COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

BEFORE THE STATE BOARD OF PSYCHOLOGY

COMMONWEALTH OF PENNSYLVANIA
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

V.

JAMES DALE HARRINGTON, M.A.
CASE NOS. 11-63-05399
11-63-05413

FINAL ADJUDICATION AND ORDER

K. KALONJI JOHNSON
ACTING COMMISSIONER
OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

VITO J. DONGIOVANNI, PSY.D.,
CHAIRMAN
STATE BOARD OF PSYCHOLOGY

P.O. BOX 69523
HARRISBURG, PA 17106-9523

JWL

HISTORY

This matter is before the State Board of Psychology (Board) for review of the Proposed Adjudication and Order (Proposed Order) of the hearing examiner, issued on June 20, 2019. The hearing examiner found that Respondent is subject to disciplinary action under the Professional Psychologists Practice Act, Act of March 23, 1972 (P.L. 136, No. 52), *as amended,* 63 P.S. §§1201 – 1218 (Act), as charged in the Commonwealth's Seventeen-Count Amended Order to Show Cause (AOTSC), and revoked Respondent's license, imposed a civil penalty of $45,000 and assessed costs of investigation in the amount of $17,233.59. A Notice of Intent to Review was issued by the Board on June 28, 2019. Respondent filed a Brief on Exceptions to the Proposed Order on July 19, 2019. The Commonwealth filed a Brief Opposing Exceptions on July 24, 2019.

The Board, having reviewed the entire record, now issues this Adjudication and Order in final disposition of this matter.

The history of this case is set forth in the Proposed Order of the hearing examiner, which is incorporated herein and adopted at length.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

It is consistent with the Board's authority under the Act, and the Administrative Agency Law, 2 Pa. C.S. §504, for the Board to adopt the findings of fact, conclusions of law, and discussion of the hearing examiner if the Board determines that they are complete and supported by the evidence and the Act. The Board has reviewed the entire record of this case and has reached that conclusion. Accordingly, Findings of Fact Nos. 1-335, Conclusions of Law Nos. 1-11, and the entirety of the hearing examiner's discussion contained in the June 20, 2019, Proposed Order are hereby adopted by the Board. The hearing examiner's Proposed Order is appended hereto as Appendix "A."

The Board adds the following discussion to address Respondent's Exceptions.

DISCUSSION

In his Brief on Exceptions (BOE) filed July 19, 2019, Respondent excepted to "all" of the hearing examiner's Proposed Order. In support of his exceptions, Respondent "incorporated" his Post-Hearing Brief, and, without identifying any findings of fact or conclusions of law to which he specifically takes exception, maintains that the hearing examiner's findings and sanctions are not supported by fact or law. Respondent argues that the "seventy-three page [Proposed Order] summarily dismisses [his] defense in eight lines of text," and in its "cursory discussion" of the witnesses and exhibits presented by Respondent, merely references this evidence as mitigation, when the evidence was offered with the expectation that it would be considered as part of Respondent's defense to the charges lodged against him. (BOE, p. 6) Respondent then reiterates verbatim under the heading "Argument and Citations to the Record in Support of Respondent's Position," the same argument and citations to the record in support of his position as he argued in his post-hearing brief before the hearing examiner under the heading "Abstract of the Evidence

Relied Upon Assembled by Subjects."[1] Respondent essentially requests the Board to consider anew the same argument and citations to the record espoused by Respondent to the hearing examiner. The Board declines this invitation. The hearing examiner's Proposed Report is an extremely thorough analysis of the evidence that was presented during the 10 days of hearing. The hearing examiner did not summarily dismiss Respondent's defense; he accorded more weight and credibility to the Commonwealth's witnesses.

Further, as the Commonwealth responds, much of the Commonwealth's case consisted of expert testimony of Dr. Rhinehart regarding his review of medical records of inmates C.B., T.B., J.M., J.W., and B.P. *Respondent did not dispute any of the factual evidence contained in these medical records* which included dates that inmates received mental health treatment; progress notes by others, including psychiatrists; Respondent's own handwritten notes and signature on certain records; and the treatment, or lack thereof, provided to these inmates at various times.

Conversely, the testimony of Respondent and his witnesses focused on their opinion that Respondent was a caring administrator who carried out his professional duties and responsibilities in a professional manner consistent with policies of the Department of Corrections at SCI-Cresson. For example, then Deputy Superintendent Jamey Luther, who was Respondent's supervisor at SCI-Cresson, testified that Respondent received mostly "outstanding" ratings in his employee reviews. Respondent introduced these performance reviews into evidence in corroboration of this testimony. (Exhibit R-2) Secretary of Corrections, John Wetzel, similarly testified that following the Department of Justice investigation and report and the subsequent closing of SCI-Cresson, Respondent was not fired or demoted. Instead, Secretary Wetzel promoted Respondent to supervise other institutional Licensed Psychology Managers (LPM) because Respondent was "one

[1] Compare pages 1 through 25 of Respondent's BOE against pages 1 through 23 of Respondent's post-hearing brief.

of the best LPMs in [the] system." (N.T. 2455-56) Whether the hearing examiner considered this evidence as mitigating, or evidence in defense of the Commonwealth's charges, is largely a matter of semantics. The hearing examiner properly assessed this evidence and gave it the appropriate weight.

To that end, the Board is not impressed by the fact that Deputy Superintendent Luther gave Respondent outstanding ratings. Deputy Superintendent Luther is not a licensed psychologist and he is not bound by the Code of Ethics of the profession. His employment reviews of Respondent were boilerplate administrative Commonwealth Employee Performance Reviews based on his personal observations of Respondent's job knowledge, work habits and adherence to institutional policies. Similarly, Secretary Wetzel is not a licensed psychologist. Secretary Wetzel received an undergraduate degree in psychology from Bloomsburg University in 1998 and did master's level coursework in an applied psychology program at Penn State, Harrisburg. However, like Superintendent Luther, Secretary Wetzel is not bound by the Code of Ethics of the Profession.

In his role as SCI-Cresson's LPN, Respondent was responsible for the psychological care and mental health services that were provided to all inmates. As the *only* member of the psychology staff at SCI-Cresson who was required to hold a license to practice psychology, Respondent had an ethical responsibility to resolve any conflicts between his professional ethics and organizational demands, consistent with the General Principles and Ethical Standards of his profession. 49 Pa. Code §41.61 (Ethical Principle 3(e)). Respondent took no stand against the organizational demands at SCI-Cresson. As the hearing examiner aptly observed, "[b]ecause one of the most fundamental violations committed by Respondent was failing to reconcile the conflicts between his ethical duties as a psychologist with the demands of the prison

organization, very little weight can be given to positive employee evaluations from the Department of Corrections to mitigate the seriousness of Respondent's ethical violations. . . ." (Proposed Order, p. 72)

Moreover, many of Respondent's citations to the record in support of evidence that he relied upon in his Post-Hearing Brief to the hearing examiner and in his Brief on Exceptions hinge on witness credibility. For example, in his Exceptions, under the heading "State Correctional Institution Cresson," Respondent seemingly defends against the Commonwealth's charges in Counts Fifteen, Sixteen and Seventeen of the AOTSC by asking the Board to accord more weight to *his* own testimony than the collective testimony of Jamey Luther (Respondent's witness), Jonathan Uhler and Dr. Rhinehart (the Commonwealth's expert). Respondent testified that in his role as the Licensed Psychology Manager (LPM) at SCI Cresson, he had no ability; control over; discretionary authority; or decision-making power to transfer or move an inmate from one housing unit to another, including the decision-making power to place an inmate in a psychiatric observation cell (POC) or a mental health unit (MHU), or to decide if or when an inmate would be deprived of items such as clothing, food trays, a mattress, or toilet paper. Conversely, the collective testimony of Messrs. Luther and Uhler and Dr. Rhinehart reveals that, as the highest-ranking member of SCI-Cresson's psychology staff, Respondent:

- was responsible for using administrative systems of categorization and identification to ensure that each inmate received appropriate assessments and treatment (FOF No. 18);
- had the authority to make informed decisions in matters of housing, discipline and institution placement (FOF No. 21);
- was a member of SCI-Cresson's Management Review Team (MRT), which determined whether an individual would progress through the Secure Special Needs Unit (SSNU) program (FOF No. 22);

- was the chairman of SCI-Cresson's Psychiatric Review Team (PRT), which was tasked with reviewing inmates with serious mental health problems to discuss treatment, appropriate housing units, and to determine stability code changes (FOF No. 23).

The hearing examiner gave more weight in his factual findings and discussion to the collective testimony of Jamey Luther, Jonathan Uhler and Dr. Rhinehart. The Board agrees with this appraisal.

The evidence reveals that Dr. Seemuth, Ms. Christoff and Mr. Uhler each expressed concerns to Respondent on numerous occasions that the corrections officers' refusal to bring inmates to group or individual therapy interfered with their availability to provide adequate psychological services to them. These same individuals discussed with Respondent their concerns about the treatment of inmates, including concerns about inmate abuse and neglect, and the cleanliness of the inmate's food. Respondent acknowledged in testimony that it was a violation of Department of Corrections (DOC) policy not to allow inmates out of their cells to receive individual or group psychotherapy. Yet, rather than intervene as department head to ensure that inmates were receiving appropriate psychological services, Respondent's response to his subordinates was, "Let the officers do their job. It's part of the modification program. Let them do their jobs" (N.T. 72)." His response to concerns about the cleanliness of inmate food, was "If I didn't see it, it didn't happen." (N.T. 520-22, 762)

As the hearing examiner aptly acknowledged, "prison is an ugly place, especially for the mentally ill. And prison officials can view and react to bad behaviors of a mentally ill inmate, not just as symptoms of mental illness, but as disobedience that must be quelled, or danger that must be avoided." (Proposed Order, p. 68) Respondent was clearly caught in the crossfire between the negative consequences of SCI-Cresson's prison institution and his professional ethics. But he was aware through his subordinates that inmates were not being brought from their

cells for therapy. He was aware through his subordinates that inmates were being kept in inhumane conditions. He was aware through his subordinates that inmates were being deprived of clothing. Respondent was personally aware and participated in a Management Review Meeting (MRT) where inmate TP was led to, and entered, the meeting, naked. It was Respondent who personally instructed inmate TP to sing the nursery rhyme, "I'm a Little Teapot," at the MRT meeting, which served no therapeutic purpose whatsoever. This was the culture and philosophy of SCI-Cresson's prison system. This culture created ethical issues for the Respondent because the culture of the institution conflicted with the ethics of the profession. When a licensed psychologist is part of an organizational process or system that is dysfunctional, broken or corrupt, the *psychologist* has the ultimate responsibility, as an individual, to remain accountable to the standards of the profession. As a licensed psychologist, Respondent had a responsibility to take appropriate steps to resolve these conflicts consistent with the Code of Ethics. He failed to do so.

In his Exceptions, Respondent also appears to ask the Board to discredit the testimony of Ms. Christoff, Mr. Uhler and Dr. Seemuth, each of whom testified against him relative to the alleged inadequate psychological care or lack of psychological services provided to inmates C.B., T.B., J.M., J.W., and B.P,[2] because: 1) an internal DOC investigation was instituted regarding potential unethical behavior, maladaptive behavior and boundary violations between Ms. Christoff and another inmate; 2) Mr. Uhler's inability to separate personal beliefs from work requirements and his difficulty in maintaining proper boundaries with inmates and their families,

[2] In Counts One through Five of the AOTSC, the Commonwealth charged the Respondent with displaying gross incompetence, negligence or misconduct, in violation of section 8(a)(4) of the Act, 63 P.S. §1208(a)(4), for being responsible for substantially inadequate psychological care or lack of psychological services provided to these inmates. Similarly, in Counts Six through Ten of the AOTSC, Respondent is charged with unprofessional conduct, in violation of section 8(a)(11) of the Act, 63 P.S. §1208(a)(11), for being responsible for substantially inadequate psychological care or lack of psychological services provided to these inmates. The hearing examiner found, as to all ten counts, that Respondent displayed gross incompetence, negligence and unprofessional conduct, as charged.

resulted in a four-year history of disciplinary problems; and 3) beginning in Spring of 2011 and continuing through Fall of 2011, Dr. Seemuth also had a number of informal and formal disciplinary problems. Respondent also challenges the expert testimony and opinions expressed by Dr. Rhinehart as it related to the behavioral modification plan that was implemented for T.P.; the incident where Respondent instructed inmate TP to sing the nursery rhyme, "I'm a Little Teapot," at an MRT meeting; the inadequate treatment plans for J.M., J.W. and B.P.; and the failure to recognize risk factors attributable to the suicide deaths of inmates J.M., J.W. and B.P. However, at the outset of his Proposed Order, the hearing examiner resolved all issues of credibility in favor of these witnesses. The hearing examiner acknowledged:

> Respondent attempted to impeach the former DOC employees who testified against him by identifying various incidents of employee discipline. The hearing examiner finds that – even if they engaged in misconduct and employee discipline was proper – Ms. Christoff, Mr. Uhler and Dr. Seemuth were credible and persuasive witnesses. They were clear and consistent in their testimony despite vigorous cross-examination. Their testimony was consistent with their prior statements. And they persevered in telling the same facts despite the repeated difficult obstacles placed before them. Any conflict between their testimony and that of Respondent and his witnesses is resolved in favor of Ms. Christoff, Mr. Uhler and Dr. Seemuth. Additionally, the hearing examiner finds the Commonwealth's expert witness Dr. Rhinehart to be credible and persuasive in his explanation of the record and his opinions and credits those opinions, whether contradicted or not.
>
> (Proposed Order, p. 53)

The Board agrees with the hearing examiner's credibility determination. Since the Respondent's exceptions simply reiterate the same argument and citations to the record regarding inmates C.B., T.B., J.M., J.W., and B.P. as he did in his post-hearing brief, without pointing to any specific flaw in the hearing examiner's analysis, these Exceptions are rejected.

The only exception raised by the Respondent that was not part of his Post-Hearing Brief is his challenge to the sanction recommended by the hearing examiner. In his Proposed Order, the

hearing examiner recommended that Respondent's license to practice psychology be revoked; that Respondent be assessed a civil penalty of $45,000; and that Respondent be assessed costs of investigation in the amount of $17,233.59. Respondent argues that these sanctions are punitive.

When a licensee violates the Act, regulations and/or professional ethics of the profession, the Act permits the Board to levy a variety of sanctions against the licensee, ranging from a public reprimand to the revocation of the license. 63 P.S. § 1208(b). The Board is also authorized under section 11(b) of the Act, 63 P.S. § 1211(b), and Section 5(b)(4) of Act 48,[3] 63 P.S. § 2205(b)(4), to impose a civil penalty of up to $10,000 per violation of the Act. Additionally, Section 5(b)(5) of Act 48, 63 P.S. § 2205(b)(5), authorizes the Board to assess costs of investigation on a licensee who violates a provision of the Act.

The Board's primary responsibility is to protect the public. It follows that the primary focus of discipline must be public protection. *Galena v. Department of State*, 551 A.2d 676, 679-680 (Pa. Cmwlth. 1988). See also, *Sklar v. Dept. of Health*, 798 A.2d 268, 275 (Pa. Cmwlth. Ct. 2002), *appeal denied,* 845 A. 2d 819 (2004); *Galena v. Dept. of State,* 551 A. 2d 676, 679-80 (Pa. Cmwlth. Ct. 1988). In the profession of psychology, the public, within the context of professional ethics, includes clients, employees, students, subordinates, supervisees, people and groups with whom the psychologist works, professional colleagues in psychology and other professions, and human and animal research participants. The imprisoned mentally ill who are in need of mental health services and psychological treatment are part of the public that are deserving of the Act's protection. Subordinate psychologists and others acting under a licensee's supervision are part of the public that are deserving of the Act's protection.

[3] Act of July 2, 1993 (P.L. 345, No. 48), *as amended*, 63 P.S. §§ 2201-2207.

Respondent has failed in his responsibility to the public to practice the profession within the standards of the Act and the Code of Ethics of the profession. When asked if, with the benefit of hindsight, he would do anything different or direct his staff to do anything differently with respect to his management of the psychology department at SCI-Cresson and the psychological services or care provided to inmates C.B., T.B., J.M., J.W., and B.P., Respondent answered "no." Respondent's allegiance at SCI Cresson was with a correctional system that had its own standards and guidelines – not the psychology profession or the clients or the public served by the profession.

Revocation is a harsh sanction, because it represents a termination of the right to practice a profession without a promise of restoration at any future time. However, revocation is necessary when, like here, the offenses at issue are serious; the offenses are repeated and of prolonged duration; and lives were impacted by a psychologist's inadequate provision of psychological services and failure to practice consistent with the standards of the profession. Respondent failed to provide or ensure the delivery by his psychology team of needed psychological treatment and services to seriously mentally ill inmates. When notified by his subordinates of the goings on of the institution, Respondent turned a blind eye to these warnings. Three inmates successfully committed suicide on Respondent's watch. All three suicides, with appropriate intervention and psychotherapy, could have been prevented. Respondent also failed to take appropriate action when inmate threats were made to his subordinate psychologists. Revocation is therefore appropriate.

The Board also agrees with the hearing examiner that because the Commonwealth incurred costs of investigation in the amount of $17,233.59 prior to the filing of formal disciplinary charges against the Respondent, it is appropriate that Respondent be assessed those costs. However, the hearing examiner's recommended $45,000 civil penalty, coupled with revocation of a professional license, and costs of investigation, is penal in nature. The Board's primary responsibility and

objective when imposing professional discipline is public protection. The revocation of Respondent's license to practice psychology, and the assessment of costs of investigation, accomplishes that objective.

Wherefore the Board enters the following order:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF PSYCHOLOGY

Commonwealth of Pennsylvania	:	
Bureau of Professional and	:	
Occupational Affairs	:	**Case Nos. 11-63-05399**
	:	**11-63-05413**
v.	:	
	:	
James Dale Harrington, M.A.,	:	
Respondent	:	

FINAL ORDER

AND NOW, this 3rd day of December 2019, the State Board of Psychology, having duly convened and considered the entire record of this case, and based upon the findings of fact, conclusions of law, and discussion set forth at length in the hearing examiner's Proposed Order, hereby **ORDERS** that the license to practice psychology issued to Respondent, **James Dale Harrington, M.A., License No. PS005934L** is **REVOKED.**

It is further **ORDERED** that Respondent is assessed **COSTS OF INVESTIGATION IN THE AMOUNT OF $17,233.59.**

Payment of the costs of investigation shall be made by certified, cashier's or attorney's check or money order payable to "Commonwealth of Pennsylvania." Respondent shall pay the civil penalty and costs in full and deliver payment to:

Board Counsel
Bureau of Professional and Occupational Affairs
State Board of Psychology
P.O. Box 69523
Harrisburg, PA 17106-9523

Within ten (10) days of the Board's Final Order in this matter, the Respondent shall return his license, wall certificate and wallet card to:

Board Counsel
Bureau of Professional and Occupational Affairs
State Board of Psychology
P.O. Box 69523
Harrisburg, PA 17106-9523

A copy of the hearing examiner's Proposed Adjudication and Order is attached to this Order as **Appendix A.**

This Order shall take effect immediately. The sanction shall take effect in thirty (30) days.

BY ORDER:

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

K. KALONJI JOHNSON
ACTING COMMISSIONER

STATE BOARD OF PSYCHOLOGY

VITO J. DONGIOVANNI, PSY.D.
CHAIRMAN

For the Respondent:

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Date of Mailing:

December 3, 2019

APPENDIX A

COPY

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF PSYCHOLOGY

Commonwealth of Pennsylvania,	:	
Bureau of Professional and	:	
Occupational Affairs	:	
	:	
v.	:	**Case Nos. 11-63-05399, 11-63-05413**
	:	
James Dale Harrington, MA,	:	
Respondent	:	

PROPOSED ADJUDICATION AND ORDER

Thomas A. Blackburn
Hearing Examiner

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE OF GENERAL COUNSEL
DEPARTMENT OF STATE
OFFICE OF HEARING EXAMINERS
P.O. Box 2649
Harrisburg, PA 17105-2649

Date Distributed 6/20/19
Prosecution _____
Counsel ✓
BFO _____
Hearing Examiner _____
Other _____

HISTORY

This case comes before the State Board of Psychology ("Board") on an order to show cause filed October 20, 2016, against James Dale Harrington, MA ("Respondent"), charging that he is subject to disciplinary action under the Professional Psychologists Practice Act[1] ("Act"), because he committed various violations of the Act while he was the licensed psychology manager at the Pennsylvania Department of Corrections' facility SCI-Cresson. On May 5, 2017, Respondent filed an answer denying most of the factual allegations of the order to show cause and requesting a hearing.

By order dated June 30, 2017, the Board delegated this matter to a hearing examiner for the Department of State to hold a hearing and issue a proposed report in accordance with the General Rules of Administrative Practice and Procedure[2] ("GRAPP"). By Notice of Hearing issued July 14, 2017, the hearing was scheduled for January 22-24, 2018, at 2601 N. Third Street, One Penn Center, Harrisburg, Pennsylvania. By order dated September 21, 2017, the previously assigned hearing examiner scheduled a prehearing conference for December 15, 2017. On November 30, 2017, the parties jointly requested a continuance of the hearing. By order dated December 4, 2017, the hearing examiner granted the motion and rescheduled the prehearing conference for April 10, 2018 and directed that the hearing be rescheduled for May 7-9, 2018. On January 16, 2018, the Commonwealth filed an unopposed motion for continuance requesting that the hearing be continued until June 4-6, 2018. By order dated January 17, 2018, the hearing examiner granted this motion for continuance and rescheduled the hearing for June 4-6, 2018.

On March 2, 2018, Respondent filed a motion to dismiss certain counts of the order to

[1] Act of March 23, 1972 (P.L. 136, No. 52), *as amended*, 63 P.S. §§ 1201 – 1218.

[2] 1 Pa. Code §§ 31.1-35.251.

show cause to the extent that they are based upon aspirational goals in general principles of the preamble of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association. Respondent also filed a motion *in limine* to preclude use of the May 31, 2013, report of the U.S. Department of Justice investigation report related to the use of isolation and solitary confinement at SCI-Cresson. Respondent filed briefs supporting both motions. On March 23, 2018, the Commonwealth filed a brief in response to Respondent's motion *in limine*. The Commonwealth also filed a motion to extend the date for the scheduled hearing on the belief that two days of hearing will not be sufficient. On March 27, 2018, Respondent filed applications for subpoenas to be issued to the Department of Corrections for production of mental health and other records of inmates CB, JM, and TP, and for production of employment records of expected Commonwealth witnesses Carolyn Christoff, Marilou Seemuth, PsyD, and Jonathan Uhler. On March 29, 2018, the Commonwealth noted that it has no objection to Respondent's applications for subpoenas.

On April 6, 2018, Respondent filed his prehearing statement. Respondent indicated that he would not be presenting an expert witness. The Commonwealth also filed its prehearing statement on April 6, 2018. The Commonwealth identified its expert witness Walter L. Rhinehart, PsyD, and provided his report. The Commonwealth also identified a number of other witnesses including investigators for the Department of State. On April 20, 2018, Respondent filed a motion for discovery of the Commonwealth's expert's supporting documentation and a motion for discovery of the Commonwealth's witnesses' investigation materials and reports. By letter dated April 23, 2018, Respondent suggested that the Commonwealth's recitation of the case in its prehearing statement exceeded the scope of the order to show cause and requested a continuance in order to prepare to address these additional allegations of wrongdoing.

The hearing examiner conducted a prehearing conference during the afternoon of April 23, 2018. By order dated April 27, 2018, the hearing examiner granted the Commonwealth's motion to extend the hearing and rescheduled the hearing to commence on October 9, 2018, and run through October 17 and, if necessary, resume November 5, 2018 to run until concluded by November 9, 2018. The hearing examiner granted Respondent's motions for discovery and ordered disclosure of materials reviewed by the Commonwealth's expert. The hearing examiner denied Respondent's motion to dismiss and deferred ruling on Respondent's motion *in limine* to exclude the U.S. Department of Justice report. The hearing examiner granted the applications for subpoenas as revised for the new hearing dates. Finally, the hearing examiner scheduled another prehearing conference for September 11, 2018. On April 30, 2018, a notice of rescheduled hearing was issued for October 9-12 and 15-17, 2018.

The Commonwealth filed an amended order to show cause on June 29, 2018. The Commonwealth also filed an amended prehearing statement including a supplement to its expert's report. Respondent filed an answer to the amended order to show cause on August 21, 2018.

On August 15, 2019, Respondent requested a continuance of 90 days to permit further investigation and preparation necessary to address the additional allegations and charges of the amended order to show cause. On August 16, 2018, the Commonwealth filed its opposition to this request for continuance, vigorously objecting to further continuance and disputing that the amended order to show cause included additional unknown allegation or charges. On August 21, 2018, Respondent responded to the Commonwealth's opposition. By order dated August 21, 2018, the hearing examiner denied Respondent's motion for continuance.

On August 21, 2018, Respondent filed applications for subpoenas to be issued to the Department of Corrections for production of mental health and other records of inmates CB, TP,

JM, BP, and JW, and for production of employment records of expected Commonwealth witnesses Ms. Christoff, Dr. Seemuth, and Mr. Uhler. On August 22, 2018, the hearing examiner granted the application and issued the subpoena. On August 27, 2018, the Commonwealth filed an application for subpoenas *duces tecum* to be issued to the Department of Corrections for mental health and other records of inmates CB, TP, JM, BP, and JW and for any reports of investigations concerning Respondent including what it referred to as the "teapot incident." On August 28, 2018, the hearing examiner granted the application and issued the subpoena.

On September 12, 2018, Respondent filed a motion *in limine* to preclude reference to the U.S. Department of Justice report concerning SCI-Cresson and to preclude reference to settlement of a lawsuit against the Department of Corrections brought by the Disability Rights Network. Respondent also filed a motion *in limine* to exclude the supplement to the Commonwealth's expert witness's report. By order dated September 21, 2018, the hearing examiner denied the motion to exclude the Commonwealth's expert's supplemental report and denied the motion to exclude the U.S. Department of Justice report; the hearing examiner granted the motion to the extent it excluded the settlement of the lawsuit.

The hearing was held as scheduled beginning October 9, 2018, before the undersigned hearing examiner.[3] Respondent attended the hearing and was represented by Allen M. Tepper, Esquire. The Commonwealth was represented by prosecuting attorneys Heather J. McCarthy, Esquire and Bridget K. Guilfoyle, Esquire. The Commonwealth presented its case through documentary evidence and the testimony of Department of Corrections psychology staff former employees Ms. Christoff, Mr. Uhler, and Dr. Seemuth, as well as its expert witness Dr. Rhinehart through October 16, 2018. Respondent began his case in chief on October 16 and 17, 2018,

[3] Board member Steven K. Erickson, PhD, was present on October 9, 2018. Neither Dr. Erickson nor any other member of the Board was present for any of the other days of hearing.

presenting documentary evidence and the testimony of Department of Corrections psychology staff employees Timothy Poruban, PsyD, and Daniel Strum as well as former SCI-Cresson deputy superintendent Jamey Luther. The hearing resumed on November 6 and 7, 2018, with Respondent testifying on his own behalf and concluded on November 8, 2018, with testimony of the Secretary of Corrections John Wetzel.

Due to having multiple days of hearing, the first volume of notes of testimony was provided on November 6, 2018, before the hearing concluded. The prosecuting attorney noticed various discrepancies. (*See*, notes of testimony of hearing November 6, 2018, at 1985-87, filed November 27, 2018; notes of testimony of hearing November 8, 2018, at 2506-10, filed November 27, 2018[4]). Following a teleconference with counsel on January 18, 2019, on January 22, 2019, the hearing examiner ordered that various errors in the notes of testimony be corrected and supplied an omitted exhibit. By separate order on January 22, 2019, the hearing examiner set a briefing schedule. The corrected hearing transcript ("N.T.") was filed on February 14, 2019. The Commonwealth then filed its post-hearing brief on March 8, 2019, and Respondent filed his post-hearing brief on April 18, 2019. By letter dated April 22, 2019, the Commonwealth indicated it would not be filing a reply brief, thus closing the record.

[4] In the corrected notes of testimony, this is found at N.T. 1985-87, 2506-2510.

FINDINGS OF FACT

1. Respondent holds a license to practice psychology in the Commonwealth of Pennsylvania, license no. PS005934L. (Exhibits C-1 and C-2 at ¶ 1; Official notice of Board records[5])

2. Respondent's license was originally issued on February 27, 1991, is current through November 30, 2019, and may be renewed, reactivated, or reinstated thereafter upon the filing of the appropriate documentation and payment of the necessary fees. (Exhibits C-1 and C-2 at ¶ 2; Board records)

3. At all relevant times, Respondent held a license to practice as a psychologist in the Commonwealth of Pennsylvania. (Exhibits C-1 and C-2 at ¶ 3; Board records)

4. SCI-Cresson was a medium security all male correctional facility in operation from approximately 1987 to June 2013. (N.T. 1854, 1949, 2455)

5. During this period of time, SCI-Cresson had beds for approximately 1,600 inmates. (N.T. 858, 1957, 2006)

6. SCI-Cresson had three isolation unites where inmates were housed in solitary confinement for various reasons, including the Restricted Housing Unit (RHU), the Secure Special Needs Unit (SSNU) and the Psychiatric Observation Cells (POC). (Exhibit C-4 at 5, N.T. 860-63)

7. Inmates were housed in RHU for violating prison rules, threatening the security of others, or to protect them from significant threats to their own safety, and were in isolation for 22 to 23 hours per day with severe restrictions placed upon their ability to engage in basic activities. (Exhibit C-4 at 5, N.T. 860-61)

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[5] Official notice of the Board's records may be taken pursuant to GRAPP, 1 Pa. Code § 35.173, which permits the presiding officer to take official notice of the Board's own records. *See, Gleeson v. State Bd. of Medicine*, 900 A.2d 430, 440 (Pa. Cmwlth. 2006), *appeal denied*, 917 A.2d 316 (Pa. 2007). All citations to "Board records" are based on this taking of official notice.

8. Inmates housed in the SSNU were those who had serious mental illness, had previously had a number of placements in RHU, and/or would have otherwise been housed in the RHU except for their mental illness. (Exhibit C-4 at 5, N.T. 861)

9. The SSNU was intended to be a therapeutic unit designed to address the serious mental health needs of prisoners who also required a more secure environment, and inmates in SSNU were in isolation for 22 to 23 hours per day. (Exhibit C-4 at 5, N.T. 861, 886)

10. SCI-Cresson housed inmates who experienced severe mental health difficulties, including mental decompensation to the point of becoming a danger to themselves, other inmates or property, in one of several POC cells, which were intended for short term usage though inmates were confined to the POC for up to 24 hours per day. (Exhibit C-4 at 6, N.T. 863)

11. SCI-Cresson also had two specialized housing units that were not isolation units – the Mental Health Unit (MHU) and the Special Needs Unit (SNU). (Exhibit C4 at 6, N.T. 862)

12. MHU housed inmates in need of short-term inpatient medical care and received admissions of inmates via the Pennsylvania commitment process. (Exhibit C-4 at 6)

13. The SNU housed inmates who, as a result of their mental illness or other disability, are vulnerable and require additional support and/or protection and is considered to be general population in terms of security operations, permissible property, and out-of-cell time. (Exhibit C-4 at 6, N.T. 862-63)

14. SCI-Cresson also housed prisoners in general population and in a sex offended unit. (N.T. 863, 1951)

15. The Department of Corrections ("DOC") classified inmates according to their mental health stability using codes of mental health roster levels A, B, C, and D based upon an inmate's mental health history and/or stability that determined the level of psychological and

psychiatric services afforded to the inmate as follows: Inmates with stability level code A had no mental health history and no present mental health concerns. Inmates with stability level code B may have had mental health concerns at one time but were no longer actively monitored and on SC-Cresson's mental health roster. Inmates with stability level code C had mental health needs and were on SCI-Cresson's active mental health roster. Inmates with stability level code D were seriously mentally ill and possibly intellectually disabled, currently decompensating or had decompensated to the point of becoming a D stability code and requiring frequent monitoring and a high level of psychological and psychiatric services for their mental health needs. (N.T. 274, 865-68, 1161, 1865-66)

16. All inmates with stability code C or D were placed on SCI-Cresson's active mental health roster; in order to be housed in SSNU, the inmate had to have a stability code D. (N.T. 273-74)

17. Respondent was the Licensed Psychology Manager ("LPM") at SCI-Cresson from 1993 until just prior to its closing in 2013. (Exhibit R-1, N.T. 1859, 1992)

18. LPM is a civil service title for the chief psychologist with a prison, whose duties include taking part in various team meetings related to mental health care, using administrative systems of categorization and identification to ensure that each inmate receives appropriate assessments and treatment, ensuring that a psychology staff member assesses each newly received inmate, supervising and training the psychological services specialists ("PSSs") and being generally responsible for mental health services for inmates in prison. (N.T. 231, 870-78, 1865-66)

19. The LPM was the "chief psychologist" as SCI-Cresson and the highest-ranking member of its psychology staff. (N.T. 231, 499, 868, 878, 880-81)

20. The LPM was the only member of the psychology staff at SCI-Cresson required to hold a state license to practice psychology. (N.T. 878, 880-81)

21. As LPM, Respondent had the authority to develop programs, training and supervise staff, and provide specialized psychological information to make informed decisions in matters of housing, discipline and institution placement. (N.T. 872, 1559, 1864, 1870, 1922, 1969-70)

22. Respondent was a member of SCI-Cresson's Management Review Team ("MRT"), a weekly team meeting consisting of members of various disciplines within the prison who would meet to discuss individuals in the SSNU, their treatment, behaviors, privileges and compliance with the program; the MRT determined whether an individual would progress through the SSNU program. (N.T. 78, 886, 1868, 1878)

23. SCI-Cresson also had a Psychiatric Review Team ("PRT"), chaired by Respondent and attended by members of the psychology, psychiatry and unit staff who were tasked with reviewing inmates with serious mental health problems to discuss treatment, appropriate housing units, and to determine stability code changes. (N.T. 884, 1046, 1778, 1867)

24. Respondent had a supervisor at SCI-Cresson; however, his supervisor was not a psychologist. (N.T. 880, 1861)

25. There was no higher authority on psychological services within SCI-Cresson than Respondent. (N.T. 880, 1861, 2183)

26. In 2011, six PSSs worked under Respondent's supervision, including Carolyn Christoff, Jonathan Uhler, and Dr. Marilou Seemuth. (N.T. 500, 506)

27. Carolyn Christoff was a member of the psychology staff at SCI-Cresson from October 2007 to June 2011 and came to the role with a bachelor's degree in psychology, a master's degree in special education rehabilitation science, and more than 20 years of experience in the

mental health field, not in a correctional setting. (N.T. 52-54, 110-14)

28. Jonathan Uhler was a PSS at SCI-Cresson from January 2005 to October 2012 and came to the role with a bachelor's degree, a master's degree in counselling and more than 12 years of experience in the mental health field, not in a correctional setting; Mr. Uhler is a licensed professional counselor in Pennsylvania. (N.T. 203, 208-11, 216)

29. Dr. Marilou Seemuth was a PSS at SCI-Cresson from June 2009 to November 2011 and came to the role with a bachelor's degree, a master's degree in art therapy, a doctorate in psychology and almost 20 years of experience in the mental health field, not in a correctional setting. (N.T. 486-87, 489-91, 493)

30. Following its announcement in December 2011 that it would do so and its March 2012 on-site investigation of the conditions of confinement at SCI-Cresson, on May 31, 2013, the United States Department of Justice, Civil Rights Division, (DOJ) issued a report concluding that conditions at SCI-Cresson violated the Civil Rights of Institutionalized Persons Act and the Americans with Disabilities Act regarding the rights of prisoners with serious mental illness and intellectual disability. (Exhibit C-4)

31. DOJ completed its statewide investigation into the DOC's use of solitary confinement on prisoners with severe mental illness and intellectual disabilities and on February 24, 2014, issued a second report, followed by a third report on April 14, 2016, closing its investigation. (Exhibits C-5 and C-6)

32. The Commonwealth's expert witness Walter Rhinehart, PsyD, is a licensed psychologist in Pennsylvania (licensed since 1982) who holds a bachelor's degree in psychology, a master's degree in clinical psychology, and a doctorate of psychology in clinical psychology (obtained in 1988). (N.T. 779, 782-83, exhibit C-8)

33. From 1991-2012 Dr. Rhinehart worked as a psychologist and as the chief psychologist (1992-2012) at the Federal Correctional Institution, McKean, a medium-security all-male prison in Lewis Run, Pennsylvania, which houses approximately 1,300 inmates with a 300-bed adjacent satellite camp. (N.T. 787-93, 812, 842, exhibit C-8)

34. As chief psychologist, Dr. Rhinehart was generally responsible for mental health care at the prison. His duties included providing direct clinical services on a daily basis (including individual and group therapy); assessing or having assessed every entering inmate; maintaining a program on mental health services; being the mental health coordinator; contracting with psychiatrists; teaching staff about suicide prevention, mental illness and hostage survival; placing inmates on suicide watch and removing them; performing rounds in the special housing units; consulting with psychiatrists and other medical professionals; performing intellectual evaluations and neuropsychological evaluations on inmates referred to him from the education department; training and supervising several staff members; and various other special projects including chairing the affirmative action committee, running the employee assistance program, and performing evaluations for the witness security program, hostage negotiation and service as the acting warden. (N.T. 794-809)

35. As chief psychologist, Dr. Rhinehart supervised up to two doctoral level psychologists, up to six treatment specialists (bachelor's to master's level individuals), a psychology technician, as well as chaplaincy services. This supervision of the psychology staff included instruction on ethical issues. (N.T. 797-98, 803-05)

36. During his tenure with the federal prison system, Dr. Rhinehart also performed program reviews at three other federal prisons: the Atlanta Penitentiary, FCI-Fairton (New York), and FCI-Elkton (Ohio); and acted as chief psychologist at FCI-Loretto (Pennsylvania) while a

colleague was away. (N.T. 806-08, 833)

37. In preparation for his review of this case and testimony, Dr. Rhinehart reviewed numerous materials, including the medical records of 5 inmates; all the materials he reviewed are those which are generally relied upon by experts in his field. (N.T. 851-58, 871)

38. Dr. Rhinehart was tendered and qualified as an expert in the fields of general psychology, mental health treatment in the corrections setting, suicide prevention in the correctional setting, ethics in the profession in particular in the corrections setting, supervision of other psychologists and psychology staff members in the corrections setting, and working with and coordinating with different mental health professionals in the corrections setting. (N.T. 825, 848-51)

39. Dr. Rhinehart was first contacted and began to consult on this case in 2013 and produced a written report on June 30, 2016, and a supplemental report in June 2018. (N.T. 781, 1269-81, exhibits C-9 and C-12)

40. Dr. Rhinehart's opinions were rendered within a reasonable degree of certainty in the field of psychology. (N.T. 978, 1043-44, 1124, 1198-99, 1261, 1269)

41. Suicides do happen in prison, but some are preventable, and suicide prevention is an issue that should always be on the mind of a psychologist providing psychology services to prison inmates. (N.T. 900)

42. For suicide prevention, it is safer to house inmates in double cells rather than in single cells. (N.T. 792)

43. Bipolar disorder is a severe axis II disorder and is a high-risk disorder in terms of risk of suicide. (N.T. 927, 947-49)

44. Restricted housing placement is a risk factor for suicide, especially when the RHU

inmate is single-celled and the person is depressed or has a mental illness. (N.T. at 1169)

45. According to a study of the New Jersey Department of Corrections, inmates who were single celled in an RHU had significantly higher risk of suicide than those housed in a double cell in general population. (N.T. 1169)

46. An inmate "checking in" (asking to be admitted) to RHU or special housing unit is a sign or symptom of mental illness and is a concern of potential suicide risk. (N.T. 1176)

47. DOC policy 13.8.1 recognized the potential for suicide and listed several risk factors that employees should be aware of; one listed factor is an inmate's sudden elevation in mood. (N.T. 881-82)

48. The DOC standard form suicide risk checklist completed quickly with the inmate was not an adequate assessment of risk of suicide. (N.T. 1557-59)

49. CB was an inmate at SCI-Cresson in 2011 when he was 23 years old. (N.T. 903, 911)

50. CB had previously been an inmate at CI-Cresson, was an "SSNU failure" and returned to SCI-Cresson on April 21, 2011 with a recent history of self-harm. (N.T. 946-47, 2301)

51. CB had a very difficult upbringing and significant mental health history, including mental health diagnoses of schizophrenia, borderline personality disorder, antisocial personality disorder, substance abuse disorder, malingering, psychosis, impulse control disorder, not otherwise specified, post-traumatic stress disorder, substance abuse disorder in institutional remission including alcohol, cannabis and opiates. (N.T. 903-10)

52. On April 27, 2011, psychiatrist Dr. Eidsvoog referred CB to the psychology department requesting therapy for CB for harm reduction, self-abuse and cutting; she requested psychology to "please see regularly." (N.T. 912-14)

53. On April 28, 2011, Respondent specifically directed Mr. Uhler not to spend extended time with CB or provide him with reading material. (N.T. 304-07)

54. On May 5, 2011, Respondent denied Dr. Eidsvoog's referral, writing, "Inmate CB is being monitored by psychology and counseling staff. Mental issues are attended to. Should self-harm become evident, more intensive intervention is available. PRT recommend continue routine intervention. Primary complaints focus of establishing legal complaints." (N.T. 912-14)

55. On May 2, 2011, CB claimed to psychology that the psychiatrist recommended weekly therapy, but CB was told his contact would only be monthly while in the RHU. (N.T. 915-16, 920-22)

56. On May 5, 2011, in response to referral for recommended therapy the PRT meeting summary form was completed and signed by Respondent among others; Respondent wrote, "psychotherapy is not indicated. BFD [borderline personality disorder] is the prevailing issue. He is very manipulative" and CB's next review would be "annual." (N.T. 922-27, 2303-04, exhibit C-20)

57. To the contrary, psychotherapy is used to treat borderline personality disorder and was indicated in CB's case. (N.T. 927, 947-49, 2307-08)

58. Respondent's opinion that psychotherapy was not indicated for CB was grossly inaccurate as this is the treatment of choice for that disorder. (N.T. 946, 2303-04)

59. After again demanding to psychology staff on May 9, 2011, that he be seen weekly and was against told he would only be seen monthly, CB became belligerent and eventually spoke to Respondent directly demanding more than monthly contact with psychology staff. When Respondent informed him that his contact would be only monthly, CB threatened Respondent, and upon CB escalating that threat by announcing Respondent's city and zip code of residence and

license number Respondent requested a separation transfer from CB due to the threats. (N.T. 927-31, 2355-56, exhibit R-15 at 7)

60. The May 9, 2011, interaction with CB displayed that Respondent experienced countertransference with CB, including anger and frustration, and Respondent's decision for CB to receive only monthly psychological treatment rather than weekly as requested by CB and the psychiatrist and appeared based on his inappropriate opinion that borderline personality disorder is not amendable to psychotherapy. (N.T. 933, 944-47)

61. Respondent's decision to have the psychology department see CB only one time per month was inappropriate treatment; the DOC policy requiring stability D inmates to be seen by psychology every 30 days was a minimum standard and did not prevent inmates from being seen more frequently, as other inmates at level D were. (N.T. 946-47)

62. CB was seen by Dr. Eidsvoog on May 11, 2011, and he threatened her; Dr. Eidsvoog's notes reflect a risk of self-harm for CB. (N.T. 934-35)

63. On May 25, 2011, Mr. Uhler was CB in POC where he was held for ingesting a large quantity of antacids in a self-harm attempt. CB was highly agitated, said he "can't take it anymore in the RHU without treatment," verbalized feeling suicidal, and repeated his request for more psychological treatment. (N.T. 953-55)

64. On May 25, 2011, the psychiatrist described CB's condition on May 18, 2011, as micro-psychosis, stating he was seen earlier in POC and had dangerous levels of impulsivity and ordered, since he was returning to RHU and had a risk of self-harm, only basic items for his safety. (N.T. 949-952)

65. On June 1, 2011, CB was again seen by a psychiatrist in the POC, and his medication was adjusted. (N.T. 956-59)

66. On June 13, 2011, Respondent signed an Individual Treatment Plan for CB that listed problems and goals as "medication compliance" and treatment objectives as "Inmate will take all prescribed medication measured by the non-compliance list" and indicated that psychology would treat CB monthly. (Exhibit C-21, N.T. 959-61)

67. The psychological treatment reflected in the June 13, 2011, treatment plan signed by Respondent was inadequate. (N.T. 961)

68. On June 14, 2011, psychology began to see CB weekly. (N.T. 961-62, exhibit R-15 at 5-6)

69. On June 14, 2011, PSS Strom noted the CB had homicidal ideation, flat affect, was grossly impaired, illogical, fragmented, and confused. (N.T. 962-63)

70. On June 17, 2011, Dr. Seemuth observed CB in a "camera cell" (where corrections officers could monitor him by camera); part of his cell was covered with a blue plastic tarp by Sgt. Fox, an act that would obstruct the camera's view of CB. CB yelled "They just want me to hurt myself" and Dr. Seemuth immediately notified Respondent and the unit manager of the situation. (N.T. 531-33, 963-64, exhibit R-15 at 5)

71. In response to this incident, Respondent told Dr. Seemuth she should have asked Sgt. Fox why he was doing that. (N.T. 533)

72. Respondent subsequently chastised Dr. Seemuth for, among other things, making entries in the inmate record system that "included statements made by another unnamed inmate, inappropriately included a lengthy narrative that alludes staff behaved inappropriately and insinuates that inmate was abused with no indication that a chain of command was made aware except an indication that the inmate was seen by the medical department." (Exhibit R-7 at 12)

73. Respondent's response to this dangerous incident in which CB was at great risk of

self-harm was inadequate. (N.T. 965-67)

74. There was no appropriate clinical reason why a camera view should have been obstructed. (N.T. 967)

75. On June 22, 2011, CB was covered in feces, rambling, and throwing things at staff. (N.T. 967-68)

76. On July 4-5, 2011, CB attempted suicide by hanging. (N.T. 968-69)

77. Respondent personally saw CB on July 6, 2011, following his suicide attempt. (N.T. 970-72, exhibit C-22)

78. On September 27, 2011, a PRT meeting occurred regarding CB, and a decision was made to upgrade CB from the D roster to the C roster; psychology staff member PSS Martinez noted her comments as "Discharged to C roster. No suicidal ideation. No need for D roster." (N.T. 973-75)

79. The upgrading of CB's status from stability roster D to C was grossly negligent and inappropriate. (N.T. 975-76)

80. By October 2011, CB was transferred to another correctional institution. (N.T. 976-77)

81. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of care with regard to CB. (N.T. 977)

82. Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care regarding CB. (N.T. 978)

83. In 2011 TP was a 43-year-old inmate at SCI-Cresson who had an intellectual disability and other mental health conditions. (N.T. 980-81, 1465, 2266-67)

84. TP was incarcerated for committing a homicide by killing 4 people in a fire as a juvenile. (N.T. 983, 1464-65)

85. TP was transferred to SCI-Cresson in 2009; he was diagnosed with schizophrenia, a history of drug and alcohol use, and a motor vehicle accident with head trauma; TP had a history of depression, suicide attempts, and self-mutilation; TP had also been the victim of sexual abuse in the prison system. (N.T. 988-90, 1009)

86. TP's IQ was reported to be approximately 68-70, although there was no IQ examination report in TP's medical record reviewed by Dr. Rhinehart. (N.T. 980-81)

87. TP was dangerous, impulsive, agitated and difficult to manage. (N.T. 980-85)

88. At times TP was amenable to treatment at SCI-Cresson. (N.T. 985-86)

89. The DOC used the Wechsler Adult Intelligence Scale, Revised (WAIS-R), an older version of the intelligence test that had been revised twice since then and was inappropriate to use in 2000. (N.T. 981-82)

90. There was no evidence that TP had ever had an individual IQ test at SCI-Cresson. (N.T. 982)

91. Respondent's mocking of TP in February 2010, saying "please don't mess up my 43 IQ" is problematic because either TP's IQ is significantly lower than the 70 reported or it is denigrating of a client. (N.T. 1015, 2268, exhibit C-4 at 20)

92. On December 24, 2010, TP was placed in POC for tying a T-shirt around his neck. (N.T. 992-94)

93. On January 28, 2011, TP was placed in POC for thoughts of drowning himself in the toilet. (N.T. 992-94)

94. On dates including January 31, 2011 through February 11, 2011, TP was housed in

POC. (N.T. 990-91)

95. On February 15, 2011, Dr. Eidsvoog treated TP and diagnosed him with schizoaffective disorder, borderline type, counseled TP with alternate ways to deal with frustration and anger and adjusted and made notes of his medications. (N.T. 992-94)

96. In the January to March 2011 time frame TP received a number of misconducts – for conduct such as yelling and kicking a door – which appeared to lead up to the implementation of a "behavioral modification plan." (N.T. 994-99, exhibit R-14 at 7-8)

97. Beginning about March 21, 2011, the staff at SCI-Cresson attempted to manage TP by using a behavior modification plan. (N.T. 985, 997-1000, 2270-71, exhibit C-15)

98. With some input from others, Respondent authored the behavior modification plan. (N.T. 1930-32, 2270-71)

99. The behavioral modification plan called for removal of all property other than an anti-suicide smock and food loaf from March 18-23, 2011; if TP behaved, he would then get a regular meal tray and an anti-suicide blanket; with positive adjustment by March 28 he could be given a jumpsuit and boxers; with continued positive adjustment on March 30 he could be given a mattress and pillow; with continued positive adjustment on April 4 he could be given socks, shoes and bed linen; and on April 6 with full return to functional and appropriate behavior he could be given all authorized property. (Exhibit C-15, N.T. 997-1001, 2271-72)

100. Consistent with this behavioral modification plan, TP did not have a mattress for at least a week and a half. (N.T. 254-55, 466, 549, 1000-01)

101. Despite instituting this harsh behavioral modification plan, Respondent did not believe that any additional intervention by psychology was necessary. (N.T. 2275-76)

102. The behavioral modification plan also states that TP would continue to have

"regular contact" with psychiatry and psychology and SSNU management review team. (N.T. 1002, exhibit C-15)

103. Nevertheless, TP did not receive psychological treatment during this time. (N.T. 2278-83, exhibit R-14 at 7)

104. The behavioral modification plan failed to adequately respond to TP's behaviors and provide adequate or appropriate treatment. SCI-Cresson did not have an adequate assessment plan about what was driving TP's behavior to all them to initiate a plan to change it. The plan was harsh and inappropriately punitive and, evidenced by the lack of evaluation leading up to it, the inclusion of food loaf and the plan to take the mattress away for 12 days. (N.T. 1005-11, 1018-21, 1033-36)

105. Respondent or other psychology staff should have done psychological evaluations of TP including IQ testing and other tests, such as the MMPI. (N.T. 1007-08)

106. In April 2011, PT was admitted back into POC. (N.T. 1010)

107. On May 11, 2011, psychiatrist Dr. Rathore saw TP, who was very ill, decompensated and had regressed in functioning; TP had smeared feces all over himself, had a lack of motivation and was unkempt; TP demanded a transfer and POC admission. (N.T. 1011-12)

108. On May 25, 2011, TP was housed in the POC for threatening suicide with a toothbrush. (N.T. 1013-14)

109. In July 2011, TP decompensated further. On July 2 TP tied a sheet around his neck after other prisoners told him to do so; on July 5 he was found banging his head on the ell wells. SCI-Cresson responded by placing him in a restraint chair for 10.5 hours in the concrete observation cell. After being released from the restraint chair SCI-Cresson kept TP in the concrete

cell without a mattress wearing only a smock for six days. A mental health staffer who was allowed to visit him at that time reported that TP's condition had deteriorated to the point of him having virtually no ability to lift himself up or talk. On July 13 TP refused to wear his suicide smock, attended review meeting naked, and later smeared feces in his cell while naked. SCI-Cresson transferred him out of the facility three weeks later in August 2011. (Exhibit C-4 at 19-20, N.T. 1014-18, 2289-90)

110. Restricting TP's ability to receive psychological treatment was inappropriate and prolonged his difficulties. (N.T. 1018-20)

111. Allowing TP to attend an MRT meeting naked was abusive. (N.T. 1021)

112. Respondent led the MRT meeting. (N.T. 1021)

113. From January to July 2011 Respondent was not very involved with TP other than authoring the behavioral modification plan. There is no record that Respondent visited with TP directly, provided any therapeutic support or made notes himself as far as what treatments were tried or the progress of any treatment. (N.T. 1021)

114. TP's case was very challenging, and it was one that the head psychologist should have been involved in. (N.T. 1021-22)

115. TP showed some improvement once he left SCI-Cresson. In August 2011, at a different institution TP showed positive behavior. In November 2011, at a different institution TP received psychological treatment daily. (N.T. 552, 554-55, 1022-24)

116. During an MRT meeting at SCI-Cresson, Respondent instructed TP to sing the nursery rhyme "I'm a Little Teapot." (N.T. 80-82, 134, 136, 267-70, 540-43, 2293, exhibit C-32 at 16-17)

117. Making TP sing was humiliating to the inmate. (N.T. 80-81, 268-69, 2291-94)

118. Mr. Uhler was so disgusted by Respondent instructing TP to sing the teapot song that he got up and left the room. (N.T. 68)

119. Dr. Seemuth was uncomfortable watching TP try to sing this nursery rhyme. (N.T. 543)

120. There was no value from a clinical psychological standpoint of having TP sing the teapot song as apart of a review team meeting to discuss the inmate's status in the program. (N.T. 543)

121. Making TP sing the teapot song in a demeaning way and for the entertainment value of the staff was unprofessional conduct. (N.T. 541-43, 1031-33)

122. Dr. Seemuth, Mr. Uhler and Ms. Christoff notified Respondent that they were concerned about the treatment of TP that they considered abusive, but Respondent failed to respond appropriately to their concerns. (N.T. 1036-38)

123. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of care with regard to TP. (N.T. 1038-39, 1043-44)

124. Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care regarding TP. (N.T. 1039, 1043-44)

125. Respondent committed gross incompetence, negligence or misconduct by failing to act appropriately in response to reported concerns of abuse regarding TP. (N.T. 1039, 1043-44)

126. JM was an inmate at SCI-Cresson for approximately 10 weeks from March 1, 2011 to May 7, 2011. (N.T. 1042)

127. JM completed suicide at SCI-Cresson on May 6-7, 2011. (N.T. 1042)

128. JM was 42 years old at the time of his death. (Exhibit C-3 at 12)

129. JM had served 8 years into a 5 to 11 year sentence. (N.T. 1068)

130. JM's mental health diagnoses included schizophrenia, delusional disorder, auditory hallucinations, narcissistic personality disorder, and polysubstance abuse in remission. (N.T. 1044-47, 1054-55, 1066)

131. On December 3, 2010, JM's condition at SCI-Frackville before transfer to SCI-Cresson was that he had schizophrenia and delusional disorder, swings quickly, accuses corrections officers of conspiring to kill his mother, had projections, and was suspicious and paranoid. (N.T. 1044-45)

132. On December 8, 2010, SCI-Frackville staff recommended that time be cut off of JM's disciplinary segregation due to his mental illness. (N.T. 1045-46)

133. On January 5, 2011, SCI-Frackville staff recommended that JM be housed in the SNU, but if that was unsuccessful, he should be sent to an intermediate care unit, which was a higher level of care due to his illness. (N.T. 1047-49)

134. On February 28, 2011, SCI-Frackville staff had a phone conference with SCI-Cresson staff, including Respondent and PSS Deena Martinez, regarding JM's transfer; the SCI-Frackville staff informed the SCI-Cresson staff of JM's diagnoses and transfer. (N.T. 1053-55)

135. Mental health and medical records would accompany an inmate who was transferred from one correctional institution to another. (N.T. 1045)

136. On March 3, 2011, SCI-Cresson PSS Metrick evaluated JM, who denied problems or reservations with population, denied medication, denied suicidal ideation; Ms. Metrick observed no impairment and wrote that psychology would "continue regular contact," and JM remained a stability code D and was housed in RHU. (N.T. 1055-57)

137. On March 2, 2011, the PRT, including Respondent, conducted an administrative

review of JM and concluded he was in "administrative custody pending recommendation from the psychiatric review team" to place him in general population. (N.T. 1060-62)

138. This conclusion was very concerning in light of JM's stability code D, his very serious diagnoses, and the housing recommendations from SCI-Frackville. (N.T. 1062-63)

139. On March 9, 2011, Dr. Eidsvoog saw JM and recognized serious psychopathology including diagnoses of being psychotic with delusional disorder, personality disorder, paranoia, and narcissistic features; JM admitted prior thoughts of overdosing, was guarded, had obvious paranoia and auditory hallucinations over the intercom. (N.T. 1065-68)

140. On March 11, 2011, JM broke his hand by punching a wall. (N.T. 1068-71)

141. Also on March 11, 2011, JM threatened to hang himself and tried to cover his cell window. (N.T. 1070-71)

142. On March 16, 2011, JM assaulted officers and was pepper sprayed. (N.T. 1071-74)

143. On March 21, 2011, JM consented to receive care by psychology. (N.T. 1074)

144. On March 22, 2011, psychology staff member PSS Martinez recorded that JM – then in the RHU – had "no mental health concerns." (N.T. 1074-75, exhibit R-16 at 1)

145. On March 28, 2011, a corrections officer referred JM for mental health services, stating JM was "highly explosive in temperament. Pacing. Uncontrolled yelling. Highly paranoid. Very unstable and disoriented with daily operations. Thinks staff (all) trying to contact his family … wants matter solved or will deal with it on a personal level. Is he med compliant?" (N.T. 1076-77)

146. A response signed by PSS Martinez stated, "inmate is a new reception. He is not taking meds" and "inmate was seen by psychiatry on March 30, 2011. Doesn't like taking meds.

Current restricted housing." (N.T. 1077-78)

147. On March 30, 2011, JM saw psychiatrist Dr. Eidsvoog and was more ill, psychotic, and delusional. JM still refused any antipsychotic medication. (N.T. 1079-81)

148. On March 31, 2011, Mr. Uhler reviewed the standard form suicide checklist with JM, noted no risk factors and "no action needed at this time." (N.T. 1081-82)

149. Assessments of JM by psychology up to this point in March 2011 were inadequate as psychology was aware of JM's severe mental illness even before his arrival, SCI-Frackville's recommendation to cut his time because he was so ill, Dr. Eidsvoog's observations of JM's severe, worsening mental illness and delusions, and JM's actions in injuring his hand by punching a wall, threatening to kill himself, trying to cover the cell window, and assaulting staff. (N.T. 1057-58, 1064-65, 1075-84)

150. Respondent, as LPM, was permitted to delegate certain tasks, but that did not relieve him of the responsibility to ensure that the tasks were completed correctly. (N.T/ 1078-79)

151. On April 6, 2011, JM was back in RHU and threatened self-harm, banging his head on the wall and kicking the cell door; JM further stated, "If you aren't a psychologist, I don't want to talk to you. I am going to kill myself." (N.T. 1084-85)

152. JM was taken to a POC where he was housed from April 6-8, 2011. (N.T. 1084-86)

153. Psychology staff did not assess JM during his time in the POC from April 6-8, 2011; upon discharge, JM returned to RHU. (N.T. 1086-87)

154. April 8, 2011 was a Friday. (N.T. 2505)

155. Psychology staff should have assessed JM prior to his return to RHU. (N.T. 1087)

156. On April 14, 2011, an individual treatment plan was created for JM and was signed

by Respondent, PSS Metrick and others. (N.T. 1087-88, exhibit C-23)

157. The individual treatment plan listed two problems and goals: medication compliance and maintain stability; treatment objectives were to "take all medication as prescribed measured by non-compliance list" and "follow rules/regulations [with] no misconducts [and] communicate appropriately with staff;" frequency of treatment by psychology was marked as "other" as opposed to daily, weekly, or monthly. (N.T. 1086-90, exhibit C-23)

158. The individual treatment plan was inadequate. JM was not taking medication, was psychotic, assaultive, threatening suicide, self-harming and had just been released from a psychiatric observation cell. (N.T. 1090-91)

159. The psychology department failed to meaningfully assess JM, failed to notice his severe mental illness (despite the phone conference with SCI-Frackville and despite psychiatry's observations), and failed to treat him. (N.T. 1090-93)

160. The psychology department abandoned its role with JM. (N.T. 1091)

161. Delusional disorder responds to psychological treatment such as cognitive behavioral treatment. (N.T. 1091)

162. JM was sent to the RHU three times, despite the recommendation from SCI-Frackville. (N.T. 1092)

163. JM asked for psychological treatment at SCI-Cresson, both by signing consent to treatment and by verbally requesting treatment. (N.T. 1085, 1093)

164. On April 18, 2011, psychology staff member PSS Martinez saw JM, noted he was noncompliant with his medication, and failed to adequately assess him. (N.T. 1093-94)

165. On April 27, 2011, Dr. Eidsvoog saw JM again in the RHU. JM was still very ill, having paranoid delusions, talking about his mother's family. JM continued to refuse

antipsychotic medication. (N.T. 1094-95)

166. In late April 2011 JM wrote grievances that clearly showed his psychotic thoughts. A corrections officer responded to one of his grievances writing, "I'm not a doctor or a psychiatrist, but it seems to me you may be experiencing some sort of delusional episode. I hope this behavior ceases for you and will speak to our psychological staff to see if they can help." (N.T. 1096-99)

167. On May 6, 2011, PSS Martinez observed JM in RHU to be smiling and pleasant where he was usually paranoid. This reflected a sudden elevation in JM's mood, which is a risk factor for suicide listed in DOC's mental health policy, including in the suicide prevention training at SCI-Cresson, and within the common knowledge of several witnesses including Respondent. (N.T. 283, 882, 1099-1101, 2531, 2489)

168. On the evening of May 6, 2011, JM attempted to cover his cell window with a towel. (N.T. 1112)

169. Respondent did not consider this to be a risk of suicide. (N.T. 2332-34)

170. In the late hours of May 6 into May 7, 2011, JM committed suicide by hanging himself in his cell. He was discovered at 11:50 pm on May 6 and was pronounced dead at 1:20 am on May 7, 2011. (N.T. 1101-02, exhibit C-3)

171. Following JM's suicide, Respondent completed and signed an evaluation of inmate self-injury form in which Respondent indicated that "yes" JM had history of mental health problems and was non-compliant with medication and that "no" the incident was not foreseen or preventable. (Exhibit C-3 at 11, N.T. 1102-04)

172. Respondent's assertion that JM's suicide was not foreseen or preventable was inaccurate; JM's suicide was both definitely foreseeable and preventable. (N.T. 1104-07)

173. JM's suicide was foreseeable based upon: JM had serious mental illness, he was

not receiving treatment by psychology, he was single celled in a restricted housing unit, he was delusional, assaultive and impulsive, JM had already made a suicidal gesture and verbal threat, and JM displayed a sudden elevation in mood on May 6. (N.T. 1104-05)

174. JM's suicide was preventable based upon: SCI-Cresson was instructed not to put JM into RHU due to his illness, another LPM recommended that JM go to the SNU and if that did not work go to an intermediate care unit for a higher level of care, and JM had previously responded to treatment. (N.T. 1105-07)

175. On May 12, 2011, at a meeting to discuss JM's suicide, Respondent summarized PSS Martinez's May 6 interaction with JM – where JM demonstrated a sudden elevation in mood – and noted there was "nothing remarkable." (Exhibit C-3 at 8, N.T. 1109)

176. Respondent failed to bring up other relevant significant events in JM's history at SCI-Cresson including threatening suicide, hurting his hand, assaulting officers and demanding to speak to a psychologist. (N.T. 1110-12)

177. SCI-Cresson's suicide review and in particular Respondent's contribution to that review failed to paint an accurate picture of JM's mental health. (N.T. 1114)

178. Respondent displayed gross incompetence, negligence or misconduct in the practice of psychology by failing to accurately portray the events leading up to JM's suicide. (N.T. 1118)

179. Respondent stated that even with the benefit of hindsight neither he nor his staff would do anything differently regarding the psychological care of JM. (N.T. 2341)

180. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of care with regard to JM. (N.T. 1117)

181. Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care regarding JM. (N.T. 1117-18)

182. BP was an inmate at SCI-Cresson from June 2011 to July 2012. In 2011 BP was 22 years old. (N.T. 1129, 1135-36)

183. BP was serving a one year and four months to four years sentence for burglary and robbery. (N.T. 1126, 1129, 1148)

184. BP had a history of suicide attempts and other self-harm; his mental health diagnoses included antisocial personality disorder, bipolar disorder, depression, polysubstance abuse, a motor vehicle accident with frontal lobe concussion, and rule out impulse control disorder, and he was prescribed psychiatric medication. (N.T. 1126-30, 1136)

185. In April 2011, in the diagnosis center at SCI-Camp Hill BP was given a personality inventory which in part assessed his potential risk for suicide, and BP's score concerning suicide risk was higher than 90% of individuals who completed the assessment. (N.T. 1130-33)

186. In January 2012, the psychology department at SCI-Cresson completed a parole evaluation for BP. Respondent and another psychology staff member signed this report documenting that BP had previously attempted suicide three times. (N.T. 1147-48)

187. BP was informed on more than one occasion how to request mental health care in the prison system. (N.T. 1135, 1139)

188. In June and August 2011 BP saw a psychiatrist at SCI-Cresson, discussed his mental health history including prior suicide attempt, and was prescribed medication. (N.T. 1137-39)

189. On November 16, 2011, psychiatrist Dr. Eidsvoog referred BP to psychology to work on anger management and his frustration levels. (N.T. 1141-42)

190. PSS Poruban responded to Dr. Eidsvoog's referral, indicating that BP agreed to begin therapy and it was scheduled. (N.T. 1141-43)

191. On October 4, 2011, and November 29, 2011, BP was placed into the RHU, and Respondent was notified both times. (N.T. 1139-40)

192. In October, BP was noted to be negative for psychiatric medication, but in November BP was noted to be positive – indicating a change in medication compliance. (N.T. 1140-41)

193. On November 29, 2011, due to BP being placed in RHU, PSS Poruban conducted the standard suicide risk assessment form. (N.T. at 1143)

194. On December 8, 2011, Respondent had the monthly RHU contact with BP and documented that "continued intervention is necessary" and the plans are to "continue regular contact" with this stability level C inmate. (N.T. 1144-45)

195. On December 29, 2011, and January 25, 2012, BP met again with psychiatrist Dr. Eidsvoog. BP continued to be easily angered and have difficulty with impulse control and also was struggling with anxiety and sadness. He was not in complete compliance with his psychiatric medication; Dr. Eidsvoog counseled him on the risks of noncompliance and adjusted some of the medication. (N.T. 1145-51)

196. On February 27, 2012, upon BP's RHU admission, Respondent completed the standard suicide risk assessment form. At that time BP was taking medication for depression and denied suicidal ideation. (N.T. 1152)

197. Also on February 27, 2012, psychiatrist Dr. Xue saw BP and noted that he was "noncompliant with a history of decompensation when he goes off medications." BP was feeling depressed four days a week and had flat affect but denied suicidal ideation. (N.T. 1152-54)

198. On March 29, 2012, Respondent and others signed an individual treatment plan for BP that listed problems and goals as "medication compliance" and "maintain stability in population," and listed treatment objectives for this stability code C inmate as he "will take all medication as prescribed measured by the non-compliance list" and "no misconducts, appropriate communication with staff, let staff know of problems and concerns prior to acting out." (N.T. 1155-58, exhibit C-24)

199. As of March 29, 2012, based on DOC policy and BP's condition and noncompliance with medication, BP's stability code should have been changed to a D. (N.T. 1158-61)

200. On April 11, 2012, BP was psychiatrist Dr. Elnagger. BP reported high anxiety, depression, and "some wish to die" but no suicidal ideation, and his prescribed medications were adjusted. (N.T. 1161-63)

201. On May 1, 2012, BP was again placed into RHU, and Respondent was notified. (N.T. 1163-64)

202. On May 9, 2012, BP had contact with PSS Poruban. BP denied suicidal ideation and PSS Poruban documented, "no remarkable psychopathology expressed or observed at this time," and BP remained a stability code level C. (N.T. 1164-65)

203. On June 7, 2012, BP was denied parole. (Exhibit R-17 at 1; N.T. at 1166)

204. On July 5, 2012, BP again saw psychiatry. BP was sad but denied suicidal ideation. BP did not believe the medication was helping but stated "he could benefit by one-to-one counseling" and agreed to restart a particular medication. (N.T. 1166-68)

205. On July 11, 2012, the standard suicide risk assessment form was conducted by a nurse. (N.T. 1168)

206. On July 12, 2012, BP was again placed in RHU, and Respondent was notified. (N.T. 1168-69)

207. The Inmate Cumulative Adjustment Records (ICAR) for BP reflects no contact with psychology in April, May, June or July 2012, although other records reflect BP did see PSS Poruban on May 9, 2012. (N.T. 1164-65, 1170, R-17)

208. On July 16, 2012, BP received an upsetting letter from his girlfriend. (Exhibit C-30 at 13)

209. BP hanged himself with a bedsheet on July 16, 2012. He was transported to Altoona Hospital and died on July 17, 2012. (N.T. 1171)

210. On July 18, 2012, Respondent completed an evaluation of inmate self-injury form. Respondent indicated "yes" to a history of mental health problems and prior attempts. Respondent indicated "no" as to whether BP's suicide was foreseen or preventable, and also wrote "not at the moment, but only in identified history." (N.T. 1171-73, exhibit C-25)

211. BP's suicide was both foreseeable and potentially preventable. BP suffered from anxiety and depression, was intermittently compliant with medication that was not working for him and was asking for counseling. BP's conditions were amenable to psychological treatment, but none was provided. BP was writing dark depressing poems, had a history of misconducts, and most recently before his death asked to be taken to the RHU in what can be termed a "check in." (N.T. 1173-77, 1196-97)

212. A meeting to review BP's suicide was held on July 20, 2012. (Exhibit C-30 at 3)

213. At the suicide review meeting, Respondent stated that BP "was a C roster inmate. He was seen by psychology on 3/30/12 for his annual PRT review by [PSS] Ketner. There were no further concerns expressed with regards to his PRT review." Respondent further commented

that BP "was seen by [PSS] Poruban on 5/9/12 while he was in the RHU. He was in and out of the RHU and suicide checklists were done each time with no indications of suicide. He was also seen by psychiatry. He was to have been seen by a psychiatrist in June, but that did not happen." (Exhibit C-30 at attachment O p. 6, N.T. 1188-89))

214. Respondent's comments in the suicide review meeting do not accurately reflect the clinical status of BP, and the presence of the psychiatrist at the meeting did not relieve Respondent of the responsibility to be aware of the deceased inmate's mental health status. (N.T. 1195-96)

215. Respondent stated that even with the benefit of hindsight there was nothing he would do differently concerning the psychological care of BP. (N.T. 2320-21)

216. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of care with regard to BP. (N.T. 1177-78, 1198-99)

217. Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care regarding BP. (N.T. 1177-78, 1198-99)

218. JW was an inmate at SCI-Cresson for less than two years from May 2010 to March 11, 2012. In 2010, JW was 22 years old. (N.T. 1201, 1207, 1246)

219. JW was serving a 7 to 14 year sentence for rape. (N.T. 1201-03)

220. In March 2010, at an initial psychiatric evaluation at SCI-Camp Hill on March 17, 2010, JW was diagnosed with psychosis, unspecified; alcohol abuse; rule out antisocial personality disorder. JW also reported that he was hearing voices of people arguing with each other and seeing things. (N.T. 1201-03)

221. JW was also indicated to have an IQ of 76 on a Beta Exam (a brief assessment) and

to have been the victim of childhood abuse. JW was taking an antipsychotic and an antidepressant. (N.T. 1204-07)

222. SCI-Cresson psychology staff were recommended to do further assessment of JW, but that never occurred. (N.T. 1206-07)

223. Hallucinations where more multiple persons are talking to each other are indicative of a person who has a serious mental illness. (N.T. 1203)

224. On April 14, 2010, the LPM at SCI-Camp Hill had contact with JW. JW was a stability code D, still hearing voices and seeing things, not sleeping well, and taking two psychiatric medications. (N.T. 1206)

225. As of May 2010, JW was diagnosed with schizophrenia, manic and depressive, bipolar disorder, and major depression. (N.T. 1208-09)

226. In 2010, JW also suffered from gynecomastia, a condition where a male develops enlarged breasts, an often-humiliating side effect of an antipsychotic medication taken by JW. (N.T. 1208-09)

227. JW was aware that gynecomastia was a potential side effect of this medication yet elected to continue taking it after a risk/benefit discussion with his psychiatrist because he felt very ill "tortured by his mental illness" and was motivated to get better. (N.T. 1209-10, 1222-23, 1236-37)

228. JW signed a consent form to receive psychological treatment at SCI-Cresson. (N.T. 1210)

229. On May 6, 2010, a psychology staff member at SCI-Cresson completed an individual treatment plan for JW, listing the problems and goals as "medication compliance" and "maintain stability in population" and provided as treatment objectives that the inmate "will take

medication as prescribed measured by the non-compliance list" and have "no misconducts, appropriate communication with staff, let staff know of problems and concerns prior to acting out;" frequency of treatment by psychology not indicated, despite blocks to check for daily, weekly, monthly or other. (N.T. 1210-11)

230. The form indicates that JW had a stability code of C, though there is no explanation in records why JW's stability code of D at SCI-Camp Hill was upgraded to C at SCI-Cresson. (N.T. 1211)

231. Stability level code decisions were ultimately made by the PRT, of which Respondent was the chair. (N.T. 1211-12)

232. JW was seen by psychiatry at SCI-Cresson on May 27, June 29, August 4, and August 17, 2010. At those times, JW was suffering from depressive disorder with psychotic features, rule out antisocial personality disorder, was hearing voices, had problems sleeping, and had anxiety and panic attacks (first mentioned in August 2010). (N.T. 1212-16)

233. JW reported his wife had recently left him. JW's psychiatric medications were discussed and adjusted during this timeframe. (N.T. 1212-16)

234. Although psychiatry was treating JW frequently, there were no regular notes to show that psychology was treating him. (N.T. 1215-16)

235. On September 2, 2010, a PRT meeting was held regarding JW. PSS Martinez was present on behalf of psychology. She recorded that JW was "stable with meds." (N.T. 1216)

236. On October 22, 2010, a staff member wrote a mental health referral form referring JW to psychology for "removal from the O Code," which refers to an inmate who was on C or D stability level roster. Respondent responded to the referral stating that JW needed to remain on the roster as he needed mental health services. (N.T. 1217-18)

237. Respondent thus had some awareness of JW's significant mental health conditions as of October 2010. (N.T. 1218)

238. JW was informed of access to mental health care on at least three occasions. (N.T. 1214, 1219, 1221-22)

239. JW continued to see psychiatrists in November 2010 and February 2011. (N.T. 1218-19)

240. On February 24, 2011, Respondent and others signed an individual treatment plan was written for JW, listing the problems and goals as "medication compliance, communication skills, and mood management." JW was listed as stability code C, and frequency of treatment by psychology was marked "other" as opposed to daily, weekly, or monthly. (N.T. 1219-20)

241. On April 18, 2012, JW saw a psychiatrist and reported hat his father had died (elsewhere the records show that JW's father committed suicide). JW was having problems sleeping, depressed, and sad, but not a threat to himself. He continued with his medications. (N.T. 1221-22, 1386-87)

242. As of August 2011, JW had been at SCI-Cresson for almost a year and a half and, other than the individual treatment plans mentioned above, had not been treated by psychology. (N.T. 1225, exhibit R-18)

243. The totality of the psychology department's contact with JW were four notes in the ICAR: a visit with PSS Martinez in May 2010 when JW was placed in RHU, a visit with Respondent two weeks later (regarding a security investigation being complete and JW being released to the SNU), the February 2011 PRT annual review, and the February 2012 PRT annual review. (N.T. 1225-26, exhibit R-18)

244. By August 2011, JW had become more ill. JW saw psychiatrists on August 4, 12

and 17. JW was experiencing severe depression, depressive disorder with psychotic features, auditory and visual hallucinations, paranoia, and difficulty sleeping. (N.T. 1223-30)

245. JW continued taking psychiatric medications. (N.T. 1226-30, 1235-36)

246. On August 12, 2011, psychiatrist Dr. Daly wrote a physician order requesting a second opinion from psychology. The order recited the psychiatric medications that JW was taking and read, "Consult psychology for 2nd opinion: Offered [patient] voluntary admission to MHU[; Patient] has depression [with] psychotic features -Do you agree -Does [patient] meet criteria for involuntary admission." (Exhibit C-28, N.T. 1227-30)

247. Psychology failed to respond to this request for a second opinion, and JW was never involuntarily committed. (N.T. 1230-31)

248. Per DOC policy, Respondent had the responsibility to have a mental health coordinator by the petitioner in the event a person needed to be evaluated for involuntary section 302 commitment and in most cases the consulting psychiatrist would be the examining physician. (N.T. 1231-35)

249. Respondent had the ability to delegate certain duties, but that did not relieve him of the responsibility. (N.T. 1234-35)

250. On September 19, 2011, JW was again seen by psychiatry, and although he was still paranoid schizophrenic and bipolar JW felt that medication was helping. (N.T. 1236-37)

251. On November 11, 2011, and January 20, 2012, JW was seen again by psychiatry. JW's condition had worsened, and he was having nightmares of stabbings. His medications were discussed and adjusted. (N.T. 1237-39)

252. JW was not treated by psychology during this time. (N.T. 1239)

253. On February 27, 2012, Respondent and others signed an individual treatment plan

for JW that listed problems and goals as "medication compliance" and "maintain stability in population," and listed treatment objectives for this stability code C inmate as he "will take medication as prescribed measured by the non-compliance list" and "no misconducts, appropriate communication with staff, let staff know of problems and concerns prior to acting out." (N.T. 1239-41, exhibit C-26)

254. JW had not, however, exhibited problems with medication compliance. To the contrary, he took psychiatric medications in an effort to feel better, even to his physical detriment. (N.T. 1209-10, 1222-23, 1236-37, 1241)

255. The February 27, 2012, individual treatment plan also lists JW's global assessment of functioning (a rating of an individual's overall health) as a 65. This was highly overrating JW, because based upon the psychiatry notes his functioning was lower than 30 most of the time. (N.T. 1241-42)

256. Respondent had the obligation to review JW's medical records prior to deciding the treatment plan. Respondent either failed to review JW's medical records, which documented his severe, persistent mental illness, or Respondent failed to appreciate the significance of JW's level of illness. Either possibility constitutes a gross failure. (N.T. 1242-45)

257. JW should not have been a stability code C, given the frequency of psychiatric services he was receiving, the standard of care of a person with major depression with psychotic features in which the involvement of psychological services is almost always warranted. (N.T. 1245)

258. JW completed suicide at SCI-Cresson on March 11, 2012, by hanging himself. (Exhibit C-27, N.T. 1200-01, 1245-47)

259. Respondent completed and signed an evaluation of inmate self-injury form

regarding JW and wrote "no overt signs of risk factors apparent." (Exhibit C-27, N.T. 1246-47)

260. Respondent's entry on the evaluation form was inaccurate, as JW had many risk factors, including a history of auditory and visual hallucinations since age 11 or 12, major depression with psychotic features, and was not sleeping well with intermittent awakening and nightmares of violent events. JW was asking for medication that caused him physical harm (gynecomastia) in an attempt to gain relief and another medication that is also not pleasant to take, and JW had also recently experienced the violent suicide death of his adoptive father in 2011 and his wife leaving him in August 2010. JW was at high risk of suicide. (N.T. 1247-49, 1256-59)

261. On the evaluation form Respondent also indicated "no" that the suicide was not foreseen or preventable. This was inaccurate, as JW's suicide was foreseeable because he was at a high risk of suicide from August 2011 through March 2012. (N.T. 1250-51, 1255-59)

262. Psychology provided no treatment to JW, despite his serious mental illness, despite JW's signed consent to receive treatment by psychology, and despite the request for a second opinion regarding involuntary commitment from psychiatry. (N.T. 1249-50, 1255)

263. Weekly psychiatry treatment was very rare and indicated the extreme level of JW's illness. (N.T. 1249-50)

264. On March 15, 2012, a meeting was held to review JW's suicide. (Exhibit C-29, N.T. 1251-53)

265. In the meeting to review JW's suicide, Respondent summarized the few psychology contacts with JW including the yearly individual treatment plans and stated, "There was no identifiers that he needed any follow-up psychological treatment and he was compliant with psychiatry and medications. He never expressed need for further contact although he was informed that, if need be, he could contact psychology." (Exhibit C-29 at minutes p. 5, N.T. 1251-54)

266. In the suicide review meeting Respondent failed to paint an accurate picture of JW's mental health condition leading up to his suicide. (N.T. 1255)

267. In the suicide review meeting, Deputy Superintendent Luther stated, "this is one of those instances where no one saw it coming and there were little or no red flags; that this is a lesson to all of us that if a guy wants to do it, he will just do it." In her report the Deputy concluded, "there were no warning signs and/or red flags that could alert staff to the possibility of suicidal thoughts or intentions." (Exhibit C-29 at memo p. 5, minutes p. 6).

268. The Deputy's conclusion was inaccurate, but she had to rely on her employees to gather evidence included in a suicide review. (N.T. 1255-56, 1942-43)

269. Although participating in a review of his department's actions, Respondent was responsible to present the facts accurately and to review the medical record prior to presenting those facts. (N.T. 1259-60)

270. While not solely responsible, the psychology department had some responsibility for JW's suicide. (N.T. 1256)

271. Respondent indicated that there was nothing he would do differently, or instruct his staff to do differently, concerning the psychological care of JW. (N.T. 2348)

272. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of care with regard to JW. (N.T. 1260-61)

273. Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care regarding JW. (N.T. 1260-61)

274. Respondent spent the majority of the time in his office and had very little interaction with the inmates in SSNU and RHU; thus, Respondent had limited knowledge as to the inmates'

psychological issues and limited interaction with the PSSs. (N.T. 87-88, 102-04, 243-44, 523-25, 529-30)

275. The psychology department headed by Respondent rarely if ever held regular meetings to discuss issues, concerns, or treatment recommendations for inmates requesting psychological services. (N.T. 507)

276. Despite claiming that after 25 years he was well-versed in the practice of psychology in a correctional setting, Respondent does not know the six Constitutional requirements for the acceptable standard of mental health care in a correctional setting. (N.T. 2189)

277. As part of his job as LPM, Respondent claimed to routinely review the records produced by his supervisees, including weekly review of ICAR notes. However, he was surprised to learn that one of the PSSs (Poruban) did not keep records of individual psychotherapy sessions with BP and made no ICAR entries for those sessions either. (N.T. 1685-86, 2198-99, 2235-36)

278. The three PSSs assigned to SSNU between 2009 and 2011 were Dr. Seemuth, Ms. Christoff and Mr. Uhler. (N.T. 91-92, 499-500, 2199-2200)

279. Upon beginning her employment in the psychology department at SCI-Cresson in October 2007, Ms. Christoff received little training or therapeutic direction from Respondent even though she was immediately assigned to SSNU – the unit where the most seriously ill inmates were housed. (N.T. 54, 59-60, 97)

280. Respondent was responsible for training and supervision of PSSs but acknowledged that there was no training or education related to the practice of psychology in a correctional setting provided to members of the psychology department. (N.T. 2201, 2203-04)

281. Respondent never taught or provided guidance to Ms. Christoff or Mr. Uhler as to

how to do a suicide risk assessment of inmates, other than a simple checklist that typically took just a few minutes with the inmates. (N.T. 105-07, 280-82)

282. Respondent could not define or describe the elements of a comprehensive suicide risk assessment even though it was his responsibility to train his supervisees how to complete such an assessment. (N.T. 2315-17, 2330-33)

283. The only training on the DOC policies for reporting inmate abuse occurred during orientation. Respondent did not provide his staff any formal training on the reporting of inmate abuse. (N.T. 2208)

284. Throughout the course of their employment at SCI-Cresson, Dr. Seemuth, Ms. Christoff and Mr. Uhler all expressed concerns to Respondent on numerous occasions that the corrections officers' refusal to bring inmates to group or individual therapy interfered with their availability to provide adequate psychological services to them. (N.T. 61-64, 92, 237-43, 275-76, 285-86, 508-09, 562-63)

285. Rather than intervening as department head to assure that inmates were receiving appropriate psychological services, Respondent did nothing but inform his subordinates that it is "a security matter" and whether an inmate was brought out of his cell for individual or group therapy was solely at the discretion of the corrections officers on duty. (N.T. 63, 241-42, 275-77, 285-86, 509, 747)

286. Respondent conceded that it was a violation of DOC policy not to allow inmates out of their cells to receive individual or group psychotherapy. (N.T. 2218-19)

287. Respondent believed that individual and group therapy was useless because inmates were hard wired and incapable of change. (N.T. 584-85)

288. Respondent encouraged his staff to spend no more than a few minutes when

providing individual therapy to an inmate at his cell, a practice Respondent dubbed a "drive-by." (N.T. 98, 511-12)

289. On more than one occasion, Respondent would respond to inmates' complaints, for example regarding the cleanliness of their food (brought to Respondent via Dr. Seemuth) with "If I didn't see it, it didn't happen." (N.T. 520-22, 762)

290. Throughout the course of their employment at SCI-Cresson, Dr. Seemuth, Ms. Christoff and Mr. Uhler repeatedly discussed with Respondent their concerns about the treatment of inmates, including concerns about abuse and neglect, only to be met with hostility, irritability and retaliatory actions. (N.T. 51-766, *passim*)

291. On June 17, 2011, Dr. Seemuth noticed a corrections officer (Sergeant Fox) covering CB's cell door with blue plastic, obstructing view into the camera cell of this inmate with a history of self-injurious behavior. (N.T. 531-33, 772, 963-64)

292. CB yelled for help from behind the plastic covering his cell. (N.T. 569-70)

293. Despite her fear of retaliation by Sergeant Fox, Dr. Seemuth immediately emailed Respondent, the unit manager Ms. Houser and Deputy Superintendent Luther about her concern of covering the camera cell of an inmate with CB's history; yet the only response she received was from Respondent who chastised her for not inquiring if Sergeant Fox had a reason for obstructing the view into the cell, rather than addressing her concerns. (N.T. 533-34, 2257-59)

294. After seeing TP huddled on the floor of a cold cell with nothing but the suicide smock, Dr. Seemuth documented her concerns in TP's record and then reported to Respondent her concerns that TP was being neglected and abused; Respondent took no action. (N.T. 546-49, 2287-88)

295. Ms. Christoff reported concerns that TP was being mistreated after she saw him

shivering on the floor of his cell with nothing on but a suicide smock, to which Respondent replied, "Let the officers do their job. It's part of the modification program. Let them do their jobs." (N.T. 68-73, 2287-88)

296. Ms. Christoff also reported to Respondent that she had concerns about TP's safety and believed he was being methodically abused after she saw bruises on his face; however, Respondent failed to do anything in response to reported concerns. (N.T. 82-85)

297. Mr. Uhler reported to Respondent on multiple occasions his concerns that TP was being mistreated when he observed TP in his cell with nothing but a suicide smock for an extended period of time; Respondent's reply each time instructed Mr. Uhler not to interfere and just do treatment. (N.T. 250-52, 262-63, 429-30, 466-68, 2287-88)

298. Despite the extreme, excessive and extended nature of the deprivation of all items except a suicide smock and with no heat, Mr. Uhler never saw Respondent go to the SSNU to investigate TP and the conditions in which he was forced to live – living conditions that likely would result in criminal charges if done to a dog. (N.T. 250, 263, 466-68)

299. After TP reported that corrections officers had stomped on his head and Mr. Uhler observed facial injuries including a black eye with the white part of his eye being blood red, Mr. Uhler made an oral report of abuse to Respondent and made a notation in TP's record that he may have been subject to abuse and that staff behaved inappropriately. (N.T. 429, 433, 455, 458)

300. An internal DOC investigation instead concluded that Mr. Uhler was at fault for failing to follow proper reporting procedures, and Respondent counseled him on his behavior. (N.T. 442, 455-56, 462-66, 475-76)

301. Ms. Christoff, Mr. Uhler and Dr. Seemuth experienced retaliation and hostility after reporting concerns of inmate abuse to Respondent. (N.T. 93-97, 159, 184, 289-90, 528-29)

302. After Ms. Christoff began complaining to Respondent about the abuse and neglect of inmates, her office was searched, and she was targeted for termination after letters from an inmate were located during the search. (N.T. 93-97, 159, 184)

303. No longer fearing retaliation, Ms. Christoff filed a complaint with the Department of State detailing the instances of abuse and neglect of inmates overlooked by Respondent, as well as the overall lack of psychological services to inmates – a practice endorsed by Respondent. (N.T. 178-79, 192-93)

304. Mr. Uhler's automobile was damaged on multiple occasion, and on another occasion he was surrounded by corrections officers who angrily accused Mr. Uhler of trying to get them fired. (N.T. 293-98)

305. Despite being made aware of these incidents, Respondent did nothing in response to these actions. (N.T. 298)

306. Mr. Uhler worked in the SSNU from 2005 until approximately 2011; however, after discussing concerns of abuse, neglect and other mistreatment of inmates, he was reassigned to work in SCI-Cresson's sex offender unit. (N.T. 216, 220-21)

307. After witnessing TP living in conditions not fit for an animal, Mr. Uhler contacted the Disability Rights Network. (N.T. 467-68)

308. Within a few months of beginning her employment in 2009, CB threatened to harm Dr. Seemuth by giving her a drawing that graphically depicted CB raping her and indicating that he was going to kill her by slicing her throat. (N.T. 564-68, exhibit C-16)

309. After being advised of the threat, Respondent instructed Dr. Seemuth to continue contact with CB. (N.T. 568-69, 2352-54)

310. On August 4, 2011, a different SSNU inmate (SS) wrote Dr. Seemuth a letter

accusing her of being complacent regarding inmate abuse and threatening, if she did not help stop the abuse, to give out her personal information including where she lived to a friend outside the prison with instructions to harm her. (N.T. 570-76, 2262-63, exhibit C-17)

311. Respondent did not file the required extraordinary incident report event though SS made allegations of abuse. (N.T. 2262-63)

312. Fearing for her safety, Dr. Seemuth notified Respondent of the threat and requested a separation from SS. (N.T. 577-79, 2352-54)

313. Dr. Seemuth filed a criminal complaint with the police ("street charges") against SS for the threat and a hearing was scheduled in Cambria County courts. (N.T. 580-82)

314. Rather than honor her request for separation from this inmate, Respondent gave Dr. Seemuth a direct order to continue rounds and individual and group therapy in the area of SS's cell. On November 4, 2011, Dr. Seemuth received counseling when she refused to do rounds near this inmate. (N.T. 582, 601-02, exhibit C-13, exhibit R-7 at 13)

315. Respondent required Dr. Seemuth to be in close contact with SS during an MRT meeting held in a small room in which people had to stand because the room could accommodate only a small number of chairs; Dr. Seemuth was surprised and upset when SS entered the room. (N.T. 582-83, 2359-60)

316. CB threatened Respondent by announcing to the RHU the city in which Respondent resided. Respondent immediately requested and was granted a separation from CB. (N.T. 2354-56)

317. Respondent asserted that he believed that simply saying the city in which he resided was a "very specific threat" that warranted immediate separation from the inmate, but the threats of rape, sodomy and slicing of her throat directed to Dr. Seemuth along with providing her home

information to a friend on the outside did not necessitate a separation. (N.T. 2356-57)

318. Respondent encouraged Dr. Seemuth to continue to provide psychological services to CB. (N.T. 568-69, 2356-57)

319. Despite receiving from Dr. Seemuth, Ms. Christoff and Mr. Uhler multiple allegations of inmate abuse between 2010 and 2011, Respondent did not file a single DC-121 report of extraordinary incident (mandated by DOC policy for reports of inmate abuse), in direct contradiction of APA Code of Ethics which requires a psychologist to safeguard the welfare and rights of clients. (N.T. 2263-66)

320. Dr. Seemuth was universally described as an outstanding employee and clinician during her first few years at SCI-Cresson. (N.T. 587-91, exhibit C-18)

321. Once she began reporting concerns about treatment of inmates and that the actions of corrections officers impeded her ability to provide psychotherapy to inmates, Dr. Seemuth's performance review drastically changed for the worse and she suddenly began receiving counseling sessions for seemingly minor issues, including three done the same day in September 2011. (N.T. 591-601, 2361, exhibits C-13 and C-18)

322. On September 14, 2011, Respondent admonished Dr. Seemuth for making an entry into an inmate's ICAR in which she insinuated the inmate was being abused and for making the entries one to two weeks after the event. (N.T. 518-20, 599-600, 2234-35, exhibit C-13, exhibit R-7 at 12)

323. After both Mr. Uhler and Dr. Seemuth had received counseling for reporting instances of inmate abuse or mistreatment and employee misconduct in the inmate's ICAR, Respondent requested that they review all potential ICAR entries with him before they were entered into the electronic record. (N.T. 455-56, 475-77, 518-20, 2228-29, 2234)

324. Respondent did not counsel or otherwise discipline PSS Poruban for failing to keep records of individual psychotherapy sessions and failing to make entries in the ICAR regrading those sessions even though Deputy Superintendent Luther specifically mentioned PSS Poruban's failure to do so during the review of BP's suicide. (N.T. 2235-36, exhibit C-30)

325. Respondent's obligations as the LPM extend to taking reasonable efforts to avoid harm to inmates and to execute his duties to supervisees who report inmate abuse to Respondent. (N.T. 1264-69)

326. In his management of the psychology department at SCI-Cresson in 2009-13, Respondent did not resolve conflicts between a psychologist's ethical code and organizational demands in favor of the ethical code. (N.T. 1266-68)

327. Regarding his supervisees, Respondent failed to respect the integrity and protect the welfare of the people with whom he worked. (N.T. at 1265)

328. Regarding his supervisees, Respondent failed to take care to do no harm and safeguard the welfare and rights of those with whom he interacted professionally and other affected persons. (N.T. 1265-66)

329. In his management of the psychology department at SCI-Cresson in 2009-13, Respondent committed gross incompetence, negligence or misconduct in the practice of psychology by being responsible for substantially inadequate psychological care or lack of psychological services. (N.T. 1268-69)

330. In his management of the psychology department at SCI-Cresson in 2009-13, Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services. (N.T. 1268-69)

331. The Commonwealth incurred $17,233.59 in total costs of investigation prior to the

filing of formal charges. (Exhibit C-10)

332. The Commonwealth filed its original order to show cause on October 20, 2016, and Respondent filed an answer to the order to show cause on May 5, 2017. (N.T. 2504-05)

333. Respondent received service of the amended order to show cause, as shown by his filing of an answer thereto. (*See*, answer to amended order to show cause filed August 21, 2018).

334. Respondent received notice of the hearing on October 9-12 and 15-17 and November 6-8, 2018, as shown by his attendance with legal counsel. (N.T. 6-7, 1184, 1985)

335. Respondent testified on his own behalf. (N.T. 1987-2237, 2244-2403)

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter. (Findings of Fact Nos. 1 – 3)

2. Respondent received reasonable notice of the charges against him and was given an opportunity to be heard in accordance with the Administrative Agency Law, 2 Pa.C.S. §504. (Findings of Fact Nos. 332 – 335)

3. Respondent is subject to disciplinary action under section 8(a)(4) of the Act, 63 P.S. § 1208(a)(4), because Respondent displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by being responsible for substantially inadequate psychological care or lack of psychological services with regards to TP, CB, JM, JW and BP. (Findings of Fact Nos. 1 – 273)

4. Respondent is subject to disciplinary action under section 8(a)(11) of the Act, 63 P.S. § 1208(a)(11), because Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services with regards to TP, CB, JM, JW and BP. (Findings of Fact Nos. 1 – 273)

5. Respondent is subject to disciplinary action under section 8(a)(4) of the Act, 63 P.S. § 1208(a)(4), because Respondent displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by failing to act appropriately in response to reported concerns of inmate abuse, with regards to TP. (Findings of Fact Nos. 1 – 48, 83 – 125, 294 – 303, 307)

6. Respondent is subject to disciplinary action under section 8(a)(4) of the Act, 63 P.S. § 1208(a)(4), because Respondent displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by failing to accurately portray the events leading up to JM's suicide. (Findings of Fact Nos. 1 – 48, 126 - 181)

7. Respondent is subject to disciplinary action under section 8(a)(9) of the Act, 63 P.S. § 1208(a)(9), because Respondent violated the Board's regulation at 49 Pa. Code § 41.61, Ethical Principle 6(a), by failing to respect the integrity and protect the welfare of people with whom he worked. (Findings of Fact Nos. 1 – 48, 274 - 330)

8. Respondent is subject to disciplinary action under section 8(a)(9) of the Act, 63 P.S. § 1208(a)(9), because Respondent violated the Board's regulation at 49 Pa. Code § 41.61, Ethical Principle 3(e), by deviating from American Psychological Association Ethical Principles of Psychologists and Code of Conduct, Principle A, by failing to take care to do no harm and safeguard the welfare and rights of those with whom he interacted professionally and other affected persons. (Findings of Fact Nos. 1 – 48, 274 - 330)

9. Respondent is subject to disciplinary action under section 8(a)(9) of the Act, 63 P.S. § 1208(a)(9), because Respondent violated the Board's regulation at 49 Pa. Code § 41.61, Ethical Principle 3(e), by deviating from American Psychological Association Ethical Principles of Psychologists and Code of Conduct, Ethical Standard 1.03, by failing to resolve conflict between ethics and organizational demands consistent with the General Principles and Ethical Standards of the Ethics Code in Respondent's management of the psychology department at SCI-Cresson, specifically in the years 2009-13. (Findings of Fact Nos. 1 – 330)

10. Respondent is subject to disciplinary action under section 8(a)(4) of the Act, 63 P.S. § 1208(a)(4), because Respondent displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by being responsible for substantially inadequate psychological care or lack of psychological services at SCI-Cresson, specifically in the years 2009-2013. (Findings of Fact Nos. 1 – 330)

11. Respondent is subject to disciplinary action under section 8(a)(11) of the Act, 63

P.S. § 1208(a)(11), because Respondent committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services at SCI-Cresson, specifically in the years 2009-2013. (Findings of Fact Nos. 1 – 330)

DISCUSSION

Respondent attempted to impeach the former DOC employees who testified against him by identifying various incidents of employee discipline. The hearing examiner finds that – even if they engaged in misconduct and employee discipline was proper – Ms. Christoff, Mr. Uhler and Dr. Seemuth were credible and persuasive witnesses. They were clear and consistent in their testimony despite vigorous cross-examination. Their testimony was consistent with their prior statements. And they persevered in telling the same facts despite the repeated difficult obstacles placed before them. Any conflict between their testimony and that of Respondent and his witnesses is resolved in favor of Ms. Christoff, Mr. Uhler and Dr. Seemuth. Additionally, the hearing examiner finds the Commonwealth's expert witness Dr. Rhinehart to be credible and persuasive in his explanation of the record and his opinions and credits those opinions, whether contradicted or not.

In counts one through five of its amended order to show cause, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(4) of the Act[6] because he displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by being responsible for substantially inadequate psychological care or lack of care of

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[6] **Section 8. Refusal, suspension or revocation of license.**

(a) The **board** may refuse to issue a license or **may suspend, revoke**, limit or restrict a license or reprimand a licensee for any of the following reasons:

* * *

(4) **Displaying gross incompetence, negligence or misconduct** in carrying on the practice of psychology.

* * *

(9) **Violating a lawful regulation** promulgated by the board, including, but not limited to, ethical regulations, or violating a lawful order of the board previously entered in a disciplinary proceeding.

* * *

(11) **Committing immoral or unprofessional conduct**. Unprofessional conduct shall include **any departure from, or failure to conform to, the standards of acceptable and prevailing psychological practice**. Actual injury to a client need not be established.

* * *

63 P.S. § 1208(a) (emphasis supplied).

psychological services with regard to CB, TP, JM, BP and JW. "Gross incompetence" may be defined as grossly lacking the qualities (as maturity, capacity, initiative, intelligence) necessary to effective independent action; insufficiency; inadequacy. *Nelson v. State Bd. of Veterinary Medicine*, 863 A.2d 129, 136 (Pa. Cmwlth. 2004). "Gross negligence" may be defined as that which grossly deviates from the standard of care. *Will v. Electrical Contractors Ex. Bd. of City of Erie*, 650 A.2d 1226, 1227 (Pa. Cmwlth. 1994). *See also, Bloom v. DuBois Reg. Med. Ctr.*, 597 A.2d 671, 679 (Pa. Super. 1991) ("gross negligence" for purposes of Mental Health Procedures Act means facts indicating more egregiously deviant conduct than ordinary carelessness, laxity or indifference; the behavior must be flagrant and grossly deviating from the standard of care). In counts six through ten, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(11) of the Act because he committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of care of psychological services with regard to CB, TP, JM, BP and JW. The Act defines "unprofessional conduct" to include "any departure from, or failure to conform to, the standards of acceptable and prevailing psychological practice. Actual injury to a client need not be established."

As established by the findings of fact,[7] Respondent was head of the psychology department at SCI-Cresson, which was developing special housing to deal with mentally ill inmates. At various times, Respondent and his department had inmates CB, TP, JM, BP and JW.

CB returned to SCI-Cresson with a history of self-harm. He had a significant mental health

[7]The degree of proof required to establish a case before an administrative tribunal in an action of this nature is a preponderance of the evidence. *Lansberry v. Pennsylvania Public Utility Commission*, 578 A.2d 600, 602 (Pa. Cmwlth. 1990). A preponderance of the evidence is generally understood to mean that the evidence demonstrates a fact is more likely to be true than not to be true, or if the burden were viewed as a balance scale, the evidence in support of the Commonwealth's case must weigh slightly more than the opposing evidence. *Se-Ling Hosiery, Inc. v. Margulies*, 70 A.2d 854, 856 (Pa. 1949). The Commonwealth therefore has the burden of proving the charges against Respondent with evidence that is substantial and legally credible, not by mere "suspicion" or by only a "scintilla" of evidence. *Lansberry*, 578 A.2d at 602.

history, including schizophrenia, borderline personality disorder, antisocial personality disorder, substance abuse disorder, psychosis, impulse control disorder, post-traumatic stress disorder, and substance abuse in institutional remission. The psychiatrist specifically requested that CB be seen regularly by psychology for therapy to aid in harm reduction. Respondent denied the referral and directed Mr. Uhler not to spend extended time with CB. While he was in RHU, Respondent directed that CB be seen only monthly. Respondent determined that "psychotherapy is not indicated" for CB. Psychotherapy is treatment of choice for borderline personality disorder, and Respondent's opinion was grossly inaccurate. CB engaged in self-harming behavior by ingesting a large quantity of antacids and verbalized feeling suicidal and requested psychological treatment. The psychiatrist noted dangerous levels of impulsivity, and with CB's history and risk of self-harm, for his safety he was to have only basic items in RHU. Still, Respondent insisted the primary problem was medication compliance and determined that CB would be seen by psychology only monthly. CB was noted by psychology to have a flat affect, was grossly impaired, illogical, fragmented and confused. In a camera cell where he could be monitored by camera, CB yelled out that "they want me to hurt myself" as a corrections officer covered part of the cell with a blue shower curtain that would obstruct the camera view. Respondent was promptly alerted by Dr. Seemuth, yet his only action was to instruct her to get the correctional officer's justification before chastising her for documenting concerns of inmate abuse in the inmate record. CB was at great risk of self-harm in his mental condition, and Respondent's response to this dangerous incident was inadequate. CB later attempted suicide by hanging. Respondent personally saw CB subsequent to this suicide attempt and. Respondent later approved upgrading CB's stability code status as "no need" for that level with "no suicidal ideations." This change was grossly negligent and inappropriate. Respondent committed gross incompetence, negligence or misconduct in the

practice of psychology and committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services regarding CB.

Inmate TP was a juvenile lifer, now in his 40s with an intellectual disability and other mental health conditions. TP was diagnosed with schizophrenia, history of drug and alcohol use, and motor vehicle accident with head trauma. He had a history of depression, suicide attempts and self-mutilation and had been the victim of sexual abuse in prison. TP was reported to have an IQ of between 68 or 70, though no testing was documented at SCI-Cresson. TP was dangerous, impulsive, agitated and difficult to manage. TP had been in POC because he tied a T-shirt around his neck and later because he had thoughts of drowning himself in the toilet. The psychiatrist diagnosed TP with schizoaffective disorder. TP had a number of misconducts for violent outbursts and a behavior modification plan. Respondent mocked TP by saying "Please don't mess up my 43 IQ!" If accurate, this is significantly below the reported IQ for which Respondent had no testing done. It is denigrating and inappropriate for a mental health professional. Respondent authored the behavioral modification plan. This called for removal of all items from TP's cell except an anti-suicide smock and use of food loaf for at least 5 days. If he behaved, TP could then get an anti-suicide blanket and a regular meal tray. With positive adjustment for another 5 days, TP could get a prison jumpsuit and boxer shorts to wear. After 2 more days of positive adjustment, he could get a mattress and pillow. Five more days of positive adjustment could get socks, shoes and bed linens. And finally, after 2 more days (19 altogether if all went according to plan), TP could have all authorized property. Respondent did not believe that any additional intervention by the psychology department was necessary. Respondent provided TP with no psychological treatment during this time. Respondent's behavioral modification plan failed to respond adequately to TP's behaviors or provide adequate or appropriate treatment. There was no adequate assessment of

TP's behaviors that would substantiate an appropriate plan to change them. The plan was harsh and inappropriately punitive. Not only was there no treatment, there was no evaluation such as an IQ test or other assessment in support. TP decompensated and was housed in POC for threatening suicide with a toothbrush. TP tied a sheet around his neck and was banging his head on the wall. So, he was placed in a restraint chair for over 10 hours. Upon release from the restraint chair, TP was kept in the concrete observation cell without a mattress wearing only a smock for 6 days. TP deteriorated further, having virtually no ability to lift himself up or talk. TP refused to wear the suicide smock and was taken to a review meeting naked. It was abusive to permit TP to be naked attending a meeting led by Respondent. Restricting TP's ability to receive psychological treatment was inappropriate and prolonged his difficulties. At another review meeting, Respondent forced TP to attempt to sing the nursery rhyme "I'm a Little Teapot." There was no clinical value in doing so. Making TP sing in a demeaning way for entertainment of the staff was unprofessional. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology and committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services regarding TP.

JM was 42 years old and 8 years into serving a 5 to 11 year sentence. He was diagnosed with schizophrenia, delusional disorder, auditory hallucinations, narcissistic personality disorder, and polysubstance abuse disorder in remission. Before transfer to SCI-Cresson, JM was reported to swing quickly and accused correctional officers of conspiring to kill his mother, had projections, and was suspicious and paranoid. The staff at the prior prison recommended that JM's time in disciplinary segregation be reduced due to his mental illness and further that he be housed where he can receive a higher level of care for his mental illness. Respondent was specifically told of these recommendations during a teleconference planning JM's transfer to SCI-Cresson. Upon

arrival, a review committee including Respondent concluded JM should continue in administrative custody pending psychiatric review to place him in general population. This decision was very concerning in light of JM's serious mental illnesses and the recommendation from the prior prison. The psychiatrist then saw JM and recognized serious psychopathology; JM had thoughts of overdosing, was guarded, had obvious paranoia and endorsed auditory hallucinations. JM broke his hand punching a wall. He then threatened to hand himself and tried to cover his cell window. JM consented to psychological care. Upon interview in RHU, a psychology staff member concluded JM had "no mental health concerns." Despite this, a corrections officer referred JM for mental health services describing his behavior. The psychology staff member – who was involved in the initial pretransfer teleconference – concluded the problem was that JM was not taking his medications and should continue restricted housing. Two days later JM was again seen by the psychiatrist. JM was more ill, psychotic and delusional and refused to start antipsychotic medications. The next day a psychology staff member went through the suicide checklist for JM and noted no risk factors and concluded "no action at this time." The assessments of JM to this point were inadequate given staff was aware of his severe mental illness and his self-injurious and assaultive behaviors at SCI-Cresson. Again in RHU, JM threatened self-harm and banged his head and kicked the wall. He repeatedly said, "If you aren't a psychologist, I don't want to talk to you. I am going to kill myself." Though kept in a POC for 3 days, psychology staff did not assess JM; he was returned to RHU without an assessment. Respondent participated in and signed JM's new treatment plan with objectives to take all medications and follow rules. Psychological treatment was indicated as "other", rather than daily, weekly or monthly. This treatment plan was inadequate. JM was severely ill and acting out in a way to indicate further self-harm. There was no meaningful assessment and no treatment; the psychology department had abandoned its role.

JM asked for and consented to treatment but received none. JM was seen again by the psychiatrist and was still having delusions and refused antipsychotic medication. He wrote a grievance that so clearly showed his psychotic thoughts that a corrections officer responded with a suggestion to see a psychologist. Finally, on May 6, 2011, a member of the psychology staff observed JM and described him as smiling and pleasant where he was usually paranoid. This sudden elevation in mood was a risk factor for suicide as listed in DOC's mental health policy and included in the suicide prevention training. That evening JM attempted to cover his cell window with a towel. (Respondent did not consider this to be a risk of suicide.) Close to midnight, JM committed suicide by hanging himself in his cell. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology and committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services regarding JM.

Twenty-two year old BP was serving a sentence of up to 4 years for burglary and robbery. BP had a history of self-harm, and his mental health diagnoses included antisocial personality disorder, bipolar disorder, depression, polysubstance abuse, a motor vehicle accident with frontal lobe concussion, and rule out impulse control disorder. He was prescribed psychiatric medication. BP had been assessed at SCI-Camp Hill as a higher suicide risk than 90% of those completing the assessment. As Respondent knew, BP had previously attempted suicide three times. Now at SCI-Cresson, the psychiatrist prescribed medication and referred BP to the psychology department to work on anger management and frustration levels. A psychology staffer responded to the referral acknowledging that BP agreed to begin therapy. BP was later placed in RHU twice, and by the second time he had a change in medication compliance. A standard suicide risk assessment form was completed, and BP had the monthly RHU contact with psychology by Respondent who

documented that continued intervention is necessary and to continue regular contact. BP was later seen by the psychiatrist and was noted to be easily angered and have difficulty with impulse control. He was struggling with anxiety and sadness. He was not in compliance with psychiatric medication. Again in RHU, Respondent completed the standard suicide risk assessment form for BP. A psychiatrist saw BP and noted he was noncompliant with a history of decompensation when off medications. BP was depressed four days a week and had flat affect but denied suicidal ideation. A month later, Respondent signed his department's individual treatment plan for BP, w which listed the primary problem as medication compliance. It also inexplicably listed BP's stability code as a C and not as a D. Two weeks later BP was seen by a psychiatrist and report high anxiety, depression and some wish to die but no suicidal ideation. BP was again placed in RHU. When assessed, psychology staff noted "no remarkable psychopathology expressed or observed at this time." BP was denied parole. He again saw psychiatry and was sad but stated "he could benefit by one-to-one counseling" and agreed to restart a particular medication. Once again, BP went into RHU. Though Respondent was notified of this placement, there is no documentation that BP had contact with the psychology department any time after the treatment plan was completed except for the one encounter while in RHU. On July 16, 2012, BP received an upsetting letter from his girlfriend. Later that evening BP hanged himself with a bedsheet. BP's suicide was both foreseeable and preventable. He suffered from anxiety and depression, was intermittently compliant with medication that was not working for him and was asking for counseling. BP's conditions were treatable. He was writing dark depressing poems and had a history of misconducts. BP asked through his behavior to go into RHU as a check-in. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology and committed immoral or unprofessional conduct by being responsible for substantially inadequate

psychological care or lack of psychological services regarding BP.

JW was a 22 year-old inmate serving a sentence of 7 to 14 years for rape. JW was diagnosed with psychosis, alcohol abuse, rule out antisocial personality disorder. JW also reported that he was hearing voices of people arguing with each other and seeing things. JW was indicated to have an IQ of 76. JW was also diagnosed with schizophrenia, manic and depressive bipolar disorder, and major depression. JW suffered from gynecomastia, a condition where a male develops enlarged breasts, an often-humiliating side effect of an antipsychotic medication taken by JW. JW was aware that gynecomastia was a potential side effect of this medication yet elected to continue taking it after a risk/benefit discussion with his psychiatrist, because he felt very ill, tortured by his mental status, and was motivated to get better. JW signed a consent form to receive psychological treatment at SCI-Cresson. The psychology department prepared an individual treatment plan for JW, where the problem listed was medication compliance. JW was a stability code C. No psychology treatment was indicated on the form treatment plan. Nor was there any explanation for why the stability code was upgraded from D just before his transfer to SCI-Cresson. Although psychiatry was seeking JW frequently, psychology was not treating JW at all. A staff member wrote a mental health referral for possible removal from the mental health roster, and Respondent indicated that JW needed mental health services and would stay on the roster. JW continued to see psychiatrists. Another individual treatment plan was developed for JW and signed by Respondent. The listed problems were medication compliance, communication skills and mood management. The stability code remained C, and the projected treatment by psychology was marked "other" as opposed to daily, weekly or monthly. JW saw a psychiatrist and reported that his father had died (separately noted as a suicide) and he was having trouble sleeping, depressed, and sad but not a threat to himself. He continued with his medications. After being at SCI-Cresson

for almost a year and a half and despite the treatment plans, JW still had not been treated by psychology. JW had four contacts with psychology: a visit when placed in RHU, a visit with Respondent two weeks later regarding a security investigation that had been completed and JW released to SNU, and two annual PRT reviews. JW had become more ill. He saw psychiatrists and was experiencing severe depression, depressive disorder with psychotic features, auditory and visual hallucinations, paranoia, and difficulty sleeping. JW continued taking the psychiatric medications. On August 12, 2011, the psychiatrist requested a second opinion from psychology – the psychiatrist had offered JW voluntary admission to a mental health unit and questioned whether JW met the criteria for involuntary admission. Psychology never responded to this request for a second opinion, and JW was never committed. No explanation has ever been given – even at hearing in this matter – as to why psychology did not respond. Through January 2012, JW was seen by psychiatry, and his conditioned worsened. JW was not treated by psychology. In February 2012, another individual treatment plan was developed for JW. Again it listed the problem as medication compliance and identified JW's stability code as C. Yet, JW had not exhibited problems with medication compliance. To the contrary, he continued to take the psychiatric medication in an effort to feel better despite the physical side effect. This new treatment plan also highly overrated JW's global assessment of functioning. Respondent either failed to obtain and review JW's medical records that documented his severe persistent mental illness, or he failed to appreciate the significance of JW's level of illness. Either is a gross failure. JW should not have been a stability code C. JW committed suicide by hanging himself on March 11, 2012. JW's suicide was foreseeable, and he was at a high risk of suicide at least from August 2011 on. Psychology provided no treatment to JW despite his serious mental illness, despite his signed consent to received treatment by psychology, and despite the request from psychiatry for a second

opinion regarding involuntary commitment. The weekly treatment of JW was psychiatry was very rare and indicated the extreme level of his illness. The psychology department, while not solely responsible, had some responsibility for JW's suicide. Respondent committed gross incompetence, negligence or misconduct in the practice of psychology and committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services regarding JW.

Clearly, Respondent grossly lacked the quality necessary to effective practice or been more insufficient or inadequate. Respondent deviated flagrantly and grossly from the standards of care. Respondent departed from and failed to conform to the standards of acceptable and prevailing psychological practice in the psychological care – or more accurately, the lack of care – provided to CB, TP, JM, BP and JW. Because he displayed gross incompetence and negligence, Respondent is subject to disciplinary action under section 8(a)(4) of the Act, as charged in counts one through five of the amended order to show cause. Because he committed unprofessional conduct, Respondent is subject to disciplinary action under section 8(a)(11) of the Act, as charged in counts six through ten of the amended order to show cause.

In count eleven, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(4) of the Act because he displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by failing to act appropriately in response to reported concern of inmate abuse with regard to TP. As established by the findings of fact, after seeing TP huddled on the floor of a cold cell with nothing but the suicide smock, Dr. Seemuth documented her concerns in TP's record and then reported to Respondent her concerns that TP was being neglected and abused; Respondent took no action. Ms. Christoff reported concerns that TP was being mistreated after she saw him shivering on the floor of his cell with nothing on but a

suicide smock, to which Respondent replied, "Let the officers do their job. It's part of the modification program. Let them do their jobs." Ms. Christoff also reported to Respondent that she had concerns about TP's safety and believed he was being methodically abused after she saw bruises on his face; however, Respondent failed to do anything in response to reported concerns. Mr. Uhler reported to Respondent on multiple occasions his concerns that TP was being mistreated when he observed TP in his cell with nothing but a suicide smock for an extended period of time; Respondent's reply each time instructed Mr. Uhler not to interfere and just do treatment. Despite the extreme, excessive and extended nature of the deprivation of all items except a suicide smock and with no heat, Mr. Uhler never saw Respondent go to the SSNU to investigate TP and the conditions in which he was forced to live – living conditions that likely would result in criminal charges if done to a dog. After TP reported that corrections officers had stomped on his head and Mr. Uhler observed facial injuries including a black eye with the white part of his eye being blood red, Mr. Uhler made an oral report of abuse to Respondent and made a notation in TP's record that he may have been subject to abuse and that staff behaved inappropriately. Dr. Seemuth, Mr. Uhler and Ms. Christoff notified Respondent that they were concerned about the treatment of TP that they considered abusive, but Respondent failed to respond appropriately to their concerns. Respondent committed gross incompetence, negligence or misconduct by failing to act appropriately in response to reported concerns of abuse regarding TP. Because he displayed gross incompetence and negligence, Respondent is subject to disciplinary action under section 8(a)(4) of the Act, as charged in count eleven of the amended order to show cause.

In count twelve, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(4) of the Act because he displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology by failing to accurately portray the events

leading up to JM's suicide. As established by the findings of fact, following JM's suicide, Respondent completed and signed an evaluation of inmate self-injury form in which Respondent indicated that "yes," JM had history of mental health problems and was non-compliant with medication and that "no" the incident was not foreseen or preventable. Respondent's assertion that JM's suicide was not foreseen or preventable was inaccurate; JM's suicide was both definitely foreseeable and preventable. JM's suicide was foreseeable based upon: JM had serious mental illness, he was not receiving treatment by psychology, he was single celled in a restricted housing unit, he was delusional, assaultive and impulsive, JM had already made a suicidal gesture and verbal threat, and JM displayed a sudden elevation in mood on May 6. JM's suicide was preventable based upon: SCI-Cresson was instructed not to put JM into RHU due to his illness, another LPM recommended that JM go to the SNU and if that did not work go to an intermediate care unit for a higher level of care, and JM had previously responded to treatment. On May 12, 2011, at a meeting to discuss JM's suicide, Respondent summarized PSS Martinez's May 6 interaction with JM – where JM demonstrated a sudden elevation in mood – and noted there was "nothing remarkable." Respondent failed to bring up other relevant significant events in JM's history at SCI-Cresson including threatening suicide, hurting his hand, assaulting officers and demanding to speak to a psychologist. SCI-Cresson's suicide review and in particular Respondent's contribution to that review failed to paint an accurate picture of JM's mental health.

As the questions suggest, a review is done to determine whether the suicide was foreseeable or preventable. Following well-done reviews perhaps future potential suicides could be foreseen and prevented. Respondent's statements are not only inaccurate, Respondent's statements are so inconsistent with the true documented course of events that to make them demonstrates that he grossly lacked the necessary qualities to participate as a professional psychologist and displayed

gross incompetence. Respondent displayed gross incompetence, negligence or misconduct in failing to accurately portray the events leading up to JM's suicide. Because he displayed gross incompetence or negligence, Respondent is subject to disciplinary action under section 8(a)(4) of the Act, as charged in count twelve of the amended order to show cause.

Turning to Respondent's duties to supervisees, in count thirteen, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(9) of the Act because he violated the Board's regulation at § 41.61[8] by failing to respect the integrity and protect the welfare of people with whom he worked, in violation of Ethical Principle 6(a). In count fourteen,

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[8] **§ 41.61. Code of Ethics.**

Whereas the Board is empowered by section 3.2(2) of the Professional Psychologists Practice Act (63 P.S. § 1203.2(2)), to promulgate rules and regulations, including, but not limited to, a code of ethics for psychologists in this Commonwealth and whereas the **Board finds and determines that the following rules are necessary to establish and maintain the high standard of integrity and dignity in the profession of psychology and are necessary in the public interest to protect the public against unprofessional conduct on the part of a psychologist, in accordance with the act, the Board does hereby adopt this code of ethics for psychologists in this Commonwealth.** Psychology students, interns, residents and trainees are put on notice that their violation of an ethical obligation imposed on psychologists by this section may be regarded by the Board of evidence of unacceptable moral character or of unacceptable supervised experience disqualifying them from licensure under section 6(a)(1) or (2) of the act (63 P.S. § 1206(a)(1) and (2)). Licensed psychologists are put on notice that an ethical violation by an individual rendering or offering to render psychological services under their supervision, as provided by the act, may result in disciplinary proceedings against the supervisor under section 8(a) of the act (63 P.S. § 1208(a)).

* * *

Principle 3. Moral and legal standards.

* * *

(e) As practitioners and researchers, **psychologists act in accord with American Psychological Association standards and guidelines related to practice** and to the conduct of research with human beings and animals. In the ordinary course of events, psychologists adhere to relevant governmental laws and institutional regulations. Whenever the laws, regulations or standards are in conflict, psychologists make known their commitment to a resolution of the conflict. Both practitioners and researchers are concerned with the development of laws and regulations which best serve the public interest.

* * *

Principle 6. Welfare of the consumer.

(a) **Psychologists respect the integrity and protect the welfare of the people and groups with whom they work.** When there is a conflict of interest between the client and the psychologist's employing institution, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational or training procedure and they freely acknowledge that clients, students or participants in research have freedom of choice with regard to participation.

* * *

49 Pa. Code. § 41.61 (emphasis supplied).

the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(9) of the Act because he violated the Board's regulation at § 41.61 at Ethical Principle 3(e) by failing to adhere to American Psychological Association Ethical Principles of Psychologists and Code of Conduct, General Principle A,[9] which requires a psychologist to take care to do no harm and safeguard the welfare and rights of those with whom he interacted professionally and other affected persons.

As established by the findings of fact, Dr. Seemuth received serious threats from both CB and SS and reported those threats to Respondent. Respondent did nothing about the danger except direct her to continue contact with the inmates. He could have taken some action, such as a separation from the inmates as he immediately did for himself when threatened by CB. Instead Respondent pursued employee discipline against Dr. Seemuth for balking about being with a dangerous inmate who threatened her. Because he failed to respect the integrity and protect the welfare of his professional staff, Respondent violated Ethical Principle 6(a) of the Board's regulation and is subject to disciplinary action under section 8(a)(9) of the Act, as charged in count thirteen of the amended order to show cause. Because he failed to safeguard the welfare and rights of his professional staff, Respondent failed to adhere to General Principle A and violated the Board's regulation. Respondent is thus subject to disciplinary action under section 8(a)(9) of the

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[9] **Principle A: Beneficence and Nonmaleficence**

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

AMERICAN PSYCHOLOGICAL ASSOCIATION ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, eff. June 1, 2010, Principle A.

Act, as charged in count fourteen of the amended order to show cause.

Turning to Respondent's overall management activities, in count fifteen, the Commonwealth charged that Respondent is subject to disciplinary action under section 8(a)(9) of the Act because he violated the Board's regulation at § 41.61 at Ethical Principle 3(e) by failing to adhere to American Psychological Association Ethical Principles of Psychologists and Code of Conduct, Ethical Standard 1.03,[10] which requires a psychologist to resolve any conflict between ethics and organizational demands consistent with the General Principles and Ethical Standards of the Ethics Code. As established by the findings of fact, prison is an ugly place, especially for the mentally ill. And prison officials can view and react to bad behaviors of a mentally ill inmate, not just as symptoms of mental illness, but as disobedience that must be quelled or danger that must be avoided. Repeatedly, Respondent experienced consequences of the prison institution, such as inmates not brought from the cell for therapy, inmates kept in solitary confinement, inmates kept in apparently inhumane deprived conditions, and an inmate deprived of clothing led to a review meeting naked and smeared with feces. As discussed above, these all raised ethical issues for a licensed psychologist that appeared to conflict with those prison circumstances. Yet nowhere did Respondent attempt to resolve any of those conflicts. He did not clarify the nature of the conflict. He did not make known his commitment to the Ethics Code. And Respondent did not take any reasonable steps to resolve the conflict consistent with the Ethics Code. Instead, he told his staff to check with the corrections officers because they probably have a reason for it. And for good

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[10] **1.03 Conflicts Between Ethics and Organizational Demands**

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

AMERICAN PSYCHOLOGICAL ASSOCIATION ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, eff. June 1, 2010, Ethical Standard 1.03.

measure Respondent took employee disciplinary action against those who raised concerns. Because he failed to take steps to resolve these conflicts consistent with the Ethics Code, Respondent failed to adhere to the Ethical Standard and violated the Board's regulation. Respondent is thus subject to disciplinary action under section 8(a)(9) of the Act, as charged in count fifteen of the amended order to show cause.

Finally, in counts sixteen and seventeen, the Commonwealth charged that Respondent is subject to disciplinary action under sections 8(a)(4) and 8(a)(11), respectively, of the Act because he displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology and because he committed immoral or unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services at SCI-Cresson specifically in the years 2009-2013. As discussed above, Respondent displayed gross incompetence, negligence or misconduct in carrying on the practice of psychology and committed unprofessional conduct by being responsible for substantially inadequate psychological care or lack of psychological services with regard to the five identified inmates. Additionally, as head of the psychology department who has the greatest responsibility to do so, Respondent failed to resolve conflicts between the prison organizational needs and the psychologists' code of ethics such that he and his department could provide competent psychological services. Respondent failed to take any action in response to legitimate reports of suspected abuse of his department's clients. These failures displayed gross incompetence and negligence and were unprofessional conduct. Because he displayed gross incompetence and negligence, Respondent is subject to disciplinary action under section 8(a)(4) of the Act, as charged in count sixteen of the amended order to show cause. Because he committed immoral or unprofessional conduct, Respondent is subject to disciplinary action under section 8(a)(11) of the Act, as charged in count seventeen of

the amended order to show cause.

The Commonwealth has proved its case at all counts, and an appropriate sanction must be determined for Respondent's violations. The purposes for imposing disciplinary action in a licensing case include protecting the public health and safety, maintaining the integrity of the profession, and deterring future violations by the licensee and similarly situated licensees. *See, e.g., Barran v. State Bd. of Medicine*, 670 A.2d 765, 767 (Pa. Cmwlth. 1996); *appeal denied*, 679 A.2d 230 (Pa. 1996); *Herberg v. Commonwealth, State Bd. of Medical Educ. and Licensure*, 442 A.2d 411, 412 (Pa. Cmwlth. 1982); *Sweeny v. State Bd. of Funeral Directors*, 666 A.2d 1137, 1139 (Pa. Cmwlth. 1995); *Nicoletti v. State Bd. of Vehicle Mfrs., Dealers and Salespersons*, 706 A.2d 891, 894-895 (Pa. Cmwlth. 1998).

For Respondent's violations of the Act, the Board is authorized under section 8(b) of the Act to take the following action:

> **Section 8. Refusal, suspension or revocation of license.**
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> * * *
>
> (b) When the board finds that the license or application for license of any person may be refused, revoked, restricted or suspended under the terms of subsection (a), the board may:
>
> * * *
>
> (2) Administer a public reprimand.
>
> (3) Revoke, suspend, limit or otherwise restrict a license as determined by the board.
>
> (4) Require a licensee to submit to the care, counseling or treatment of a physician or psychologist designated by the board.
>
> (5) Suspend enforcement of its findings thereof and place a licensee on probation with the right to vacate the probationary order for noncompliance.
>
> * * *

63 P.S. § 1208(b). The Board is also authorized under section 11(b) of the Act, 63 P.S. § 1211(b), to impose a civil penalty of up to $10,000 on a licensee who violates a provision of the Act.

Because the Board is authorized by the Act to impose a civil penalty for a licensee's violation of the Act, the Board may levy a civil penalty of up to $10,000.00 per violation of the Act. Section 5(b)(4) of Act 48,[11] 63 P.S. § 2205(b)(4). Because Respondent committed 16 violations, the maximum civil penalty is $160,000. Additionally, the Board may assess against a respondent found to be in violation of the disciplinary provisions of its practice act the costs of investigation underlying that disciplinary action. Section 5(b)(5) of Act 48, 63 P.S. § 2205(b)(5). In determining an appropriate sanction, the Board weighs the seriousness of the violations against any mitigating evidence.

A professional license authorizes one to practice. But with that authority a license also imposes upon its holder responsibilities to practice consistent with the standards of the profession. As a licensed psychologist in charge of the psychology department at SCI-Cresson Respondent failed in those responsibilities. He failed to provide psychological services to multiple seriously mentally ill inmates. Three of the five identified inmates successfully committed suicide, and all three were foreseeable and could have been prevented. Respondent failed to take action upon legitimate reports of suspected inmate abuse. In reviewing an inmate's suicide for the purpose of improving institutional performance, he failed to accurately portray the events leading to an inmate's suicide – those actions or inactions of the psychology department that may have had the greatest impact on enabling the suicide. Respondent failed to take action upon threats to his subordinate psychologists. Respondent failed to adhere to the ethics of the psychology profession when those ethical responsibilities may have been in conflict with demands of the prison. As head of the psychology department, perhaps meeting this professional ethical obligation could have helped Respondent avoid the other violations. Respondent repeatedly displayed gross

[11] Act of July 2, 1993 (P.L. 345, No. 48), *as amended*, 63 P.S. §§ 2201-2207.

incompetence and negligence and failed to meet the standards expected of a licensed psychologist. Respondent's violations are of the utmost seriousness.

In mitigation, Respondent presented the testimony of then-Deputy Superintendent Jamey Luther who supervised Respondent while at SCI-Cresson. Dep. Sup. Luther testified that in his employee performance reviews Respondent was mostly rated as outstanding. (N.T. 1927). Respondent also presented the testimony of Secretary of Corrections John Wetzel. Sec. Wetzel testified that, following the DOJ investigation and report and closing of SCI-Cresson, he did not fire Respondent but instead promoted him to supervise other institutional LPMs, because Respondent was "one of the best LPMs in our system." (N.T. 2455-56). Because one of the most fundamental violations committed by Respondent was failing to reconcile the conflicts between his ethical duties as a psychologist with the demands of the prison organization, very little weight can be given to positive employee evaluations from the Department of Corrections to mitigate the seriousness of Respondent's ethical violations.

The Board's responsibility is to protect the public from unethical o incompetent practice of psychology. That public is primarily a licensee's group of clients. Clients remain entitled to that protection even in prison and no matter what crimes the clients have committed to arrive in prison. The imprisoned mentally ill or intellectually disabled are not fodder for sport of their captors. Nor are they subjects for permitting known mental illness to run its course of self-harm. Being so dependent and thus vulnerable, mentally ill inmate clients may need even greater protection from licensees such as Respondent who so utterly abdicate the responsibilities of the professional practice of psychology. And given the risks to anyone inside a prison's walls, protection of the welfare of subordinate psychologists and others acting under the licensee's authority is also a concern. Respondent's actions and inactions clearly demonstrate that he cannot

be trusted to practice psychology within the standards of the Act and Board regulations or the APA ethical standards. Respondent was asked if, with the benefit of hindsight, he would do anything different or direct his staff to do anything different. He repeatedly refused. Sadly, this may have been the most honest or accurate statement made by Respondent. It could not be more clear that the Board must revoke Respondent's license to practice psychology. Temporary suspension, retraining and monitoring would not create any reason to believe that Respondent could engage in the competent practice of psychology.

In order to deter Respondent and other licensees from committing similar violations, it is also necessary to require Respondent to pay a significant civil penalty. In addition to assessment of the costs of investigation incurred by the Commonwealth, Respondent will be levied a civil penalty of $45,000. This civil penalty is comprised of $5,000 for each of the violations of failing to provide appropriate psychological treatment to the five identified inmates, $5,000 for the violation of failing to be truthful and forthright in review of a suicide, $5,000 for the violation of failing to protect the welfare of subordinate psychologists, and the maximum of $10,000 for the violation of failing to resolve conflicts consistent with the code of ethics.

Accordingly, based upon the above findings of fact, conclusions of law and discussion, the following proposed order will issue:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF PSYCHOLOGY

Commonwealth of Pennsylvania,	:	
Bureau of Professional and	:	
Occupational Affairs	:	
	:	
v.	:	**Case Nos. 11-63-05399, 11-63-05413**
	:	
James Dale Harrington, MA,	:	
Respondent	:	

PROPOSED ORDER

AND NOW, this 20th day of **June, 2019,** upon consideration of the foregoing findings of fact, conclusions of law and discussion, it is hereby ordered that the license to practice psychology of **James Dale Harrington, MA,** license no. PS005934L, is **REVOKED** and that he shall pay a **civil penalty of $45,000 and is assessed costs of $17,233.59.**

Payment of the civil penalty and costs shall be made by certified, cashier's or attorney's check or money order payable to "Commonwealth of Pennsylvania." No later than the effective date of revocation as ordered by the Board (30 days after the mailing date of the Board's final order), Respondent shall pay the civil penalty and costs in full and deliver payment to:

Board Counsel
State Board of Psychology
P.O. Box 69523
Harrisburg, PA 17106-9523

The State Board of Psychology has announced its intention to review this Proposed Report in accordance with 1 Pa. Code § 35.226(a)(2).

BY ORDER:

Thomas A. Blackburn
Hearing Examiner

For the Commonwealth: Heather J. McCarthy, Prosecuting Attorney
Bridget K. Guilfoyle, Prosecuting Attorney
GOVERNOR'S OFFICE OF GENERAL COUNSEL
DEPARTMENT OF STATE OFFICE OF CHIEF COUNSEL
PROSECUTION DIVISION
P.O. Box 69521
Harrisburg, PA 17106-9521

For Respondent: Allen M. Tepper, Esquire
123 South Broad Street, Suite 2500
Philadelphia, PA 19109

Date of mailing: June 20, 2019

NOTICE

The attached Adjudication and Order represents the final agency decision in this matter. It may be appealed to the Commonwealth Court of Pennsylvania by the filing of a Petition for Review with that Court within 30 days after the entry of the order in accordance with the Pennsylvania Rules of Appellate Procedure. See Chapter 15 of the Pennsylvania Rules of Appellate Procedure entitled "Judicial Review of Governmental Determinations," Pa. R.A.P 1501 – 1561. Please note: An order is entered on the date it is mailed. If you take an appeal to the Commonwealth Court, you must serve the Board with a copy of your Petition for Review. The agency contact for receiving service of such an appeal is:

Board Counsel
P.O. Box 69523
Harrisburg, PA 17106-9523

The name of the individual Board Counsel is identified on the Order page of the Adjudication and Order.

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE OF GENERAL COUNSEL

Jackie Wiest Lutz
Assistant Counsel

jlutz@pa.gov

December 3, 2019

Heather J. McCarthy, Prosecuting Attorney
Bridget K. Guilfoyle, Prosecuting Attorney
Commonwealth of Pennsylvania
Department of State
Office of Chief Counsel
P.O. Box 69521
Harrisburg, PA 17106-9521

Allen M. Tepper, Esquire
123 South Broad Street, Suite 2500
Philadelphia, PA 19109

Re: Final Adjudication and Order
Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs v. James Dale Harrington, MA
Case Nos. 11-63-05399 and 11-63-05413

Dear Hearing Participants:

Enclosed please find an order issued this date in the above-referenced matter.

Sincerely,

Jackie Wiest Lutz, Counsel
State Board of Psychology

JWL/jwl

Enclosure

cc: Chris Stuckey, Board Administrator
State Board of Psychology