial detainee will be assessed by**
25 **mental health staff within 24 hours of discharge.**

26 Defendants initially reported the following monthly compliance rates for March
27 through August 2015: 68%, 65%, 62%, 73%, 76%, and 82%. In their supplemental
28 report, Defendants added to the initial compliance rates the percentage of relevant pretrial
detainees who were released within 24 hours, which yielded the following monthly

1 compliance rates: 79%, 75%, 72%, 84%, 87%, and 91%. As previously noted, including
2 those released within 24 hours in the total somewhat inflates the compliance rates, and
3 adding the percentages double counts any pretrial detainees who were both assessed by
4 mental health staff and released within 24 hours. Even taken at face value, however,
5 these compliance rates indicate that 10-15% of pretrial detainees remain at the Jail and
6 are not assessed by mental health staff within 24 hours of discharge from suicide watch
7 or a safe cell.

8 Defendants offer no justification for noncompliance with subparagraph 5(a)(29).
9 A possible explanation is that their revised procedure J-G-05 is ambiguous. It requires
10 that patients discharged from suicide watch “are scheduled to be seen,” not that they
11 actually are seen, within 24 hours of discharge.

12 The Court finds that Defendants have not sufficiently implemented the remedy
13 described in subparagraph 5(a)(29).

14 **AA. Subparagraph 5(a)(30): Defendants will document in pretrial**
15 **detainees’ health records evidence of timely administration of**
16 **prescription medications or reasonably diligent efforts to administer all**
17 **medications prescribed and explanation for any delay.**

18 Defendants reported the following monthly compliance rates for March through
19 August 2015: 97.3%, 97.4%, 97.4%, 97.1%, 97.3%, and 97.6%. Dr. Cohen reviewed 49
20 records and opined that 12 of the 49 records demonstrated serious problems with
21 continuity of medications. Defendants provided explanations for the cases identified by
22 Dr. Cohen, such as the patient was hospitalized during the relevant timeframe.

23 The Court finds that Defendants have sufficiently implemented the remedy
24 described in subparagraph 5(a)(30).
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1 **BB. Subparagraph 5(a)(31):** A pretrial detainee’s psychotropic
2 **medications will not be prescribed, altered, renewed, or discontinued**
3 **without a face-to-face examination by a psychiatrist, psychiatric**
4 **physician assistant, or psychiatric nurse practitioner in an area that**
5 **affords sound privacy.**

6 Defendants initially reported the following monthly compliance rates for March
7 through August 2015: 79%, 78%, 89%, 80%, 85%, and 80%. Many of those reported as
8 noncompliant involved a face-to-face examination that was conducted without sound
9 privacy for various legitimate reasons. Including those as compliant resulted in the
10 following adjusted monthly compliance rates: 90%, 85%, 89%, 88%, 92%, and 83%.

11 Defendants conducted manual chart audits for June, July, and August 2015 for the
12 22 patients shown on the electronic reports as not being seen at all. In each of the 22
13 cases, Defendants found that the pretrial detainee was seen or there was documentation in
14 the record regarding why the patient was not seen. In 3 cases, the pretrial detainee was
15 not seen by a provider. In 2 of those, an appointment was scheduled, but the pretrial
16 detainee was released from custody before the appointment. In the third case, the pretrial
17 detainee was at court at the time of the scheduled appointment. After the manual chart
18 audits, Defendants reported for June, July, and August 2015: face-to-face examination
19 with sound privacy, 88%, 93%, and 88%; face-to-face examination without sound
20 privacy, 8%, 7%, and 10%; combined, 96%, 100%, and 98%.

21 Dr. Stewart reviewed a sample of medical charts and found discrepancies,
22 inadequate documentation, and what he considered insufficient reasons for seeing a
23 patient cell-side rather than in an area with sound privacy. He found that in some cases
24 the assessment occurred after the medication was ordered or so far in advance of the
25 order that the assessment seemed unrelated. Because Dr. Stewart did not identify
26 specifically which patient charts he found to be noncompliant, Defendants were not able
27 to respond specifically to his contentions.

28 The Court finds that Defendants have sufficiently implemented the remedy
described in subparagraph 5(a)(31).

1 IT IS THEREFORE ORDERED that Plaintiffs' Motion to Enforce Fourth
2 Amended Judgment and for Additional Relief (Doc. 2373) is denied.

3 IT IS FURTHER ORDERED that Plaintiffs' Motion for Evidentiary Hearing
4 (Doc. 2380) is denied.

5 IT IS FURTHER ORDERED finding that Defendants have demonstrated
6 compliance with the following subparagraphs of Paragraph 5(a) of the Revised Fourth
7 Amended Judgment: (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14),
8 (15), (16), (18), (19), (21), (30), and (31).

9 IT IS FURTHER ORDERED finding that Defendants have not demonstrated
10 compliance with the following subparagraphs of Paragraph 5(a) of the Revised Fourth
11 Amended Judgment: (17), (20), (22), (23), (24), (25), (26), (27), (28), and (29).

12 IT IS FURTHER ORDERED that by **March 17, 2017**, Defendants will meet and
13 confer with Plaintiffs regarding Defendants' plan for collecting and summarizing data to
14 show compliance with the following subparagraphs of Paragraph 5(a) of the Revised
15 Fourth Amended Judgment: (17), (20), (22), (23), (24), (25), (26), (27), (28), and (29).

16 IT IS FURTHER ORDERED that Defendants will collect and summarize data for
17 the months of **April, May, and June 2017** (*i.e.*, April 1-June 30, 2017, summarized
18 monthly) that shows the extent to which Defendants have complied with the following
19 subparagraphs of Paragraph 5(a) of the Revised Fourth Amended Judgment: (17), (20),
20 (22), (23), (24), (25), (26), (27), (28), and (29).

21 IT IS FURTHER ORDERED that upon reasonable notice to Defendants, during
22 April, May, and June 2017, Plaintiffs' counsel and experts may tour the Maricopa County
23 Jails facilities, speak with pretrial detainees and staff, and review records on-site related
24 to the following subparagraphs of Paragraph 5(a) of the Revised Fourth Amended
25 Judgment: (17), (20), (22), (23), (24), (25), (26), (27), (28), and (29).

26 IT IS FURTHER ORDERED that by **July 28, 2017**, Defendants file with the
27 Court a report of their corrective actions, compliance data collection procedures, and
28

1 compliance data summaries for April, May, and June 2017 related to the following
2 subparagraphs of Paragraph 5(a) of the Revised Fourth Amended Judgment: (17), (20),
3 (22), (23), (24), (25), (26), (27), (28), and (29).

4 IT IS FURTHER ORDERED that beginning **August 1, 2017**, Defendants make
5 available to Plaintiffs the raw data summarized in Defendants' compliance report filed
6 with the Court, electronically to the extent practical.

7 IT IS FURTHER ORDERED that Plaintiffs file a response to Defendants'
8 compliance report by **September 1, 2017**.

9 IT IS FURTHER ORDERED that Defendants file a reply in support of their
10 compliance report by **September 22, 2017**.

11 Dated this 1st day of March, 2017.

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16 Neil V. Wake
17 Senior United States District Judge
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