Psychiatrist Jennifer Tufts Timeline Testimony

September 12, 2022 — Intake paperwork

Three days before her first appointment, Clancy completed extensive psychiatric intake forms. She reported anxiety attacks, decreased appetite, depressed mood, distractibility, excessive worry, guilt, inability to feel pleasure, insomnia and racing thoughts.

But she **did not** endorse risky behavior, excessive energy, hopelessness, abandonment, emptiness or impulsivity.

Her suicide-risk questionnaire was especially notable. She answered **"no" to every item**, including wanting to die, having a suicide plan, self-harm, hearing voices commanding self-harm, thoughts of killing or seriously hurting another person, and voices telling her to hurt others.

Her GAD screening was highly suggestive of an anxiety disorder. The PHQ-9 also contained positive depressive symptoms warranting evaluation.

She reported previous Prozac and Wellbutrin use during nursing school without side effects. [In later testimony we found out from NP Jollotta that Clancy was on Prozac for a year.]

She also reported drinking one to two drinks at a time, perhaps five times per week, and feeling guilty about it, although the substance-use assessment did not indicate a substance-use problem. [In later testimony from Leticia Dukes, it was stated that Lindsay reported not drinking since 2019, which makes this “guilt” a bit inconsistent.]

September 15 — First Tufts appointment

Approximately three months postpartum.

Clancy described feeling overwhelmed. Dawson required more attention, the older children were challenging, and she had difficulty leaving the baby because he would not take a bottle. Leaving caused intense anxiety: physical tension, racing heart and fears that he would not eat or sleep. Importantly, she **denied thoughts of hurting the baby.**

She denied SI, HI, auditory/visual hallucinations and symptoms of mania. Tufts observed no psychosis. Judgment, insight, orientation, memory, attention and concentration were intact. Clancy described her mood as "okay"; Tufts observed an anxious affect.

Diagnosis:

- **Generalized anxiety disorder**
- **Adjustment disorder with depressed mood**

Treatment recommendation:

- **Individual therapy**
- **Zoloft/sertraline 25 mg for one week, then 50 mg**

Tufts selected Zoloft because it is a first-line anxiety medication and particularly appropriate during breastfeeding.

But Clancy was **reluctant to take medication because she feared side effects.** Tufts explained the risks and benefits; Clancy did not necessarily commit to actually taking it.

Treatment goals were symptom reduction and improved functioning.

September 28

Clancy told Tufts she had **picked up the Zoloft but had not taken it.** She actually felt somewhat better because Dawson was sleeping more, allowing her to sleep more.

Mental status was essentially normal: alert, oriented, appropriately dressed, euthymic, full affect, appropriate speech and thought process, no hallucinations, excellent judgment and no cognitive deficits.

Tufts rated her **insight as poor**, however, largely because she continued to have clinically significant anxiety yet remained unwilling to try the medication.

Plan: **pause the medication question and proceed with therapy.**

September 30

Clancy messaged Tufts seeking paperwork extending her maternity leave. She wrote that she was feeling **"just better enough to function without medication"** but did not feel mentally well enough to return to nursing because the baby's refusal of a bottle and having to work overnight would trigger too much anxiety.

October 3

Appointment largely associated with leave paperwork. They agreed she would remain out of work until approximately **January 1**.

Her anxiety had increased again and she said she was **"on the verge" of taking Zoloft**, but still wanted to try therapy first.

That same day she had her **first therapy appointment with Jennifer McAllister, LMHC.**
Mental status remained essentially unchanged. Tufts continued to describe her insight as poor.

October 10

Clancy contacted Tufts to correct her leave paperwork because it appeared to authorize a reduced work schedule immediately when their discussion had been that she would remain out until January 1.

Approximately October 13 — Zoloft finally started

At the October 20 appointment, Clancy said she had been taking Zoloft for **one week** and had increased from 25 mg to 50 mg the previous night.

So she apparently did **not begin the September 15 prescription until approximately October 13.**
That means the prescription existing in September absolutely does **not** mean she had been taking Zoloft for a month.

October 20

After approximately one week at 25 mg and one night at 50 mg, Clancy reported feeling **"awful."**
Symptoms included:

- increased insomnia
- appetite loss
- diarrhea
- depressed mood
- tearfulness
- fogginess
- significant anxiety

Tufts told her to **stop Zoloft**.
This is also where an important distinction emerged. Clancy said she was **afraid she might eventually develop suicidal thoughts if she continued feeling badly**, but she was **not presently suicidal**.

She denied SI and HI. Tufts found her clearly **not psychotic**.

Tufts also offered nonprescription alternatives such as fish oil and L-methylfolate because Clancy remained afraid of prescription medications.

October 21

Tufts saw her **the very next day because she was doing poorly**, which undercuts any suggestion that she wasn't being followed.

Clancy reported no sleep the previous night and significant anxiety. She denied SI, HI and hallucinations. No mania or mental-status deterioration was observed.

Ativan 0.5 mg PRN was started — the lowest dose — for severe anxiety, intended initially as a short-term measure.

Therapy was again recommended, with follow-up in one week.

October 26

Ativan had not helped sleep but **did reduce anxiety**.
Clancy had ***independently*** tried Benadryl and found it helpful.
She again denied SI/HI; no psychosis and no communication difficulties.
The Zoloft side effects had resolved, but the **original anxiety remained**, an important distinction

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Tufts proposed:

- **Buspirone 5 mg twice daily**
- Ativan PRN for severe anxiety
- Hydroxyzine 25 mg PRN as a safer alternative to Ativan
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Again, these were low starting doses.

October 31

Approximately one-hour <u>therapy session</u> with McAllister.

November 2

Clancy revealed that she **never started the buspirone because she was too afraid to take a new medication.**
She continued Ativan.
Her mood/affect were essentially normal. No SI, HI or psychosis.
Tufts did not want Ativan used long-term because of dependency risk. She discussed Remeron, trazodone, pregabalin and hydroxyzine as alternatives.
They agreed to **taper Ativan by 0.25 mg every two weeks.**
No replacement medication was selected.

November 22

Clancy told Tufts she had enrolled in the **South Shore Perinatal Mental Health Clinic** and apparently intended to transfer medication management there.
She reported she would begin Prozac and was still using Ativan and Benadryl for sleep as needed.
She denied SI/HI and showed no psychosis.
She also requested a return-to-work letter.

December 1 — Major turning point

Clancy scheduled another appointment with Tufts despite receiving treatment at South Shore because **she wasn't improving.**
She described multiple medication trials prescribed by South Shore:

- **Trazodone 50–150 mg:** minimal effect
- **Ativan + Benadryl:** helpful
- **Prozac 10 mg + Ativan + Benadryl:** sleep worsened → Prozac stopped
- **Remeron + Klonopin:** disorientation, rebound anxiety, minimal benefit
- **Remeron + Seroquel:** Seroquel prescribed but apparently not yet taken
- Remeron associated, in Clancy's mind, with intrusive thoughts described as **"I'm going to die."**

Crucially, Tufts clarified this was **not "I want to die."**
Clancy denied suicidal ideation but said she felt **close to developing suicidal thoughts**, was very hopeless, but had **no active self-harm thoughts, intent or plan.**

And this is where Clancy herself said:

"I think it's my problem. I keep reaching out to different people and not sticking with the plan."

Tufts recommended **one medication manager**.
Bipolar disorder was specifically evaluated because of the insomnia and poor medication reactions.
Tufts concluded Clancy **did not meet criteria for bipolar disorder and had no history of mania.**
Lamictal/lamotrigine was discussed but not prescribed.
Because Clancy was struggling significantly, Tufts recommended a **partial hospitalization program** for intensive daytime treatment while allowing her to remain home.

December 16

Clancy told Tufts:
"I'm having a really rough time."

Valium plus Seroquel was finally helping her sleep, but she felt very depressed during the day, lacked motivation and had experienced some suicidal ideation.
She had gone to the **Mass General emergency department**, where inpatient treatment at McLean was offered; she declined.

Again, Tufts elicited the specifics: Clancy described **hopelessness and fear that she would never get better**, but had **no suicide plan or intent.**
Clancy believed Seroquel was causing her depression. Tufts wasn't convinced because she had already observed depression **before Seroquel**.

Clancy was being **referred to the Women & Infants postpartum program in Rhode Island.**

Tufts now prescribed **Lamictal 25 mg**, the lowest dose, because the depression was continuing/worsening and other antidepressants had been poorly tolerated.

January 6, 2023 — Immediately after McLean discharge

This appointment occurred the day after her McLean discharge.
Clancy reported that she had gone to McLean specifically so she could be safely tapered off Seroquel because she continued believing it caused her depression.

Current medications:

- **Trazodone 100 mg**
- **Ativan 1 mg**
- **Melatonin 5 mg**

She denied SI and HI. Tufts observed **no psychosis**.
Her only reported medication issue was possible **rebound anxiety from Ativan** in the morning.
She reported no side effects from trazodone.
Clancy described herself as **"numb."** Her affect matched that description and Tufts believed she remained significantly depressed.
Trazodone increased to **150 mg**; Ativan 1 mg and melatonin continued.

Tufts marked her condition **"deteriorating,"** but importantly explained that the electronic record offered only three choices: improving, unchanged or deteriorating. She meant Clancy appeared somewhat worse than at the previous appointment.

Tufts nevertheless saw **nothing indicating imminent danger to herself or others and no basis for a Section 12 involuntary evaluation.**

January 9

Trazodone increase was helping sleep.
Clancy continued experiencing morning rebound anxiety after Ativan.
Mood "okay," but still flat; unable to cry although she could laugh somewhat.
No recent SI. No HI. No psychosis.
Because she had now been off Seroquel for several weeks **without the depression resolving**, Tufts increasingly believed Seroquel wasn't causing the depression:

the depression itself needed treatment.
Wellbutrin and amitriptyline were discussed.
Ativan was changed to **Valium**, which has a longer half-life and was expected to produce less rebound anxiety and be easier to taper.

January 11

Clancy emailed Tufts asking about **ketamine therapy**.
She wrote that she still had very low mood, no motivation and was "very depressed," that it had lasted months, and that she was becoming **"desperate for something that would work quickly."**

Tufts considered ketamine reasonable eventually because Clancy was beginning to appear treatment-resistant, but did not believe they had reached that stage yet.

January 16

Clancy remained significantly depressed but was:

- getting out of bed
- maintaining hygiene
- eating
- concentrating normally
- taking care of the baby

She said bonding with Dawson **felt forced**.
Again: **no SI, no HI, no psychosis.**
She wanted to taper off Valium because she did not want to depend upon a benzodiazepine for sleep.
Tufts started **amitriptyline 10 mg**, the lowest dose.
Mood depressed; affect depressed and flat.
Again, Tufts saw **no grounds for a Section 12.**

January 23 — Day before the deaths

This may be the single most important Tufts appointment.
Clancy had started **amitriptyline** and apparently experienced **no side effects**.
She described herself as "doing all right," although somewhat more anxious. She reported heart racing and decreased appetite.
She was down to **Valium 2 mg** during the taper.
She continued to describe herself as flat, anxious, numb and lacking motivation. She had to force herself to get out of bed and leave the house — **but she was able to do so and was sleeping okay.**

Mental-status examination:

- appropriately dressed
- appropriate rapport
- appropriate speech
- appropriate thought content
- appropriate thought process
- no cognitive deficits
- normal psychomotor activity
- no change in communication
- no psychosis
- no SI
- no HI

Tufts continued to rate insight as poor, largely because Clancy tended to **overattribute her symptoms to medications** rather than recognize the underlying depression.

Plan:

- slow the Valium taper because anxiety had increased
- increase amitriptyline from **10 mg to 20 mg**
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The prosecutor then asked Tufts explicitly whether Clancy had said she intended to kill herself.
No.
Whether she had said she intended to kill her children.
"No, absolutely not."
Whether anything in Clancy's demeanor, affect or behavior indicated that she posed a danger to herself or others.
No.
Whether there was any basis to Section 12 her.
No