**IN THE UNITED STATES DISTRICT COURT**
**FOR THE MIDDLE DISTRICT OF ALABAMA**
**NORTHERN DIVISION**

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| **JOSHUA DUNN, *et al.*,** | ) | |
| | ) | |
| **Plaintiffs,** | ) | |
| | ) | |
| **v.** | ) | **CIVIL ACTION NO.:** |
| | ) | **2:14-cv-00601-MHT-TFM** |
| **JEFFERSON S. DUNN, *et al.*,** | ) | |
| | ) | |
| **Defendants.** | ) | |

**MEMORANDUM OF LAW IN SUPPORT OF**
**PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

# TABLE OF CONTENTS

# TABLE OF AUTHORITIES

## CASES

**STATUTES**



**RULES**



**OTHER AUTHORITIES**

## I. Introduction.

This case arises from the systemic failures of the defendants to provide constitutionally adequate medical care, including mental health and dental care, to prisoners in facilities operated by the Alabama Department of Corrections ("ADOC"). Defendants' deliberate indifference to these systemic failures results in serious harm, and a substantial risk of serious harm, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

Plaintiffs seek to represent a general class of "all prisoners in the custody of ADOC who have or will in the future have a serious medical condition and are now, or will in the future will be, subject to Defendants' health care policies and practices" by virtue of serious medical, dental or mental health needs. Plaintiffs seek an order certifying the case as a class action under Federal Rules of Civil Procedure 23(a) and 23(b)(2). Plaintiffs seek declaratory and injunctive relief, including an order compelling defendants to develop and implement plans to provide plaintiffs and the proposed class with constitutionally adequate health care.

In addition, plaintiffs seek certification of two subclasses:

(a) A "Dental Subclass" consisting of "all persons with serious dental conditions who are now, or will in the future be, subject to defendants' dental care policies and practices at ADOC facilities."

(b) A "Mental Health Subclass" consisting of "all persons with a serious mental health disorder or illness who are now, or will in the future be, subject to defendants' mental health care policies and practices in ADOC facilities and policies and practices relating to the treatment of persons with disabilities;"

Pursuant to the Court's expressed interest in identifying additional subclasses within the medical care class, plaintiffs have considered a number of ways in which the class could potentially be subdivided.

As has previously been discussed, it is not helpful or appropriate to attempt to divide the class by the facilities in which prisoners are currently housed. Male prisoners all begin their incarceration at Kilby[1] but most are soon transferred out to other facilities based on a host of considerations. Some of those considerations are related to medical or mental health needs, but many others are not. Prisoners also are frequently transferred among the facilities - again for reasons that may or may not be related to health care. Some prisoners remain in one facility for an extended period, while others are moved around often. In addition, the policies and procedures that govern the provision of care in ADOC facilities are mostly dictated centrally, either by ADOC's Office of Health Services ("OHS"), or by the health care vendors, and apply to prisoners throughout the system. In order to provide relief that will benefit the class as a whole, that relief will have to apply to the

[1] The only exception to this is that male inmates sentenced to death go through intake at Holman.

ADOC system as a whole. Changes in the provision of care at a specific facility will benefit those housed there only until they are transferred elsewhere. Moreover, given the importance of continuity of care and the frequency of transfers, changing the policies regarding care facility by facility may actually harm class members.

Similarly, efforts to divide the class according to particular medical conditions will not be helpful and will likely lead to more complication and confusion rather than less. Many prisoners suffer from multiple illnesses. While large numbers of prisoners might fall within some specific disease categories - diabetes, for example - some will have conditions that are shared by few (or even no) others. An attempt to catalogue all the various medical conditions from which prisoners may suffer would undoubtedly wind up excluding some who have conditions that were not accounted for in that effort. The glue that binds all of those class members together is that they are subject to the same system of care - the same contracts with health care vendors, same lack of ADOC OHS oversight, same staffing policies and practices, same cost-cutting philosophy that denies or delays care to save money, same doctors and nurses at whichever facilities they currently inhabit, the same chronic care policies and practices. While it might be possible to fashion relief for a condition-specific subclass - diabetes, hepatitis C, etc. - the Court would embark on an unnecessarily complicated effort to address

issues of medical care on a disease by disease basis, and would likely venture into areas of medical judgment. Further, by creating subclasses by condition, the Court might create difficulties for class members with multiple conditions by requiring them to seek treatment for their different conditions in different manners. Relief that will benefit the medical care class as a whole, on the other hand, may be fashioned by addressing the overarching deficiencies in the system of delivering care. If ADOC and its contract vendors implement a plan to staff ADOC facilities with an adequate number of medical staff who are properly qualified, and then ADOC allows those medical providers to exercise their sound medical judgment in prescribing and providing needed care, class members with all kinds of medical conditions will receive the same benefit.

All current and future ADOC prisoners are at substantial risk of harm due to the medical, mental health and dental care policies and practices of defendants, and may now or in the future be subject to any or all of those policies and practices. However, specific policies and practices related to mental health and dental care are distinct from the overall provision of medical care within ADOC, and the relief necessary to reform care in those areas will also be largely distinct. Additionally, the Mental Health Subclass brings claims under the Americans with Disabilities Act and § 504 of the Rehabilitation Act of 1973 (collectively referred to herein as "ADA") for discrimination and failure to accommodate in violation of the ADA.

For decades, Defendants' system of providing healthcare for prisoners has been afflicted by numerous serious deficiencies, which are systemic and intertwined. These deficiencies proceed from policies, practices and procedures adopted by defendants that impede or prevent the provision of adequate care, and from defendants' deliberate indifference to the resulting harm. Defendants' deliberate indifference to the obvious healthcare needs of prisoners in their custody results in numerous prisoners going for months or years without appropriate diagnosis or treatment, leading to unnecessary pain and suffering, loss of function, injuries and deaths.

Defendants have chosen to entrust the implementation of their obligation to provide constitutionally adequate care to private contractors, though they remain, of course, liable for the fulfillment of that obligation. Since at least 2007, ADOC has required companies bidding for contracts to provide health care in Alabama prisons to offer "capitated" or "full-risk" contracts, pursuant to which the contractor bears the full risk that health care costs may exceed the per prisoner price dictated by the contract's pricing schedule. The contractor receives a fixed amount of money regardless of how much or how little care it provides to prisoners.[2] Thus, its profit margin increases as the cost of the care it provides goes down and vice versa, creating a perverse and persistent incentive to cut corners

[2] If the total number of prisoners goes above or below set numbers, the total to be paid to the contractor is adjusted by a set amount per prisoner. Ex. 92 (ADOC-Corizon Contract); Ex. 153 (ADOC-MHM Contract excerpt).

and/or delay or deny care at every opportunity. This incentive has grown stronger over the years as Defendants continually sought to reduce the price paid to providers. The incessant pressure to reduce the costs of care by delaying, denying or providing less than adequate care has had a direct and profound impact on Plaintiffs and members of the class who suffer inadequate care. For the years 2000-2013 (the period for which the latest nationwide data is available), Alabama prisons had among the highest mortality rates in the nation, both generally and for illness-related deaths. Bureau of Justice Statistics Mortality in Local Jails and Prisons, 2000-2013, available at:

http://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf.

Defendants and their contractors fail to maintain minimally sufficient medical, dental and mental health staff, and the staff that are hired are often not qualified or competent to carry out the duties to which they are assigned. Defendants also fail to maintain the number of custody staff minimally necessary to facilitate provision of needed care to prisoners, and custody staff members are not properly trained or supervised in their roles in the medical care system. The resulting failures occur at both critical and routine levels.

The overextended and underqualified healthcare staff at ADOC facilities work within an overarching structure of policies that do not facilitate, and often prevent, the provision of adequate care. Healthcare needs are improperly

identified, or not discovered at all, because underqualified staff handle diagnosis and referral for care, and do so using tools that are inadequate. Even where health care needs are identified, appropriate treatment is not provided in a timely or thorough manner because too few staff (and often underqualified staff) are available to provide the necessary care. The routine management of chronic conditions is impeded by a system that is abysmally incapable of providing regular therapeutic care and treatment, or even reliable administration of needed medications. Patients who need to be sent outside of a prison for specialty or emergency care languish in their cells, or in prison infirmaries, watched by nursing staff who may or may not document their deterioration, but do little or nothing to address it. Doctors are often not present, and provide inadequate supervision and oversight for their subordinates. Doctors fail to order diagnostic tests or specialist referrals, or their orders are simply not carried out until it is too late to prolong or save a life. Continuous quality improvement measures are ineffectual, focusing on process rather than quality of care, and the recommendations that are generated are frequently ignored system-wide.

Defendants provide inadequate facilities for the provision of all types of medical care, including mental health and dental care. Insufficient space is available to accommodate many basic medical examinations - space for the patient to lie flat, for example - or for any privacy to be afforded for discussion of

confidential medical information. With respect to mental health care, most of the counseling and other therapeutic activities necessary for adequate treatment are absent, due in large measure to insufficient space to conduct them. Inadequate facilities for dental care mean that dental emergencies often go untreated, let alone routine examinations or preventive care. Defendants' failure to provide adequate resources for their contractors to provide care leads to reliance upon inappropriate medications, whether because a cheaper medication is chosen to cut costs, needed medication is not prescribed, or outdated medications are handed out rather than being replaced. Even so, medication is often the only treatment afforded to prisoners whose conditions require more, such as physical therapy for injuries, surgical procedures, or counseling and therapeutic activities for mental illness.

Defendants' internal policies and operational practices and, in many cases, their routine failure to even comply with their own policies, mean that contractors engaged to provide care receive inadequate resources and inadequate oversight. OHS maintains audit procedures that are not adequate to allow it to monitor the quality of the care being provided in its prisons. Those procedures focus almost entirely on adherence to processes and documentation. OHS does not participate in activities to evaluate the quality of patient care, such as peer review of physicians, and reviews of mortality and sentinel event reports. The office does not employ or engage with doctors, dentists, psychiatrists or psychologists to assist

it in conducting monitoring of the performance of medical, mental health or dental care contractors. OHS ignores woeful deficiencies detected in the areas it does evaluate.

Even without these systemic failures of staffing and policies, Defendants' inadequate and chaotic system of maintaining healthcare records makes it almost impossible to deliver minimally adequate care. Volumes of paper records are stored in a variety of haphazard ways, often making them difficult to locate. Records frequently fail to be transferred, timely or at all, with prisoners who are moved between facilities. Vital documentation is often missing from the medical records.

As detailed below, the multiple grave deficiencies in the systems of providing care to ADOC prisoners render care constitutionally inadequate across the board. Every ADOC prisoner is at risk, every day, of being subjected to that substandard care and of being harmed in very profound ways.

## II. Statement of Facts.

### A. The Overarching ADOC/OHS System Controls the Provision of Care.

#### a. The Organizational Structure and Key Players

The Alabama Department of Corrections contracts with Corizon, LLC to provide medical care in ADOC prisons. The parties entered into their first contract

in 2007 and subsequent renewals in 2010 and 2012. Ex. 94 (Corizon 2014 Annual Report) at Dunn(Corizon) at 363143.

The contract is premised on a risk model in which ADOC paid a lower contract price in return for the private contractor bearing virtually all of the risk associated with increased healthcare costs, including the costs of offsite care. Ex. 92 (ADOC and Corizon Medical Services Agreement).[3] By placing the financial responsibility for each instance of medical care, including dental, on the private providers, Defendants have created a financial incentive for Corizon to provide less or no care in order to keep costs low and maximize profit. The impact of this has been significant. According to ADOC's 2010 Annual Report (Ex. 90), the cost of medical and mental health services increased 295% from 2000 to 2005, but from 2006 through 2010, annual cost increases averaged only 6%. Ex. 90 at 23, 27 (ADOC Annual Report 2010). From Fiscal Year 2010 through Fiscal Year 2015, the cost increases slowed even further – increasing by just 7% total over the five years.[4] *Compare* Ex. 91 at 24 (ADOC Annual Report 2015) *with* Ex. 90 at 27 (ADOC Annual Report 2010). Those cost savings come at the detriment of prisoners.

[3] The Corizon-ADOC Medical Services Agreement was amended effective February 5, 2015. The amendment does not impact any of the issues discussed herein.

[4] In 2010, health care costs totaled $116,054.713, and in 2015, health care costs totaled $124,258,626.

Since first contracting with ADOC, Corizon has failed nearly every major performance audit of it conducted by ADOC.[5] Despite this abysmal performance, ADOC has continued to extend its Corizon contracts. ADOC has also contracted with Corizon to provide dental services to Alabama prisoners. Corizon, in turn, has contracted with its subsidiary, CDAA. CDAA's president, Dr. Charles King ("King"), serves as Corizon's Regional Dental Director. Ex. 151 (Dunn(Corizon)_10175 Corizon Dental Services Summary). All of the dentists and dental assistants are selected by CDAA and employed by Corizon, Ex. 152. (Dunn(Corizon)_10178 Corizon Dental Clinic Organization and Operations), with the treatment to be provided governed by Corizon and CDAA Policies and Procedures. As will be discussed later in this brief, CDAA's provision of dental care falls well below the standard of care, exposing all ADOC prisoners to harm or a substantial risk of harm, including needless pain and suffering and tooth loss.

As a result of the settlement agreement in *Bradley v. Haley*, discussed in more detail below, MHM Correctional Services, Inc. ("MHM") entered into a contract to provide mental health services throughout ADOC in 2001. Ex. 158.

[5] Ex. 138 (Audit reports from multiple facilities) REDACTED

(MHM 2013 Response to RFP), at MHM025964. The contract was renewed in 2008. *Id*. The current contract went into effect in 2013. Ex.153 (MHM Contract) at ADOC000323. The Mental Health Contract charges MHM to carry out "the State's constitutional duty to provide mental health care to state inmates" through "specialized mental health programming that conforms with correctional and constitutional standards." *Id*. at 323. Tragically, inadequate mental health and corrections staffing, inadequate identification of mental illness, and inadequate treatment options and space prevent constitutional treatment for people with serious mental illness incarcerated in ADOC. ADOC routinely fails to carry out its duty to monitor and oversee MHM, thus failing to ensure that MHM provides even minimally adequate mental health care.

**b. Policies and Procedures**

The policies and procedures maintained by ADOC and its healthcare contractor, Corizon, provide the overarching authority that governs the provision of all care afforded to prisoners. Unfortunately, there is no coherent source of policy and procedure to guide healthcare. Instead, policies and procedures are issued from multiple sources.

Five different categories of policies and procedures, often incomplete and outdated, and sometimes in conflict with each other, govern medical care within ADOC. Ex. 84 (Puisis Report) at 34-35. These include ADOC Administrative

Regulations, Office of Health Services policies and procedures, Corizon regional policies and procedures, facility-specific ADOC Standard Operating Procedures, and Corizon facility-specific policies and procedures. *Id.* at 34-41. Despite both ADOC and Corizon having policies and procedures that apply both across facilities and within specific facilities, these are largely inadequate for their purposes and often in conflict with each other.

ADOC fails maintain policies for all essential areas and to update the policies and procedures. At least 12 of the 15 major facilities have Standard Operating Procedures (SOP), which are facility-specific procedures issued by wardens. SOPs cover areas relating to medical care, such as handling of medical files, responsibilities in emergency situations, security on and access to the medical unit, pill call and medication procedures, and others. SOPs are supposed to be updated annually. Ex. 84 (Puisis Report) at 35. This does not happen with consistency.[6] The SOPs do not cover all essential areas of medical care, but they do give wardens inappropriate authority to direct medical care. Ex. 84 (Puisis Report) at 35. As an example, Dr. Puisis points to a facility SOP that dictates a frequency of sick call different from Corizon's policy. Dr. Puisis notes that the frequency of sick call is a health care decision that should be made by the central medical authority, not decided by facility wardens.

[6] While at least one SOP shows a review date of 2014, another shows a last-review date of 1994. Ex.84 (Puisis Rep. at 35; Ex. 116 (Easterling SOPs C-45 and C-42).

The ADOC/Corizon contract requires the vendor to follow both ADOC OHS policies and procedures and by the National Commission on Correctional Healthcare ("NCCHC") standards, with ADOC OHS taking precedence in the case of conflict. However, OHS policies and procedures fail to address areas considered essential by NCCHC, including infection control, environmental health and safety, credentialing, medication administration, management of chronic diseases, and others. Ex. 84 (Puisis Report) at 37-38.[7]

Corizon similarly fails to update and maintain adequate policies and procedures. Rather than developing site-specific policies that address the needs of a facility's unique population, the provider applies generic corporate policy templates to most institutions. Ex. 84 (Puisis Report) at 38; see also Ex. 96 (Tutwiler Policy, Management of Tuberculosis). This contributes to inadequate medical care throughout the system, as providers must be able to turn to tailored and up-to-date policies and procedures for instruction and guidance. Ex. 96 (Tutwiler Policy, Management of Tuberculosis).

## A. The Inadequate Medical Care System Within ADOC Endangers The Entire Class.

### a. Many prisoners in the ADOC have serious medical needs.

[7] The NCCHC reviews and accredits correctional facilities and systems throughout the country and sets forth standards for correctional healthcare Nat'l Commission on Correctional Health Care, *About Us*, http://www.ncchc.org/about (last accessed Aug. 15, 2016). Although the contracts with Corizon and MHM require the vendors to comply with the NCCHC standards, ADOC is not

All prisoners in the custody of ADOC rely on ADOC for all medical needs – from a cold, to the measles, to cancer or a broken back. Some prisoners currently have no serious medical needs, but they may develop serious medical needs at any time, whether as a result of an illness, an accident or violence.

Many prisoners already have serious medical needs. ADOC and Corizon use a number of lists to identify—albeit, not always thoroughly—prisoners who have specific medical needs, including chronic care lists and high acuity reports. While the numbers of prisoners listed on these reports varies somewhat by facility and over time, they consistently show that a large number of ADOC prisoners suffer from serious medical conditions during any given month. Because processes for identifying and diagnosing medical problems in the prisons are deficient, the numbers shown on ADOC and Corizon reports understate the actual population of prisoners with serious medical needs.

Prisoners enrolled in "chronic care clinics" are persons whom Corizon has identified as being "chronically ill" in an “increasing chronically ill population.” Ex. 94 (Corizon 2014 Annual Report) at 8. For March of 2016, Corizon reported REDACTED hronic care enrollments (made up of those patients suffering from one or more chronic diseases who are seen every 90 days in chronic care clinics) and REDACTED chronic care clinic visits that month. Ex. 93 (Corizon March 2016 Monthly Report) at 15. The chronic care clinic make-up was as follows:

- Diabetic Clinic: REDACTED
- Pulmonary Clinic: REDACTED
- Cardiac/Hypertension Clinic: REDACTED
- Seizure Clinic: REDACTED
- General Clinic: REDACTED
- TB Clinic: REDACTED
- HIV Clinic: REDACTED
- Liver Clinic: REDACTED

Ex. 93 (Corizon March 2016 Monthly Report) at ADOC 0317832-33). An individual prisoner may be enrolled in multiple chronic care clinics.[8] While the precise number of individuals with recognized chronic conditions is unknown, the largest single clinic had REDACTED enrollees in March 2016.

"Highest Acuity Reports" are produced monthly for each facility and identify the following categories of people:

REDACTED

As of December 2014, REDACTED individuals were listed on Corizon's Highest Acuity Reports across all facilities. Ex. 95 (December 2014 Highest Acuity Report). People on the Highest Acuity Lists are not only those who are sickest,

[8] Many individuals who are in one chronic care clinic are also enrolled in others. For example, a person may suffer from both diabetes and hypertension, resulting in being enrolled in two chronic care clinics. In such an instance, the prisoner would go to a single chronic care appointment at which both conditions should be addressed.

but also those Corizon considers REDACTED

Ex. 93 (Corizon March 2016 Monthly Report) at 15.

At the very least, then, there are about 6,000 prisoners in ADOC custody who have been identified as currently having a serious medical need. Ex. 93 (Corizon March 2016 Monthly Report) at ADOC 0317832-33 (largest single clinic had REDACTED enrollees in March 2016). All prisoners in ADOC custody rely on ADOC for healthcare and are subject to ADOC's medical policies and practices. On any given day, many prisoners who do not suffer from chronic conditions or grave illness or injury will nevertheless be ill or injured, requiring some level of medical attention and adding to the demand for care.

As described by Plaintiffs' expert Eldon Vail, the horrific overcrowding across ADOC facilities also increases the demand for medical care, further overburdening the insufficient numbers of medical staff available to handle that demand. Mr. Vail explains in his report that increased demand due to overcrowding results from inmates being housed in very close quarters in open dormitories,[9] leading to the spread of infectious diseases and to increased levels of trauma due to violence. ADOC and Corizon have independently recognized that overcrowding is increasing trauma-related care. In an email from Corizon Vice

[9] According to the Federal Bureau of Prisons, "prisoners housed in large, open bay dormitories are more likely to visit clinics than are prisoners in other housing arrangements." Gees, Gerald G., *The Effects of Overcrowding in Prison*, University of Chicago (1985).

REDACTED

REDACTED

REDACTED

Ex. 86 (Greifinger Rep. 16).

**a. There is an inadequate number of medical staff throughout ADOC.**

ADOC is unable to provide constitutionally adequate medical care at existing medical staffing levels. According to the most recently negotiated contract between ADOC and Corizon, there are 493 Corizon medical staff positions for the entire system. Ex. 92 (Corizon-ADOC Medical Services Agreement) at 37.[10] As of March 2016, ADOC incarcerated REDACTED people. Ex. 93 (Corizon Monthly Report, March 2016) at 8. Many of those nearly 25,000 people have chronic conditions or serious medical needs, and even those who do not require routine care and care for less serious illnesses or injuries. Corizon provides an insufficient number of physicians and nurses to satisfy the demand for care, and critical positions are missing.

The number of nurses working in the ADOC is insufficient. In his review of medical records, Plaintiffs' medical expert, Dr. Michael Puisis, found numerous instances in which essential and basic nursing tasks simply had not been carried out. Ex. 84 (Puisis Rep.) at 12-13, 100-106. Ex. 84 (Puisis Rep.) at 12. For example, Corizon discovered in 2010 that of 2,800 inmates with a positive

[10] This includes support staff.

tuberculosis test, one-third had not had initial tuberculosis screening and one-third had not had an annual test. *Id*. at 133; see also Ex. 230 (Corizon Annual Report to ADOC 2010) at 15.

The number of physicians is also insufficient to provide adequate care. Physicians working within ADOC typically have significant administrative responsibilities in addition to their patient care duties, because they act as site medical directors in addition to providing regular care. Site medical directors are responsible for covering infirmaries, seeing high acuity patients and performing administrative tasks. This leaves mid-level providers to handle most chronic care, and places those patients at substantial risk of harm due to the lack of appropriate physician involvement and oversight. Ex. 84 (Puisis Rep.) at 14.

In some facilities, one physician is ultimately responsible for thousands of patients. At Staton, Draper and Elmore Correctional Institutions, for example, one physician and three nurse practitioners handle the medical caseload of more than 3,000 patients. Ex. 84 (Puisis Rep.t) at 14. ADOC is well aware that the ratio of providers to patients is inadequate. In 2013, Defendant Naglich raised the issue in an email to ADOC personnel, stating REDACTED

Ex. 140

(ADOC0141649 8.23.2013 email from Ruth Naglich to Lynn Brown et al).

Corizon has repeatedly recognized its own inability to meet its obligations with current staff.

As of March 2016,REDACTED

Ex. 93

(Corizon Monthly Report, March 2016) at ADOC0137846-848. Chart reviews conducted by Dr. Puisis showed prisoners with serious medical needs were suffering neglect of their conditions because medical staff were not available and care was being managed remotely by phone. Ex. 84 (Puisis Rep.) at 13-14.

In general, medical personnel work eight hour days, but the amount of time spent actually providing patient care to prisoners is less. Ex. 84 (Puisis Rep.) at 14. Each provider sees 20-25 patients a day, spending an average of 15 minutes with each. Dr. Puisis found in conducting chart reviews that almost all notes in patient records lacked adequate history and physical exam. Ex. 84 (Puisis Rep.) at 14. Given the inadequate number of medical staff available to see patients, many simply are not seen in any remotely timely manner. Dr. Puisis reports that Plaintiff William Sullivan, who suffered from hypertension and had a prior stent due to coronary artery disease, was seen only twice in four years. Ex. 84 (Puisis Rep.) at 14. During that time, his symptoms indicate he was developing heart failure, but ADOC providers failed to evaluate him for this. *Id.*

Another patient, Plaintiff Augustus Smith, had a catheter, diabetes, hypertension, and high blood lipids. Ex. 84 (Puisis Rep.) at 15. He was seen almost exclusively by a nurse practitioner. On a number of occasions, the nurse felt he needed to be seen by a physician, but none was available, causing him to be rescheduled several times over a number of weeks. *Id.*

Similarly, there are inadequate numbers of mid-level providers (nurse practitioners and physician assistants).

**b. Medical staff have inadequate qualifications and often practice outside or above their qualifications**

In addition to the overall shortage of medical staff, many of those who are present are tasked with providing care at a level that exceeds their qualifications. Site medical director physicians, overtaxed by large patient caseloads and administrative responsibilities, inappropriately rely on mid-levels to provide the majority of chronic illness care, placing patients at a substantial risk of serious harm. Ex. 84 (Puisis Rep.) at 14.

Nurse practitioners (also called CRNPs or mid-level providers) are required to be supervised by physicians.[11] Nurse practitioners in the ADOC are not supervised properly by physicians. *See* Ex. 24 (Rahming Dep.) at 24:13-15; *see also* Ex. 23 (Pavlakovic Dep.) at 36:13-37:1. Dr. Pavlakovic, who supervises

[11] By law, in Alabama, the "collaborating physician" must spend 10% of the collaboration time for each CRNP on site with the CRNP and review 10% of each CRNP's records.

Nurse practitioner Vivian Odom, has never found anything requiring correction in his supervision of her. Ex. 23 (Pavlakovic Dep.) at 107:10-15. Mid-level providers are practicing outside of the scope of their qualifications, in that they are practicing medicine without supervision. This places patients at a substantial risk of serious harm.

While physicians inappropriately rely on mid-levels for care outside of their qualifications, mid-level medical staff, in turn, inappropriately rely on licensed practical nurses, or LPNs. Pursuant to Ala. Code 34-21-22(a), an applicant for a license to work as an LPN need only have a high school degree or equivalent, and have completed one year of training at a school of practical nursing. LPNs are not qualified to perform independent patient assessments. Ex.84 (Puisis Rep.) at 51-52. Yet LPNs conduct intake screenings of prisoners, which leads to failure to properly identify medical needs. In doing the intake screenings, LPNs have to determine whether an incoming prisoner has an immediate medical need, a task for which they are not qualified. Ex. 84 (Puisis Rep.) at 51. LPNs also perform sick call triage and evaluation, again improperly performing independent patient assessments, and often staff medical offices without supervision on nights and weekends, despite having inadequate training to do so. Ex. 84 (Puisis Rep.) at 51-53, 63-65. As with the intake screening, this leads to prisoners not receiving appropriate care because an under-qualified staff person failed to properly identify

medical needs. The LPN must determine the urgency of a complaint and LPNs are not qualified to make this determination.

When Plaintiff Willie McClendon presented to medical on a Saturday with a swollen testicle, the LPN gave him ibuprofen and told to follow the sick call process if his condition did not improve. *See* Ex. 84 (Puisis Rep.) at 100-101. A swollen testicle is a urological emergency. *Id.* By the time Plaintiff McClendon was sent to the hospital two and a half days later, his condition was significantly worse. *Id.* He was in septic shock and his testicle had to be amputated. *Id.* Leaving LPNs to make the decision – unsupervised – as to whether a condition is an emergency places prisoners at risk of serious harm.

The LPN may be the only medical staff to evaluate a prisoner's complaint for a week or more. It can take nearly a week to see a nurse after filling out a sick call form. *See* Ex. 79. REDACTED at ¶ 12). Often, the nurse who sees the patient for the nursing encounter is also an LPN. See Ex. 84 (Puisis Rep.) at 61. According to policy, nursing encounters by LPNs must be reviewed by a registered nurse ("RN"). See Ex. 121 (OHS Policy No. E 7, Health Services Inmate Sick Call Request) at 3. However logs of these reviews indicate that the reviews often do not happen and, when they do, they are cursory and often not timely. See Ex. 125 (ADOC Sick Call Tracking Logs). RNs review only a one or two word description on a sick call log, not the actual complaints of the patients or the record of the care

provided and basis for decision. Once a nurse triages a patient's sick call concerns, it can be two weeks before a patient sees a doctor, if he sees one at all. *See* Ex. 48 (REDACTED .) at ¶ 14; Ex. 51 (REDACTED .) at ¶ 10. Some prisoners fill out sick call slips and are never seen by any medical staff. Ex. 82 (REDACTED Decl.) at ¶¶ 31-33; *see also* Ex. 59 (REDACTED Decl.) at ¶ 9; *see also* Ex. X (Aug. 11, 2015 Multidisciplinary Meeting minutes from Donaldson stating REDACTED ). Similarly, Defendants' expert Greifinger found that REDACTED

Ex. 86 (Greifinger Rep.).

Physicians working with ADOC typically lack the appropriate subject-area credentials to provide general medical care for a large population. Among the 10.4 physicians currently assigned to work within ADOC facilities are four obstetricians and one surgeon. Ex. 84 (Puisis Rep.) at 21; *see also* Ex. 92 (Corizon-ADOC Medical Services Agreement) (showing contractual staffing requirements of 14.6 MDs in facilities), Ex. 93 (Corizon Monthly Report, March 2016) at ADOC0317846-848 (showing REDACTED ). Their training, however

[12] REDACTED

x. 86 (Greifinger Rep.).

sufficient it may be for those specialty areas, is inadequate to provide primary care in a correctional setting. In order to be qualified to practice correctional medical care, most physicians should be primary care physicians. *See* Ex. 84 (Puisis Rep.) at 20. Dr. Hood acknowledged this in deposition; primary care training is important in order to serve the medical needs of an adult male population. *See* Ex. 13 (Hood Dep.) at 37:8-14, 38:20-39:5.

ADOC does not place any credentialing requirements on its medical provider. Ex. 22 (Naglich Dep. II) at 15:21-22. Corizon's credentialing procedures REDACTED

. Ex. 114 (Corizon Policy P-C-01.01, Credentialing).[13] Physicians who are not qualified and credentialed to practice primary care should not serve as site medical directors, but they do.

Defendants' expert Dr. Greifinger also REDACTED

REDACTED

[13] Dr. Hood testified in deposition that Corizon does look for primary care experience among its physicians. *See* Ex. 13 (Hood Dep.) 38:20-39:22. However, the lack of objective standards for the amount of primary care experience needed (See *Id.*), combined with Corizon's hiring history, cast doubt on how much emphasis Corizon actually places on primary care experience.

REDACTED

Ex. 86 (Greifinger 6-17). Defendants and their vendor, Corizon, provide no such training or supervision for physicians they hire who are not board certified in a primary care area.

Physicians within ADOC also exceed the scope of their practice and qualifications by attempting to provide care in prison infirmaries for acute patients who require acute or hospital care. Ex. 84 (Puisis Rep.) at 100-106. This places patients who are already in critical condition at a substantial risk of serious harm.

**c. ADOC fails to maintain adequate custody staff to accommodate medical needs**

ADOC's failure to provide adequate medical care is further exacerbated by the lack of adequate custody staff to accommodate medical needs. Custody staff play a critical role in the provision of medical services, as they are responsible for the movement and transportation of prisoners. Without adequate custody staff to provide security, prisoners are prevented from accessing medical care. *See* Ex. X (July 7, 2014 email exchange between Laura Ferrell and Bennie Andrews REDACTED ); Ex. 128 (August 26, 2014 email from Laura Ferrell to Larry Linton REDACTED ); Ex. 102(Jan. 3, 2013 email from Warden Carter Davenport to James Deloach and Grantt Culliver regarding REDACTED

REDACTED

.”); Ex. 118 (September 2014 MAC meeting minutes from Bibb Correctional Facility) at 1, 7, 8, 16, 21 REDACTED); Ex. 142 (Dunn(Corizon)_0252970 July 2014 MAC meeting minutes from Fountain Correctional Facility).

Plaintiffs' expert Vail explains in his report that ADOC is severely understaffed with correctional officers, leaving it incapable of adequately facilitating the provision of care to prisoners. As of March 2016, ADOC had 5,832 authorized positions (including both custody staff and administrative support employees) for a population of more than 24,000 prisoners. Many of those positions were unfilled. Vail termed the shortages of custody staff at major facilities "alarming." That same month, ADOC staffing levels for those facilities were - Holman: 45.8%, Kilby: 65.5%, St. Clair: 50.6%, Tutwiler: 46.9%, Bibb: 33.8%, Easterling: 39.8%, and Fountain: 31.5%. Overall, staffing for close custody facilities was at 57%, and for medium custody facilities was at 42%. As early as 2006, when staffing shortages were much less severe, ADOC noted that "it is not uncommon for a single Correctional Officer to be supervising up to 250 - 300 medium or higher level prisoners for an extended period of time. At the time of this writing, the problem is getting worse." See Doc. 555-2 (Vail Rep.) at 38-

39. Today, Vail notes, "in many cases correctional officers are not regularly in the dorm where the inmates reside. In some cases there are simply not enough officers on duty to assign one to each dorm." Doc. 555-2 (Vail Rep.) at 41. Little wonder, then, that if there is not enough custody staff to even have one present in each housing unit, the custody staff needed to escort prisoners to the medical unit, to respond to urgent medical issues, or to take them to offsite care, are frequently not available for that task.

Issues with a lack of available custody staff interrupting medical care pervade the system and are demonstrated at multiple facilities. REDACTED

REDACTED

Ex. 54 (REDACTED .) at ¶ 7.

REDACTED has missed his 4:00 a.m. pill call because custody staff report it is too foggy to go outside or that there are not enough staff to move prisoners. Ex.74 (REDACTED Decl.) at ¶ 9. Mr. REDACTED suffers from asthma, diabetes, high blood pressure, acid reflux, cholesterol problems, and requires twice-daily medication. *Id*. at ¶ 4, ¶¶ 6-9. During an approximately four year period when Mr. REDACTED was housed in segregation, he was denied the ability to keep his asthma inhaler with him in his cell. *Id*. at ¶¶ 13-14. He was forced to bang on the cell door to get an officer's attention when he suffered an asthma attack. *Id*. Sometimes Mr. REDACTED

had to go to pill call to receive his inhaler, which often meant waiting hours. *Id*. A nurse told him that she could not bring his inhaler to him because there no custody staff were available to escort her to segregation. *Id*.

**d. ADOC maintains inadequate staff for specialized positions, namely quality assurance and infection control.**

ADOC has failed to designate specific medical staff as responsible for quality assurance or infection control, two critical components of correctional health care. See Ex. 22 (Naglich Dep. II) at 148:12-14; see also Ex. 84 (Puisis Rep.) at 12. Those staff who have some responsibilities for infection control—Brandon Kinard and Laura Ferrell—have significant other responsibilities as regional medical coordinators. See Ex. 21 (Naglich Dep. I) at 19:8-20:5.

ADOC similarly fails to staff a quality assurance program. The OHS conducts periodic audits of individual facilities and, as with infection control, relies on staff members with significant other duties to participate in the audits—two regional coordinators, the director of medical services, the chief psychologist and Defendant Naglich. Ex. 22 (Naglich Dep. I 71:3-72:2, Dec. 8, 2015). None are medical doctors. Ex. 84 (Puisis Rep.) at 48. Corizon has not dedicated a single staff person to quality assurance responsibilities. See Ex. 92 (Corizon-ADOC Medical Services Agreement) at Appendix A. These system-wide deficiencies place prisoners at a substantial risk of serious harm, as evidenced by the infectious disease outbreaks, which will be discussed below, and the poor quality of

physicians. Defendants' expert Dr. Greifinger writes REDACTED

Ex. 86 (Greifinger 18).

**3. ADOC provides inadequate screening and diagnoses of prisoners, placing them at a substantial risk of serious harm during all stages of their incarceration.**

**a. ADOC's intake screening fails to meet the needs of incoming patients.**

Intake screening is essential to ensuring that contagious diseases are identified, and that incoming prisoners receive needed medications, appropriate treatment plans for illness or disability, and are properly housed. Ex. 84 (Puisis Rep.) at 50. Those who have been on prescription medications prior to arrival need to continue receiving those medications without substantial delay, and some prisoners arrive with urgent medical needs that require immediate treatment. *Id.* ADOC fails to provide adequate intake screening, even when provided with information related to diagnoses and medical problems. Policy and procedure calls for LPNs to conduct intake screening histories, with providers performing only the physical examination. Intake screenings should be conducted by RNs, as LPNs lack sufficient qualifications to perform an appropriate medical history and identify medical needs. Ex. 84 (Puisis Rep.) at 53. The physical examination is not

required to include vital signs, which may result in missing important findings. Ex. 84 (Puisis Rep.) at 54. The poor screening often results in a failure to continue medications, inadequate transfer and sharing of records from prior incarcerations and insufficient record review at intake—all ultimately contributing to poor medical care. Ex. 84 (Puisis Rep.) at 54-58. The screening failures are due, in part, to LPNs conducting various assessments at intake when they are not qualified to do so. *Id.*

Medical intake interviews and examinations are cursory and rushed. Ex. 73 (REDACTED Decl.) at ¶¶ 4-7. Dr. Rahming, the medical director at Kilby, which serves as ADOC hospital and the reception center where all intake screenings occur, does not even know whether he conducts intake physical examinations of all incoming patients, or a select few. Ex. 24 (Rahming Dep.) at 34:5-9. In addition to the lack of a requirement for vital signs in physical examinations, Dr. Puisis found in his review that practitioners performing them were documenting normal examinations when in fact the prisoners had "significant physical abnormalities." Dr. Puisis also found that the intake screening process fails to consistently ensure that prisoners on prescription medications for chronic illness continue receiving medications in a timely way.

Once a person is screened at intake, he or she may experience a gap in treatment or no follow-up treatment at all. Plaintiff John Maner entered ADOC 18

years ago, following a gunshot wound that left him partially paralyzed. Ex. 58 (Maner Decl.) at ¶ 3). At Kilby, where Mr. Maner underwent his intake screening, he was recommended for physical therapy. *Id*. at ¶ 4. Eighteen years later, Mr. Maner has yet to receive therapy for his partially paralyzed leg.

Plaintiff Roger Mosely arrived in ADOC custody following a car accident that left him temporarily in a wheelchair. Ex. 62 (Mosely Decl.) at ¶¶ 4-9). Prior to entering ADOC, Mr. Mosely had been receiving physical therapy and hoped to be able to walk again. *Id*. Mr. Mosely asked medical staff at intake to continue his therapy. He later asked the physician at his assigned facility to continue his therapy. *Id*. at ¶¶ 8-12. Mr. Mosely was told he would not receive therapy. *Id*. He did not "push this issue" out of fear of retaliation. *Id*. at ¶ 13. He resorted to trying to treat himself with exercise. *Id*. at ¶ 14. He continues to be in constant pain resulting. *Id*. at ¶ 15.

**b. ADOC's sick call process creates barriers to adequate care, and relies on screenings and assessments by unqualified staff, resulting in delays and substantial risk of serious harm.**

ADOC's sick call process is inadequate to facilitate access to needed medical care. Indeed, many aspects of the process impose barriers to obtaining care.

Sick call is the primary method by which prisoners obtain non-emergency health care. According to Dr. Puisis, in a typical correctional setting about 10% of prisoners would be expected to seek sick call care on any given day. Ex. 84 (Puisis

Rep.) at 59. From October 2014 to March 2015, 40,006 sick call requests were triaged at ADOC facilities, or an average of just 15 per day at the 15 major facilities. *Id*. at 59-60. Dr. Puisis opines that this small number is indicative of barriers preventing prisoners from accessing care. *Id*. Of those requests, only 28,665 resulted in actual contact with a nurse - less than 1% of inmates on a daily basis. *Id*. at 60.

There are numerous barriers to accessing non-emergency care through the sick call process. First, obtaining and submitting sick call requests is difficult at many facilities. While OHS policy requires sick call slips to be available on all housing units, some facilities did not keep the slips on housing units. Ex. 84 (Puisis Rep.) at 60. Some facilities maintained only one collection box for submitting sick call requests in the entire facility, making it impossible to submit a request in situation such as lockdowns. *Id*. Many patients, particularly the elderly and infirm, cannot access sick call regularly or easily. At Kilby, sick call forms are kept in the infirmary. That means that a prisoner seeking to fill out a sick call form must receive permission from custody staff to travel to the infirmary, fill out a sick call form, and then wait for a response. Ex. 24 (Rahming Dep. 65:3-66:20, Feb. 18, 2016). In some facilities, REDACTED

(stating that REDACTED

).

Second, ADOC has chosen to impose co-pay fees related to sick call requests. Prisoners are charged $4 to see an LPN, even though LPNs are not qualified to perform assessments. Ex. 84 (Puisis Rep.) at 60. They are charged another $4 for each medication provided (such as ibuprofen for pain). *Id.* at 60-61. Dr. Puisis found that the per pill charge to prisoners is often many times more than what would be paid in the free world for the same medication. *Id.* at 61. Moreover, fees are charged even when prisoners decline certain types of care—$8 for refusing an on-site specialty appointment, $12 for refusing an off-site specialty appointment. *Id.* at 61.

LPNs conduct most of the sick call triage, including providing health assessments. Ex 84 (Puisis Report) at 61. LPNs are not qualified to perform independent assessments. OHS implicitly acknowledges this limitation by requiring an RN to review sick call logs filled out by the LPN. See Ex. 121 (OHS Policy E-7, Health Services Inmate Sick Call Request) at ¶ 9. However, by requiring a review of the log, rather than the actual sick call forms or records of the assessment or care provided, OHS allows the review to be essentially meaningless. See, e.g., Ex. 125 (ADOC Sick Call Tracking Logs) at ADOC132231-74

Frequently, even this cursory review is late or missing entirely. *See, e.g, Id.* at ADOC0132231-235, ADOC0132243.

LPNs and RNs utilize Nursing Encounter Tools in their evaluations of patients. While the forms themselves are not inadequate as to things they address, they must be properly used in order to be effective. For example, in one instance, an LPN used the respiratory Nursing Encounter Tool for a patient who complained of coughing, vomiting and a runny nose. The respiratory Tool did not contain any questions about vomiting. The LPN, using the tool, ordered sinus medications without documenting questions or answers about vomiting. Ex. 84. (Puisis Rep.) at 61. A month and a half later, the same patient returned to sick call with continued coughing and vomiting, this time being evaluated using a gastrointestinal Nursing Encounter Tool. The nurse failed to ask questions about weight loss or the quality of the vomitus, and reported the vomiting as a new symptom. *Id*. Ultimately, the patient was determined to have active tuberculosis, but only after many people in the facility had been exposed. *Id*. Had an adequate evaluation been done on this patient, ADOC might have avoided the 2014 outbreak of tuberculosis at St. Clair Correctional Facility.

**c. Patients within ADOC frequently experience delays in seeing a provider or receiving a diagnoses.**

REDACTED has been diagnosed with a stomach ulcer that causes him pain, loss of appetite and weight loss. His weight has dropped to 88 pounds. Ex.

59, (REDACTED Decl.) at ¶ 7). He vomits blood and bleeds when he has a bowel movement. *Id*. at ¶ 8. Mr. REDACTED has submitted numerous sick calls about this condition, but has received no responses. *Id*. at ¶ 9.

Plaintiff Brian Sellers suffered from kidney stones for a year and a half before he received surgery. Ex. 84 (Puisis Rep.) at 304-09. He experienced frequent bloody urine and back pain for years until his surgery. Ex. 25 (Sellers Dep.) at 168:2-12; 171:21-24.

As noted above, the patient who was evaluated by an LPN and an RN using Nursing Encounter Tools actually had active tuberculosis. It was not diagnosed until two years later. By that time, it had progressed to the point the patient had the

REDACTED

Ex. 229. (Feb. 5, 2014 email from Eric Morgan to Hugh Hood, et al.).

**d. Numerous additional obstacles to adequate diagnoses exist within ADOC.**

**a. ADOC facilities uniformly include inadequate exam room and infirmary space and equipment.**

REDACTED

Ex. 86 (Greifinger Rep.) at 17.

Every medical unit within ADOC suffers from inadequate exam room space and a lack of adequate equipment. Exam rooms often lack examination tables or, if they have one, the tables are difficult to access due to clutter. Exs. 132, 133, 135 (photographs of examination rooms at multiple facilities). Medical staff may conduct examinations in storage rooms, x-ray rooms, hallways or other areas not designed for patient exams. Ex. 84 (Puisis Report) at 29. Exam rooms often have poor lighting and insufficient equipment. *Id.* at 29-30. These conditions demonstrate a shortage of medical space and inability of ADOC to provide adequate medical care in its current facilities.

Privacy—or the lack thereof—presents an additional barrier to care. Patients may have to meet with medical providers while custody staff is present. See Ex. 48 (REDACTED Decl.) at ¶ 16; see also Ex. 51 (REDACTED Decl.) at ¶ 11. This can deter patients from seeking medical care. Custody staff comment inappropriately on patients' medical care. See Ex. 48 (REDACTED Decl.) at ¶ 16); see also Ex. 51 (REDACTED Decl.) at ¶¶ 6-7 (upon collapsed lung requiring hospitalization, custody staff told infirmary nurse REDACTED was merely having a breathing attack).

The infirmaries at ADOC similarly lack adequate space and equipment. The infirmaries are crowded and afford no privacy to patients receiving care. See Exs. 134, 136 (photographs of infirmary units in multiple facilities). As the infirmaries

often house a facility's most vulnerable and ill patients, the lack of adequate space to provide adequate care presents a substantial risk of serious harm.

**b. Medical records are maintained in a disorganized manner that makes them difficult or impossible to find and use.**

Medical records are vital because they document the history of treatment over time. Failure to properly document medical care falls below the standard of care, and can result in harm to the patient. ADOC maintains a cumbersome paper medical files that present multiple obstacles to adequate care, particularly in a large, multi-prison state system. The medical records of many prisoners include multiple volumes, and older volumes are often not stored in the same location as current records. Ex. 84 (Puisis Report) at 31. Medical record rooms are frequently cluttered, cramped and disorganized, presenting a challenge to utilization. Ex. 84 (Puisis Report) at 30. This is particularly true at Kilby, where the prison hospital and many of the sickest patients are located. See Ex. 137 (photographs of medical records room at Kilby).

Individual medical records are similarly disorganized. The OHS policy related to health records requires that when a new volume is created, one prior year of records be moved forward to the new volume. It also requires that certain documents such as original intake history and immunization records (including TB testing) travel with a current record, no matter what their date. Ex. 122 (OHS Policy H-1, ADOC Inmate Health Record) at ¶ 1-3. That does not consistently

happen, however. Ex. 84 (Puisis Report) at 31-32. The maintenance of incomplete medical records makes it difficult for medical staff to provide thorough care. *See Id*. Dr. Puisis found that in many records reviewed, there was no original intake documentation, and it was often difficult to make important determinations, such as whether the prisoner had a prior positive tuberculosis skin test. *Id*. Many other important documents also were missing from many medical records, including hospital and lab reports. Some documents that were not included in individual medical records of persons who had died nevertheless turned up in sentinel event reports. Dr. Puisis opines that not having complete records, including the older records for individuals with multiple volumes, can impair the provider's ability to provide adequate care.

**4. ADOC Does Not Provide for Adequate and Timely Treatment, Placing Prisoners at Risk for Serious Harm**

**a. Poor pharmacy and medication management place patients at a substantial risk of serious harm.**

**a. Patients often miss medication at no fault of their own or fail to receive it, placing them at substantial risk of serious harm.**

ADOC fails to maintain an effective pharmacy and medication administration program. Ex. 84 (Puisis Rep.) at 76-81. This is a critical issue, as a high number of prisoners within ADOC are prescribed medications. See, e.g., Ex. 93 (Corizon Monthly Report, March 2016) at ADOC0317895-96 (REDACTED

REDACTED ), ADOC0317889-90 (REDACTED

REDACTED ), ADOC0317883-84 (REDACTED ); see also Ex. 84 (Puisis Rep.) at 76-81. The failure to maintain adequate policies and procedures on medication administration results in harm to prisoners through delays in receiving prescribed medications as well as through errors in administering medications. ADOC and its provider ignore errors in medication administration and renewal, as well as physical barriers to medication receipt. While an electronic medication administration record was implemented in the last few years, neither ADOC nor Corizon has updated policies in order to adequately incorporate the electronic record, or "eMAR," into their systems. Ex. 84 (Puisis Report) at 77.

Patients often experience a delay in receiving medication, even when they timely request refills. Mr. REDACTED uses an emergency inhaler that he is allowed to "keep on person" or "KOP." Ex. 64 (REDACTED Decl.) at ¶ 15). Medical staff has told him to make the inhaler last two months. *Id*. When it runs out before two months has passed, he is sometimes told he has to wait for a refill, despite relying on the inhaler daily. *Id*. Another patient experienced delays in receiving his Zocor prescription every month during 2012, resulting in him missing 56 days of prescribed medication.

Plaintiff William Sullivan suffers from congenital heart disease and high blood pressure, in addition to other ailments. Ex. 26 (Sullivan Dep.) 24:6-25. He has suffered two heart attacks while incarcerated and had stents implanted. *Id*. at 98:2-99:25. Mr. Sullivan takes numerous prescription medications and has experienced unexplained stoppages of medications, delays in receiving refills and many-week gaps when he does not receive medicine. *Id*. at 47:7-50:19, 64:10-21, 70:1-10; Ex. 127 (William Sullivan grievances regarding unexplained missed medication doses). Mr. Sullivan identified problems with his medication administration on numerous occasions. Ex. 127 (William Sullivan grievances) at 1 (went to pick up prescription Niacin and was told it had not been ordered), 2 (aspirin dosage changed without explanation, than changed back), 3 (describing two-month problem running out of medications and not having them refilled), 4 (describing six-day delay in receiving heart medication; received response that meds would be available January 4, 2013, resulting in 10-day gap in dosage), 6 (describing three attempts to receive medication from the pill call window in one month and being told at each one the medication was out), 7 (describing two-week gap in receiving medication), 8 (complaining of medication related to heart condition being discontinued). Despite Mr. Sullivan's serious medical condition, ADOC fails to provide him with consistent medication or with explanations of why his medication was stopped. *Id*.

By failing to provide patients with information related to their changes in medication, ADOC sets up a barrier to their healthcare. While Mr. Sullivan was denied information related to the sudden stoppage in of his medication (Sullivan Dep. at 66:16-24), Mr. REDACTED was denied information related to new medication he was prescribed. Ex. 59 (REDACTED Decl.) at ¶ 10-11. Mr. REDACTED was scared to take his unidentified new medication because no one explained it to him and he did not know what it was. *Id*.

The timing of pill call—often in the middle of the night—makes it difficult for patients to receive medication. Ex. 84 (Puisis Rep.) at 79. It can be particularly difficult for the most vulnerable prisoners, the elderly and infirm. In some facilities, patients must line up to receive their medications at 4 AM. See Ex. 74 (REDACTED Decl.) at ¶ 8). At Kilby, the prison hospital, pill call is held at 3 AM. Ex. 24 (Rahming Depo. 70:21-71:1, Feb. 18, 2016). There are often only one or two windows for pill call. For example, REDACTED

. Patients may be forced to wait hours in line for their medication. REDACTED has had to wait four hours for his medication on more than one occasion. Ex. 55 (REDACTED Decl.) at ¶ 17). Based upon the numbers of prisoners taking prescription medications and the facilities and staff available for medication administration, Dr. Puisis found that it did not

appear possible that medications were being administered on a timely basis according to the standard of care.

Additionally, ADOC providers fail to prescribe necessary medication or delay providing them. Plaintiff Rick Martin failed to receive timely medication related to his heart condition, resulting in a clotted stent and likely damage to his heart muscle. Ex. 84 (Puisis Rep.) at 79-80. Mr. Martin experienced multiple delays related to his medication administration, including a two-month delay in increasing the dose of the beta blocker Coreg following an order by his cardiologist to do so. *Id.*

Plaintiff Augustus Smith, who suffered from diabetes and high blood lipids, received inadequate doses of medication to address his blood lipids, as well as repeatedly untimely medication for his diabetes over the course of years. Ex. 84 (Puisis Rep.) at 80. This resulted in elevated blood lipids and a deterioration in his diabetic condition, placing him at a substantial risk of serious harm. *Id.*

REDACTED suffers from a clotting disorder that results in a very high risk for blood clots. Ex. 54 (REDACTED Decl.) at ¶19. Before coming to prison, Ms. REDACTED was being treated with Lovenox injections. Since being incarcerated, she has been routinely treated with a very high dose of Coumadin, and has not seen a hematologist. *Id.* She is rarely within therapeutic levels using Coumadin, meaning that she remains at a high risk for blood clots. *Id.* The ADOC physician

occasionally orders Lovenox injections for her, but discontinues them and puts her back on Coumadin as soon as her test results reach normal limits. *Id*. at ¶20.The doctor advised her that he won't keep her on Lovenox because it's too expensive, and also because it allegedly causes osteoporosis. *Id*.

Defendants' own expert, Dr. Robert Greifinger, REDACTED

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Ex. 86 (Greifinger Rep.) at 10-11. REDACTED

Ex. 86

(Greifinger Rep.) at 12. REDACTED

REDACTED

Ex. 86 (Greifinger Rep.) at 12.

**b. The treatment of chronic conditions is constitutionally inadequate.**

Chronic care clinics REDACTED

Ex. 113 (Corizon Policy P-G-01.00, Management of Chronic Disease).

Providers take inadequate histories and provide inadequate physical exams and follow-up to chronic care patients. Ex. 84 (Puisis Rep.) at 68. Chronic care notes across records are inadequate. *Id.* The impact of this poor care is discussed further in the examples below. REDACTED

Ex. X (Greifinger 20)

Inadequate chronic care has led to emergency surgeries for REDACTED

REDACTED.

[14] REDACTED

REDACTED

The majority of chronic care is provided by nurse practitioners and physician assistants, rather than physicians. Ex. 84 (Puisis Rep.) at 69. The patients seen in the chronic care clinic often have multiple serious illnesses that require a higher level of care that is often outside the qualifications of mid-level providers. Ex. 84 (Puisis Rep.) at 69-75. Inadequate physician oversight of their care places prisoners at a substantial risk of serious harm.

REDACTED , who has been incarcerated REDACTED suffers from high blood pressure, a lower stomach hernia, three slipped discs, nerve damage, Hepatitis C and cataracts. Ex. 39 (REDACTED Decl.) at ¶¶ 3-4. He is on the chronic care list and previously saw a physician for his high blood pressure in chronic clinic. *Id*. at ¶¶ 5-6. Now, he only sees a nurse practitioner. *Id*. Due to unusually high blood pressure, Mr. REDACTED was told he needed to have his blood pressure

taken daily for a period of 10 days. He went at least four days of the 10-day period without that happening. *Id*. at ¶ 8.

REDACTED is assigned to chronic care because of COPD and gout. Ex. 79 (REDACTED Decl.) at ¶ 4. He takes one 400 mg dose of ibuprofen three times per day for his gout, in addition to other medications for his COPD. *Id*. at ¶¶ 5-7. He has gone to pill call to pick up his ibuprofen and been told at times that it is unavailable. *Id*. at ¶ 9. Despite having more than one chronic care diagnosis and being on multiple medications, Mr. REDACTED sees a nurse, not a physician, for his conditions. *Id*. at ¶ 10.

**c. ADOC's infection control system is inadequate, ineffective, and places all prisoners at a substantial risk of serious harm.**

Incarcerated people are at a higher risk for infectious diseases than people in the free world. Ex. 84 (Puisis Rep.) at 126. Being incarcerated is a risk factor for both Hepatitis C and tuberculosis. ADOC has failed to recognize these risks and implement the necessary control systems to prevent infection and outbreaks.

Corizon has not dedicated any staff to infection control exclusively. See Ex. 92 (Corizon-ADOC Medical Services Agreement) at Appendix A.[15] Nor does ADOC have any dedicated infection control staff, or even a policy with respect to infection control. Ex. 22 (Naglich Dep. II) at 148:12-14; Ex. 84 (Puisis Rep. at

[15] Corizon has an infection specialist. This is a doctor who treats people with infectious diseases. This is distinct from an infection control position. Infection control staff is responsible for tasks such as following trends and identifying conditions that increase the risk of contagion.

127). Ms. Naglich testified that two of her Regional Clinical Managers have some responsibilities for infection control. She stated that Brandon Kinard is coordinator for infectious disease and Laura Ferrell is responsible for policy and procedure coordination with Public Health. Ex. 21 (Naglich Dep. I) at 20:2-5. Mr. Kinard's responsibilities for infectious disease, as described by him at his deposition, are minimal. See Ex. 17 (Kinard Dep.) at 45:07-77:09.

In his expert report, Defendants' expert Dr. Greifinger REDACTED

Ex. 86 (Greifinger Rep.) at 25.[16]

Despite having experienced several recent outbreaks of infectious diseases, ADOC fails to adequately screen prisoners. Almost all cases of TB should be identified at intake. When large numbers of TB cases develop within a prison system, this indicates a breakdown of the screening process. Ex. 84 (Puisis Rep.) at 126. Since 2010, there have been 38 cases of active TB within the ADOC system, including two major outbreaks at Donaldson (2010) and St. Clair (2014). In 2010, following the appearance of tuberculosis at Donaldson, Corizon determined that 2,800 prisoners had previously tested positive for tuberculosis.

[16] Even Dr. Keldie, another of Defendants' experts REDACTED

Ex. 87 (Keldie Rep.) at 38.

Ex. 84 (Puisis Report) at 133. Of those 2,800, one-third had not received an initial screening and one-third had not had their annual tuberculosis screening. *Id.* The same strain of TB that was at Donaldson in 2010 has appeared in other prisons as recently as 2015. Ex. 84 (Puisis Rep.) at 131. This suggests that – even with the realization that they had failed to adequately screen for and treat TB prior to 2010 – Defendants continued to fail to adequately screen for and treat TB.

In addition to these substantial failures of screening and surveillance, the incompetence of medical staff has resulted in failure to identify and diagnose active cases of TB before the disease is spread to others. For example, a St. Clair prisoner was evaluated by an LPN for coughing, vomiting and a runny nose. The LPN used the wrong tool to evaluate the patient, and diagnosed a common cold. She did not ask questions about his cough, concluded the TB skin test was not applicable, and did not document his weight despite complaints of vomiting. The screening was not reviewed by an RN. Over the next six months, the prisoner was seen twice more for the same complaints without a proper diagnosis. In fact, the third nurse to evaluate him completed a TB screening form and checked "no" for all symptoms. A year after first presenting with these symptoms, the patient was evaluated by an LPN for chest pain and a productive cough. He weighed 137 pounds but was not asked about his weight loss. The nurse referred the patient for a provider evaluation, but that didn't occur. Several more encounters with nurses

and nurse practitioners still produced no appropriate screening or diagnosis. Another year passed. The patient had trouble breathing and his blood pressure was abnormally low. Instead of having the patient seen by a physician, a nurse called a physician who ordered 10 days of medications over the phone. Several days later, the prisoner again presented with a pulse of 123, and a weight of 110 - he had lost 30 pounds since the ordeal began. He was admitted to the infirmary and remained there three days without seeing a doctor. A chest x-ray was finally ordered, which showed a large lesion in a lung. A CT scan was ordered but not performed for about another two weeks. A day after the test, the prisoner was transferred to isolation at Donaldson for suspected TB. The disease had disseminated throughout both his lungs, and many other people had been exposed and placed at substantial risk of harm. Ex. 84 (Puisis Rep.) at 135-36.

Another inmate who was housed at St. Clair in 2014 and into early 2015, was tested twice for TB. Ex. 53 (REDACTED Decl.) at ¶ 4. REDACTED

he was told he had tested positive for TB; he was then sent to his general population dorm. *Id*. at ¶ 7. Two or three months later, he was taken to the hospital for a chest x-ray, and was confirmed to have TB. *Id*. at ¶8. He was started on treatment immediately. *Id*. He has not been retested. *Id*. at ¶9.

ADOC also fails to screen and treat prisoners for Hepatitis C, as evidenced by the significantly lower than average number of people with Hepatitis C in the system. The estimated correctional population with Hepatitis C is between 16% and 59%. Ex. 84 (Puisis Rep.) at 140. According to the population the March 2016 Monthly Client Report, REDACTED

. Ex. 93 (Corizon March 2016 Monthly Report) at 19. A number this low indicates that ADOC is not adequately screening prisoners.

Of those patients who are diagnosed as Hepatitis C positive, an incredibly small number are actually being treated. According to Mr. Kinard, only 20 patients were treated for Hepatitis C in 2015. Ex. 17 (Kinard Dep.) at 56:20-57:4. This constitutes less than 1% of the infected population. Mr. REDACTED was diagnosed with Hepatitis C 15 years ago and has never been offered treatment. Ex. 39 (REDACTED Decl.) at ¶ 17). In August 2014, REDACTED

. 100 (Aug. 19, 2014 email from Ruth Naglich to Dave White and Kim Thomas, REDACTED

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Ex. 93 (Corizon Monthly Report, March 2016) at ADOC0317866.

Patient 9 from Dr. Puisis' Report suffers from Hepatitis C and, in January 2012, showed indications of significant fibrosis and cirrhosis of the liver. Ex. 84 (Puisis Rep.) at 143. Twelve months later, indications demonstrated likely cirrhosis. *Id*. Despite that, medical providers did not evaluate Mr. REDACTED for treatment for Hepatitis C and failed to recognize his cirrhosis as a problem. *Id*. Mr. REDACTED cirrhosis was not recognized until June 2013, during a hospital stay. *Id*. This is indicative of the poor care provided for prisoners with Hepatitis C, even within the chronic care clinics where they should be receiving regular monitoring and treatment.

Another example of poor infection control is the spread of scabies and ADOC's handling of the infestation. Over the course of 11 months in 2015, 362 cases of scabies were reported at Easterling, meaning almost a quarter of the population had scabies. Ex. 84 (Puisis Rep.) at 144. In October 2014, ADOC REDACTED Ex. 101 (Oct. 9, 2014 email from Peggy Minyard to Henrietta Peters). Prior to that, Ventress experienced a scabies infestation among approximately one-third of the population. Ex. 105 (Summary report of Scabies at Ventress) at 1 REDACTED ); see also Ex. 120 (Corizon Monthly Report, Oct. 2013) at 90 (REDACTED ). REDACTED

REDACTED

. Ex. 105 (Summary report of Scabies at Ventress) at 2.

REDACTED

See Ex. 107 (REDACTED ) at 2. REDACTED

*Id*. at 1. REDACTED

. *Id*. at 2. REDACTED

. *Id*.

REDACTED

See Ex. 106 (Spreadsheet of scabies cases throughout ADOC). The Alabama Department of Public Health determined that these outbreaks are caused by poor sanitation, inadequate screening and treatment, failure to follow physician instructions and deterrents to seeking treatment. As discussed above, ADOC also fails to maintain staff dedicated to infection control. The spread of scabies to up to one-third of a facility's population highlights the substantial risk of serious harm from infectious diseases facing all prisoners within ADOC.

**d. ADOC fails to timely refer patients to specialty care or provide emergency and hospital care when necessary.**

When correctional facilities do not employ properly trained and credentialed physicians to manage patients' needs, those patients must be referred off-site for appointments with specialty providers. As discussed above, many of the medical providers within ADOC practice beyond the scope of their qualifications. This is evident both in routine care and specialty or emergency care. Site medical providers sometimes try to manage acute care despite lacking the experience to do so. This places patients at a substantial risk of serious harm and has caused actual harm to numerous prisoners.

A patient with a very rare disease, scleromyxedema, is an example of the Corizon providers improperly attempting to give care in the prisons, rather than sending the patient out. This is a disease that is difficult to treat and usually requires a multidisciplinary team of specialists. Ex. 84 (Puisis Rep.) at 92. Treatment involves intravenous infusions of a medication that requires careful monitoring, as it has serious, even fatal, potential side effects. *Id*. at 93. The patient was treated for a year by sending him to an outside oncology infusion center that had the necessary expertise to manage the infusions, and he did well. *Id*. But Dr. Rahming decided to attempt to give the infusions at Kilby. Within three months, the patient died from complications of the side effects, apparently

caused by the failure to follow the standard precautions when administering this medication. *Id*. at 94.

Plaintiff Hubert Tollar had a chest x-ray to check for TB in February 2014. A lesion, suspected of being cancer, showed up on the x-ray and a CT scan was ordered on March 3, 3014. Ex. 84 (Puisis Rep.) at 96. It was not performed until April 9, 2014. *Id*. Although the results of the CT scan showed a mass in Plaintiff Tollar's lung, it took another five and a half months to begin chemotherapy. *Id*.

Plaintiff Augustus Smith came into prison in 2007 with a catheter as a result of an injury. Prior to coming to prison, he was supposed to have surgery to allow him to urinate normally, however it was rescheduled and he was incarcerated before he could have the surgery. In ADOC, the surgery was not performed, leaving him with the catheter. As a result, Plaintiff Smith suffered chronic infections for years. Ex. 84 (Puisis Rep.) at 167-191. Six months after filing this lawsuit, the surgery was finally performed. *Id*. at 191.

Earlier this year, Plaintiff Maner suffered a broken hand. Ex.58 (Maner Decl. at ¶ 9). He was taken to the emergency department at Staton, but did not receive x-rays of his hand until 16 days later. *Id*. at ¶¶ 9-10. Once x-rayed, he was told he needed a cast for his broken hand. He never received one. *Id*. at ¶ 11.

In February 2016, REDACTED was burned while sleeping when a prisoner through a combination of hot chemicals on his face. Ex. X (REDACTED Decl.) at ¶ 4.

Mr. REDACTED pleaded with an officer and nurses to send him to an outside hospital. *Id*. at ¶¶ 7-12. They refused. *Id*. Mr. REDACTED was not sent to an outside burn center until three days after he was burned. See *Id*. at ¶ 14. When Mr. REDACTED returned to prison, he was denied his pain medication prescription. *Id*. at ¶ 16.

Approximately two years ago, Mr. REDACTED received surgery and was informed that he has a hernia. Ex. 39 (REDACTED Decl.) at ¶ 9. Upon return to prison, a nurse dismissed it as "just a muscle." *Id*. Mr. REDACTED hernia worsened, and last year, he was referred for surgery. *Id*. at ¶¶ 10-11. Mr. REDACTED has yet to receive follow-up to the surgery referral, despite complaining of the need at his chronic care visits every 90 days. *Id*. at ¶ 7) at ¶ 12. Mr. REDACTED suffers intense daily pain as a result of his hernia. *Id*. at ¶ 13. In addition to his hernia, Mr. REDACTED has failed to receive the treatment he needs for his nerve damage and related pain. *Id*. at ¶ 14-15. He was told by his chronic care provider that ADOC does not provide back surgery. *Id*. at ¶ 16.

OHS has no policy related to specialty consultations. Corizon is responsible for managing all referrals for specialty care. Referrals to an outside provider are requested by providers who fill out a form that then must be approved by the regional medical director. The regional office receives 80-100 such requests per week. In practice, this constitutes a barrier for care, as requests are frequently denied. Dr. Hood, who, as the Regional Medical Director, must approve a request

if a prisoner is to be sent out, testified that he never denies a request, but instead offers an alternate treatment plan. Ex. 13 (Hood Dep.) at 210:3-11. According to Dr. Puisis, these "alternative treatment plans" often make no sense and amount to a denial of care. Ex. 84 (Puisis Rep.) at 88. REDACTED , who suffers from herniated discs and sciatica that causes severe pain and has forced him to use a wheelchair, was referred by Dr. Kouns for surgery because he was at risk for paralysis. Ex. 44 REDACTED Decl.) at ¶ 13). Dr. Hood denied his surgery. *Id*.

When Joseph Torres arrived in ADOC custody in 2011, he received an eye exam at intake that confirmed he required surgery. Ex. 78 (Torres Decl.) at ¶ 9). He saw an outside eye doctor who confirmed the same need. *Id*. at ¶ 10. ADOC has failed to provide the surgery, citing financial reasons. *Id*. at ¶ 11. Mr. Torres suffers from headaches as a result of his eye problems. *Id*. at ¶ 14.

Similarly, ADOC delays in sending patients for hospital care when needed. Once patients are sent to the hospital, ADOC may force their return prematurely or object to a treating physician's orders that they remain at the hospital. See Ex. 104 (May 29, 2013 email from Larry Linton to Ruth Naglich REDACTED ). In another example, after being sent to Jackson Hospital due to low blood oxygen levels, Mr. REDACTED was forced to return to the DOC prematurely, despite an outside physician saying he need to remain at Jackson. Ex. 64 (REDACTED Decl.) at ¶ 7. Once back in prison,

Mr. REDACTED did not receive the medication that had been ordered by the outside physician. *Id.* at ¶ 8. Since he returned from the hospital more than two years ago, Mr. REDACTED has not been referred for follow-up care. *Id.* at ¶ 17.

**e. The infirmary care provided within ADOC facilities is inadequate, placing all prisoners, particularly the most infirm, at a substantial risk of serious harm.**

**a. Infirmaries maintain inadequate nursing and physician care.**

Infirmaries house patients who are too sick to be in general population, but don't require hospitalization. Patients within ADOC are being kept in the infirmary as an alternative to the long-term nursing care or more specialized hospital care they actually need. Ex. 84 (Puisis Rep.) at 100. Dr. Puisis found that ADOC is using infirmary care in lieu of hospitalization even when it is dangerous for the patient. *Id.* At times, there is no physician coverage for an infirmary. *Id.* This places patients at a substantial risk of serious harm and even death.

ADOC maintains inadequate staffing levels in infirmaries. As with other areas of medical care discussed above, LPNs are inappropriately providing infirmary care outside of their qualifications. See Ex. 84 (Puisis Report) at 100-106. Physician care in the infirmaries is similarly inadequate and a reflection of the same staffing issues discussed above. Responsibilities for overseeing infirmary care fall to the same physicians who serve as the only physician on-site and medical director, adding to their already significant responsibilities.

A man who had a stroke and was moved into the infirmary serves as an example of the harm caused by Defendants' infirmary practices. The man was given a Do Not Resuscitate order. Ex. 84 (Puisis Report) at 102. Although he was in an apparently vegetative state, there was no order to turn him. Turning such a patient prevents the formation of decubitus ulcers. *Id*. Raising his head to prevent aspiration pneumonia was not ordered. *Id*. The patient slowly recovered, but the DNR order was not lifted and there is not documentation that it was discussed with him. *Id*. at 103. He developed decubitus ulcers and, over the course of about 6 months, slowly died from them. *Id*. at 104-05.

REDACTED is assigned to the infirmary at Kilby. Ex. 64 (REDACTED Decl.) at ¶ 3, ¶ 5. He has numerous chronic conditions. *Id*. at ¶ 4. Despite being in the infirmary, Mr. REDACTED must go to the pill call window to receive his medication. *Id*. at ¶ 6. He does this four times each day. *Id*.

**f. ADOC systems result in unconstitutional end-of-life care that is abused in order to deny treatment to patients.**

While OHS has a policy establishing that end-of-life decisions are voluntary and uncoerced, it has a practice of allowing two physicians to make a decision—independent of a patient's wishes—to classify a patient as "Do Not Resuscitate" ("DNR") or "Allow Natural Death." See Ex. 109 (OHS Policy I-4, Living Wills, End of Life Care, and Organ & Tissue Donation). This is inhumane and abusive.

The abuse of this system is perhaps most blatantly demonstrated by REDACTED

See, e.g., Ex. 95 (Corizon Dec. 2014 Highest Acuity Report) at 27. One patient whose chart Dr. Puisis reviewed had no documented terminal illness, but was noted as "DNR" in his transfer forms when sent from Staton to Bullock in 2013. Ex. 84 (Puisis Report) at 114. The patient suffered from dementia, and there was no indicator that he had meaningfully consented to his DNR status. *Id*. Providers appear to have made the decision to stop rendering care to the patient, despite the fact that he did not suffer from a terminal disease, because his dementia made the patient difficult to treat. Ex. 84 (Puisis Report) at 116.

Dr. Rahming testified about a case in which he and Dr. Hood made the decision to make a patient "DNR," despite the patient's altered mental state preventing him from consenting. Notably, when Dr. Rahming allegedly could not communicate with the patient, he failed to contact any of the patient's family members. Ex. 24 (Rahming Dep.) at 51:18-52:10, 53:4-54:12, 94:21-95:15. This patient's case presents further evidence that ADOC utilizes the end-of-life process to facilitate its independent decisions about what course of treatment is appropriate.

**5. ADOC fails to adequately oversee the provision of medical care, or to implement adequate quality assurance programs and effective hiring and credentialing systems.**

**a. ADOC OHS fails to maintain a regular and effective audit process.**

Because ADOC has chosen to delegate its responsibility to provide adequate medical care to Corizon, ADOC must ensure that Corizon is carrying out that responsibility. ADOC's audit process is not systematic or thorough. OHS audits address only process, not quality of care, and they do not address many critical areas at all. Ex. 84 (Puisis Rep.) at 46. Most of the audit questions are compliance type questions that fail to help determine whether patients are receiving proper care. *Id*. "Failure to address quality of care is causing harm and risk of harm on an ongoing basis but there is no means in the quality improvement program to address this issue." *Id*. at 48.

Moreover, even the flawed audits that exist on paper are not properly carried out by OHS. The audit team consists of two regional managers and an administrative services employee, all of whom are nurses with numerous other responsibilities. Ex. 84 (Puisis Rep.) at 48. Having no physician involved, and not auditing physician quality, results in harm and risk of harm to prisoners with serious medical needs. *Id*. Having no physicians at all in OHS makes it impossible to evaluate physician quality. While Ms. Naglich testified that she could not recall ever having seen something on a hospital report that caused her to

have concern about the care ADOC provided, Ex. 22 (Naglich Dep. II) at 104:3-7, there were in fact many adverse events in prisoners with serious medical conditions shown in hospital reports identified by Dr. Puisis. Ex. 84 (Puisis Rep.) at 49. Hospital reports should be reviewed by physicians, not just by nurses. *Id.*

The OHS team conducts the audits in an incomplete manner, and may only use some of the audit tools at a given facility, ignoring others. See Ex. 21 (Naglich Dep.I ) at 69:16-18. Defendant Naglich could not identify the number of facilities that are typically audited in a given year or the total number of audits that had occurred since the 2012 contract with Corizon was entered into. I Ex. 21 (Naglich Dep.I ) at 72:3-22. If a facility demonstrates problems in a certain audit area, the team "typically"—but not conclusively—will revisit it. See Ex. 21 (Naglich Dep.I ) att 72:23-73:4. When they do so depends on the other activities happening within ADOC. Ex. 21 (Naglich Dep.I ) at 73:5-18. This, combined with the lack of a regular and systematized process, demonstrates that quality assurance and auditing of the medical program are a low priority for ADOC.

**b. Inadequate oversight and minimal requirements for physicians result in a high rate of poor quality physicians.**

Credentialing of physicians, through which their qualification for the work to be performed is evaluated, is a key component of a medical program. It includes a review of training, experience, licensure, malpractice history, and professional competence. Credentialing is essential to patient safety. Ex. 84 (Puisis Rep.) at

18-19. The RFP for the contract pursuant to which Corizon provides ADOC medical care requires the vendor to be responsible for credentialing of medical staff pursuant to specified standards. However, OHS not only plays no role in credentialing, it does not even regularly monitor Corizon to ensure that Corizon meets the credentialing requirements outlined in its contract. Ex. 22 (Naglich Dep. II) at 15:21-16:2. Naglich testified that "the Department does not credential," and that she makes no effort to review malpractice claims against physicians working in ADOC because they are not ADOC employees. At the time of Dr. Puisis' report, REDACTED

Ex. 111 (Corizon Policy CR-001, General Credentialing Process); see also Ex. 13 (Hood Dep. 35:2-9, Mar. 10, 2016). Despite that, Dr. Hood testified in deposition that he had never seen Corizon's credentialing policy. Ex. 13 (Hood Dep.) at 160:11-161:2. Dr. Hood testified that he reviews a candidate's CV and interviews the candidate. *Id*. at 34:2-7. However, of 30 credential files for physicians working within ADOC, only nine had documentation of interviews with the Regional Medical Director. Ex. 84 (Puisis Report) at 19. Dr. Hood does not review the complete documents in a candidate's application packet; that is left to Corizon's recruiter, who is not a physician. Ex. 13 (Hood Dep.) at 34:8-19. Dr. Hood testified that when he interviews physicians as

prospective hires for ADOC positions, he has no information about past malpractice claims, loss of privileges, or licensing board sanctions.

This is consistent with Corizon's failure to set minimal requirements for physicians. See Hood Dep. at 38:11-19. The only requirement appears to be that a physician have an active license. See Ex. 84 (Puisis Report) at 20. The impact of this is illustrated by the quality of physicians working within ADOC. In addition to hiring physicians whose specialties are not primary care, Corizon hires a high number of physicians with prior restrictions on their licenses, including adverse reports from medical boards and loss of privileges. *Id*. at 21. An astounding 40 percent of the physicians had such problematic histories, including sexual misconduct, physician impairment, lost privileges, falsely reporting education credits and criminal charges. *Id*. According to Dr. Hood, Corizon provides an opportunity for physicians "to get back in practice and to redeem themselves." Ex. X (Hood Dep. at 100:7-19, Mar. 10, 2016). In other words, physicians that no free world provider wants to employ are good enough for ADOC prisoners – they work cheap and do not have other options. After hiring physicians whose qualifications are dubious, at best, Corizon fails to provide adequate supervision and monitoring for these physicians, placing patients at a substantial risk of serious harm. Ex. 84 (Puisis Rep.) at 18-19. With only one physician typically working in any facility, there is no opportunity for a physician who is "redeeming" himself from problems

with his license or practice to be properly overseen by a qualified doctor, and neither ADOC nor Corizon has put any supervision program in place.

**c. The peer review system is inadequate and lacks appropriate oversight and clarity.**

Peer review processes provide a means for monitoring the quality of care and protecting patient safety. Ex. 84 (Puisis Rep.) at 22. Two types of peer review are typically done – routine periodic review of all physicians, and specialized review when a physician appears to be in trouble, having committed a serious error or exhibiting troubling behavior. The peer review process within ADOC includes only the first type, and the procedure used is inadequate, resulting in the ongoing employment of under-qualified and reckless medical staff, and placing patients at a substantial risk of serious harm. See Ex. 84 (Puisis Report) at 22-27. Corizon maintains insufficient policies and procedures on peer review; these policies and procedures REDACTED

See Ex. 123 (Corizon Policy P-C-02.00, Clinical Performance Enhancement); see also, e.g., Ex 117 (Kilby site-specific policies P-C-02.00, Clinical Performance Enhancement, edited Oct. 2012 and Sept. 2014). According to Dr. Lovelace, facilities throughout the system use substantially the same peer review policy and procedure. Ex. 19 (Lovelace Dep. 167:18-23, Dec. 21, 2015).

The peer review process consists primarily of document review. Ex. 13 (Hood Dep.) 130:2-133:2. If a review involves an "on-site" assessment, that refers to reviewing charts on-site, not observing the care offered by a medical staff person in action. See Ex. 19 (Lovelace Dep.) at 30:8-19. The document review involves assessments of chronic illness, infirmary and sick call treatment, and questions do not address quality of care provided. Ex. 84 (Puisis Rep.) at 24-25; see also Ex. 126 (REDACTED peer review documents). Instead, like ADOC's audit program, they focus on superficial reviews of "process," such as whether the proper documentation was completed and included in a medical file. *Id.* This process is inadequate to address patient care.

Dr. Hood testified that he has only discovered quality-of-care problems through the peer review process on one occasion. Ex. 13 (Hood Dep.) at 156:19-157:10. Dr. Hood made the decision to terminate Dr. George Koons after a series of extremely poor medical decisions came to his attention in late 2015. *Id.* at 66:3-23. However, the poor performance of Dr. Kouns came to Dr. Hood's attention by chance, not through the peer review process. *Id.* at 72:3-20. In fact, at Dr. Kouns's last peer review, REDACTED

. Ex. 237 (Dr. Kouns Peer Review Certificate, July 23, 2015). REDACTED

Dr. Hood has identified no other member of the medical staff as having problems — combined with the

fact that Dr. Kouns' inadequate medical treatment was incredibly problematic — demonstrates the ineffectiveness of the peer review system.[17]

The OHS does not participate in the peer review process. Ex. 21 (Naglich Dep. I) at 139:23-140:6. Ms. Naglich cannot describe the process, does not monitor it, and is unaware of whether Corizon has ever identified any problems through peer review. Ex. 22 (Naglich Dep. II) at 153:19-155:21. Asked whether the process is adequate, Ms. Naglich replied that "we have good quality physicians," and "very little issues with the day-to-day delivery of care." *Id*. at 152:14-22. Of course, Ms. Naglich is not a physician, nor does she employ any physicians in OHS who would be qualified to make such a determination.

**d. The sentinel event and mortality review process is improperly staffed and fails to recognize problems and implement corrective action.**

The sentinel event process is triggered by "an event involving death or serious physical or psychological illness/injury or risk thereof." Ex. 115 (Corizon Policy PS-01, Sentinel Event Review). Corizon's process for sentinel event reviews (including mortality reviews) is ineffective and biased. See Ex. 84 (Puisis Rep.) at 106-112.

[17] REDACTED

Errors in health care are a leading cause of death and injury. It is therefore critically important that adverse events, particularly deaths, be reviewed to identify and attempt to eliminate preventable errors. Ex. 84 (Puisis Rep.) at 109.

Mortality review, including an autopsy, should be performed for every death.[18] The review should be performed by a team that includes a senior physician (but not the physician who provided cared for the patient, since that person will likely be biased), and other senior leaders of services that may have had an impact on the death (such as pharmacy). Persons involved in the patient's care should be interviewed. Ex. 84 (Puisis Rep.) at 107. The review should look as far back as necessary to understand the evolution of the illness or other cause of death. *Id*. When a vendor provides care, the hiring department should participate in the reviews, since the vendor may perceive identification of errors as a source of liability or a threat to its contract. *Id*.

Ms. Naglich of OHS testified that she has not generally participated in Corizon's morbidity and mortality review meetings. Ex.22 (Naglich Dep. II) at 124:08-16. When a death occurred, she usually reviewed the prisoner's name, date of birth, general history, and who responded to the emergency. Ex. 22 (Naglich Dep. II) at 107:10-08:08.

[18] Ms. Naglich testified that an autopsy is performed whenever a prisoner dies, but there was no evidence that the autopsy results are actually used in the mortality review process or considered in quality improvement. Ex. 22 (Naglich Dep.II) at 38:15-22; Ex. X (Puisis Rep.) at 112.

Over the last few years, Corizon stopped having mortality and morbidity meetings and began using a computerized process called STARS to facilitate sentinel event review. Ex. 22 (Naglich Dep. II) at 125:08-26:17; Ex. 13 (Hood Dep.) at 243:11-17. Ms. Naglich does not know what Corizon looks for in the mortality and morbidity review process at ADOC. OHS does not review Corizon's mortality or sentinel event reports. It reviews the charts of persons who have died, but that review does not include review by a physician, since OHS has no physicians on its staff. Ms. Naglich testified that she believed the sentinel event review process was adequate because Corizon was identifying issues and notifying her of them, but she also admitted that she does not know what Corizon's sentinel review process is, or whether it actually identifies any problems. Ex. 22 (Naglich Dep.II) at 155:55-157:18.

According to Dr. Hood, the STARS system is used to capture certain types of sentinel events, including mortalities, suicides or attempted suicides, and certain "catch-all groups," including diabetic ketoacidosis and ruptured viscus. Ex. X (Hood Dep.) at 242:9-243:2. Dr. Hood participates in each of the sentinel event reviews on behalf of the regional office. Ex. 13 (Hood Dep.) at 240:17-21. REDACTED

See Ex. 84 (Puisis Report) at 337 (Patient 13), 360 (Patient 16), 381 (Patient 17), 447 (Patient 22).

After the review meetings were discontinued in 2013, site medical directors were required to fill out a form and send it to the Regional Medical Director, who would then discuss it with the site medical director by phone. In his seven and a half years as Regional Medical Director, Dr, Crocker (Dr. Hood's predecessor), could not recall having identified a single quality of care problem as a result of this process. Ex. 3 (Crocker Dep.) 83:7-21. There was no documentation or discussion of the findings, and any feedback provided to the site medical director by Crocker was general in nature. *Id*. at 96:13-97:19.

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. See Ex. 84 (Puisis Report) at 316-39 (REDACTED ) and 392-433 (RE DA CT ED ).

**C. ADOC's System of Providing Dental Care is Constitutionally Inadequate.**

As it has done with medical care, ADOC has sought to contract out its constitutional dental care obligations through its RFP contract with Corizon.[19] The current ADOC contract requires the dental program to be staffed by 12.6 dental full-time equivalents ("FTE"s), 12.6 dental assistant FTEs and 3.2 dental hygienist FTEs, with actual dental care be provided consistent with federal guidelines. Ex. X (Medical Services Contract) at ADOC000554, ADOC000633. The contract further specifically requires that "all inmates are required to receive initial dental screening, under the supervision of a licensed dentist". *Id*. at ADOC000633.

Other notable contractual obligations for the dental program include: t conducting sick call triage in accordance with ACA and NCCHC standards, providing "Routine care . . . within fourteen (14) days of an inmate's request for treatment", providing "annual dental screenings", and the responsibility for "contract arrangements and budgeting for oral surgery services". *Id*. at ADOC000633-634. Moreover, Corizon must engage in ongoing self-monitoring, specifically including the obligation to establish and maintain a Comprehensive Quality Improvement Program (CQIP) for purposes of "assuring that quality care

[19] ADOC's "constitutional duty to provide adequate medical treatment" is a non-delegable one, however, *See West v. Atkins*, 487 U.S. 42, 56, 108 S.Ct. 2250, 101 L.Ed.2d 40 (1988); *Ancata v. Prison Health Servs., Inc*., 769 F.2d 700, 705 (11th Cir.1985); *Scott v. Clarke*, 64 F. Supp. 3d 813, 815 (W.D. Va. 2014).

and services are provided to inmates." *Id*. at ADOC000633. Associate Commissioner Naglich and the OHS are responsible for monitoring the provision of health care to ADOC inmates, providing direction and oversight to the health services vendors, and directing and supervising the ADOC Contracted Medical Director.

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Plaintiffs' dental expert, Dr. Jay Shulman, details the pervasive, system-wide policies, practices, and/or customs that expose all putative class members to a substantial risk of serious harm in violation of the Eighth Amendment. See

generally Doc. 555-4 (Shulman Rep.). Dr. Shulman explains that the focus of correctional dentistry is the control of acute and chronic dental pain, stabilization of dental pathology and maintenance or restoration of function. Doc. 555-4 (Shulman Rep.) at 10. ADOC's dental program falls well short of the standard of care, placing the entire class of incarcerated individuals at serious risk of needless pain, tooth morbidity and tooth loss.

**1. Dental Staffing Is Inadequate to Provide Constitutional Care.**

The pervasive dental program deficiencies begin with patently inadequate staffing. The contracted staffing of 12.6 FTE dentists, 12.6 dental assistant FTEs, and 3.2 dental hygienist FTEs is substantially below the staffing levels needed to treat approximately 24,189 prisoners. See Ex. 92 (Corizon-ADOC Medical Services Agreement) at ADOC000554; ADOC March Statistical Report, available at http://doc.alabama.gov/docs/MonthlyRpts/2016-03.pdf at 2. This equates to an inmate-to-dentist ratio of 1,920:1 and an inmate-to-dental hygienist ratio of 7,740:1. For CDAA to provide dental care in conformance with accepted professional standards, it would require a substantial staffing increase. Doc. 555-4 (Shulman Rep.) at 35. The staffing ratios should be increased to between 1,000:1 and 1200:1 for dentist and 2,000:1 for dental hygienists. *Id*. This must be in conjunction with the policies and procedures and practices being brought to

accepted professional standards." *Id.* Defendants' dental expert, Dr. Barbara De Lap, REDACTED Ex. 85 (De Lap Rep.) at 23.

**2. ADOC, Through Its Contractors, Does Not Adequately Screen and Diagnose Dental Conditions.**

Corizon has either omitted important requirements set forth in the ADOC Contract or has allowed CDAA to maintain its own policies that are contrary to ADOC contract requirements. Doc. 555-4 (Shulman Rep.) at 26. For example, in contravention of the requirement that dental care be provided consistent with federal guidelines, (Ex. 92 (Corizon-ADOC Medical Services Agreement) at ADOC000633), REDACTED which is at variance with a policy published by the Food and Drug Administration. See Ex. 145 (CDAA Resource Binder) at Dunn(Corizon)_10255-10283. CDAA policies are also mute as to the ADOC requirement that routine care be provided within 14 days of request. Ex. 9 (Corizon-ADOC Medical Services Agreement) at ADOC000634.

The inadequacy of the staffing, along with other failures, contributes to the inadequate diagnosis of serious dental problems. Dental examinations and screenings are inadequate to determine whether or not treatment is needed. King stated that at intake prisoners receive "a thorough dental examination" that includes

an examination, a charting, a treatment plan and a PSR. Ex. 29 (King Dep.) at 41:16-42:3; 44:19-45:8. However, the exam is inadequate because x-rays are not taken. ADOC's dental program does not provide for x-rays of any kind at intake or in conjunction with the formation of an initial treatment plan. X-rays are not done until treatment is to be undertaken based upon a complaint. Ex. 29 (King Dep.) at 46:5-15.

This policy and practice of "performing routine examinations and treatment plans without x-rays results in under diagnosis of dental caries and periodontal disease that subjects prisoners to substantial risk of tooth morbidity, tooth mortality, and gratuitous pain." Doc. 555-4 (Shulman Rep.) at 36. Further, because periodontal probing was not done before October 2014 and radiographs are still not taken at the intake, examination, and recall examinations in accordance with accepted professional standards, CDAA dentists consistently underdiagnose periodontal disease. Doc. 555-4 (Shulman Rep.) at 38. Dr. De Lap REDACTED

Ex. 85 (De Lap Rep.) at 24. ADOC's process for screening and diagnosis is therefore constitutionally inadequate.

Dental screening is generally performed by a dental hygienist who may or may not make a referral to a dentist. Doc. 555-4 (Shulman Rep.) at 31. A dental

hygienist may miss significant pathology that a dentist would notice. Furthermore, a dental hygienist is not qualified to make a treatment plan. Doc. 555-4 (Shulman Rep.) at 32. After intake, subsequent examinations performed by a dentist are not routinely performed. Instead, only a "screening" that can be performed by any qualified health personnel is performed. Ex. 29 (King Dep.) at 116:21-117:16. Screening is "basically looking in to see if there is any problems visible and listening to any complaints that the inmate may have." *Id*. at 117:17-22. Although King acknowledged that an examination (as opposed to a mere screening) should be performed at least yearly, he has compromised care – based on the inadequate staffing in the ADOC. Ex. 29 (King Dep.) at 124:16-125:23 (because of "the conditions that we have as far as staffing and our populations", two year intervals between exams is "not unreasonable").

Thus, in the ADOC dental program the accepted interval between examinations has been doubled because of overcrowding and staffing issues, to the detriment of the entire prison population. The direct result is a serious risk to class members. REDACTED

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Ex. X(MAC meeting minutes re: REDACTED ) at 11, 7. REDACTED

. *Id*. at 9, 4, 1.

**3. Dental Treatment Is Inadequate**

As discussed above, dental caries (cavities) and periodontal disease are consistently underdiagnosed. However, even when they are diagnosed, it was rare that treatment other than a prophylaxis was planned. When moderate or advanced periodontal disease is identified, the appropriate non-surgical procedure is not ordered. Doc. 555-4 (Shulman Rep.) at 36; Ex. X(King Dep.) at 94:21-95:1.

The dental program's failure to inform treatment plans with x-rays and consistently plan non-surgical treatment for mild to moderate periodontal disease places prisoners at risk of advancing periodontal disease with attendant pain and tooth loss. Doc. 555-4 (Shulman Rep.) at 40.

Treatment of prisoners' dental pain and infection is untimely, at best, subjecting the prisoners to preventable pain and unnecessary exposure to

antibiotics. Prisoners complaining of dental pain are generally offered analgesics and those with infections are referred to a dentist for an antibiotic within a day of submitting an HSRF, but the system breaks down at that point. Doc. 555-4 (Shulman Rep.) at 40. A course of antibiotic therapy may be an appropriate first step in treating a dental abscess, but the treatment is not complete until the source of the infection is removed; that is, by root canal or extraction. *Id*. This should occur within 7 to 10 from the initial request for treatment. *Id*. at 40-41. The appointment for extraction is usually scheduled weeks or months in the future. *Id*. Failure to remove the source of infection timely is below professional standards and often results in gratuitous pain and unnecessary antibiotic exposure. *Id*.

One prisoner whose care was addressed by Dr. Shulman a sick call request on March 19, 2014 regarding a toothache. He was seen the next day by a physician who ordered a course of Amoxicillin and Naprosyn. He submitted another sick call request on March 31, 2015, stating he was in extreme pain. He was triaged by an LPN who made a dental referral. He was finally seen by a dentist on April 22, 2014 for the extraction – more than a month after he first requested relief from his pain. Because of this delay in seeing a dentist, this patient suffered more than a month of gratuitous pain. Doc. 555-4 (Shulman Rep.) at 41.

Similarly, Plaintiff Robert Dillard put in a request several years ago to see dental to have his teeth cleaned and some pulled. He had to wait seven or eight months. He was then told that he would be scheduled, but was not seen again. Later, he put in a sick call request because of dental pain. He was put on antibiotics. It took three weeks for him to be seen and the tooth to finally be pulled. Ex. 30 (Dillard Dep.) at 142:9-145:14. This Plaintiff suffered weeks of unnecessary pain. Dr. De Lap REDACTED

Ex. 85 (De Lap Rep.) at 2.

**4. Oversight of the Dental Program Is Inadequate**

Compounding the deficiencies in staffing, diagnosis and treatment, Corizon's self-monitoring efforts and ADOC's auditing and contract monitoring program are minimal. Associate Commissioner Ruth Naglich conceded that ADOC's auditing of its vendor's contract compliance does not actually evaluate the quality of medical care but instead will "audit the access, the appropriate level, the appropriate provider. These are the general things we look for." Ex. _(Naglich Dep. II) at 95:10-96:1. Monitoring of the ADOC's dental program, however, is either nonexistent or ineffective with actual audits performed inconsistently. This problem is consistent from top to bottom of the program. The ADOC Office of Health Services purports to audit the dental programs but some prisons were not

audited at all during a four year period and some were audited only once during that time.

| Table 4. ADOC Dental Services Audits, 2011-2015 | | | |
|---|---|---|---|
| **Prison** | **Date** | **Score** | **Page (s)** |
| Bibb | 3/11/11 | 78.4% | ADOC045251-254 |
| | 6/28/11 | 73.3% | ADOC045201-204 |
| | 5/2/12 | * | ADOC0220384 |
| | 1/18/13 | 97.4% | ADOC0220383-5 |
| | 1/15/15 | 94.0 | ADOC0220382 |
| | 6/19/15 | * | ADOC0220381 |
| Bullock | | | |
| Donaldson | 12/3/12 | 94.0 | ADOC0220379 |
| | 1/23/13 | 59.0 | ADOC0220378 |
| | 2/11/14 | 100 | ADOC0220375-76 |
| | 8/12/14 | 100 | ADOC0220377 |
| | 2/26/15 | 100 | ADOC0220374 |
| | 4/30/15 | 100 | ADOC0220373 |
| Easterling | 10/22/14 | 100 | ADOC045562-64 |
| Fountain | 2/9/11 | 78.8 | ADOC045654-57 |
| | 5/24/11 | 97.4 | ADOC045631-34 |
| Holman | 12/18/13 | 100 | ADOC045880-82 |
| Kilby | 2/24/11 | 65.9 | ADOC045934-37 |
| | 6/14/11 | 94.7 | ADOC045982-85 |
| Limestone | | | |
| St. Clair | 11/22/11 | 87.5 | ADOC046098-101 |
| Staton | | | |
| Tutwiler | | | |
| Ventress | 2/11/15 | 97.4 | ADOC0220385 |

Doc.555-4 (Shulman Report) at 53 (Table 4). Even when ADOC conducts audits, they are done by non-dentists, as ADOC's OHS employs no dentists.[20] Important clinical elements, such as the adequacy of treatment plans and timeliness of routine and urgent care, are not audited at all.

Equally deficient and wholly inadequate is both Corizon's monitoring of its dental subsidiary CDAA and King's monitoring of the individual Dental Directors at the prisons. ADOC either intentionally allows or chooses to be unaware of the inadequate and untimely care being provided to inmates. Where a program is substantially unmonitored, as is this one, inmates are put at a substantial risk of serious harm including gratuitous pain and preventable tooth loss. Doc. 555-4 (Shulman Rep.) at 50-51.

King testified at deposition that he conducts peer reviews and performance reviews of all Dental Directors on their anniversary dates each year. Ex.X (King Dep.) at 52:19-53:06. The peer review involves the review of 10 records. *Id*. at 53:7-9. According to King, he has never found any problem or given anything other than a good evaluation to any dentist. *Id*. at 53:16-55:9. This alone, as with Corizon's peer review process, is a clear indication that the process is ineffective.

[20] In her expert report Defendant's dental care expert Barbara DeLap REDACTED
Ex. 85 (De Lap Rep.) at 18.

King's performance is monitored by Dr. Hood, the Corizon Regional Medical Director. While Hood's review addresses clinical performance (most recently, King received excellent ratings in everything on the review), it does not purport to address CDAA's dental program for which Dr. King is responsible. Consequently, errors such as those discussed above were not picked up or discussed.

Overall, the ADOC audits of Corizon/CDAA's performance are substantively deficient. They omit prisons and are inconsistent for those audited, as shown in the table above. The auditors are not dentists (ADOC's OHS has no dentist on staff) so the areas audited are limited to those not requiring dental expertise. Because of these deficiencies, ADOC has no knowledge of most important clinical outcomes data and has to rely instead on what Corizon and CDAA say to determine the extent to which they are incompliance with the contract. This breakdown in clinical monitoring places the prisoners at risk because inadequate care cannot be identified and corrected, and therefore is allowed to persist. Doc. 555-4 (Shulman Rep.) at 52.

Defendants' expert Dr. De Lap REDACTED

REDACTED

Ex. 85 (De Lap Rep.) at 7.

## D. ADOC's System of Providing Mental Health Care is Constitutionally Inadequate

For at least two decades, the Alabama Department of Corrections has relied on outside contractors to provide mental health care to incarcerated individuals in its custody. In 1992, Thomas Paul Bradley, on behalf of a class of men incarcerated in ADOC, challenged the mental health care provided by the ADOC through its outside contractor. *Bradley v. Harrelson*, No. 92-A-70-N (M.D. Ala.). According to mental health experts at the time, "ADOC fails to provide even minimally adequate mental health care for its inmates with serious mental illness, and the record provides evidence that ADOC administration either knew or ignored the serious shortcomings of the system." Ex. 222 (Expert Report of Kathryn Burns[21] and Jane Haddad, *Bradley v. Hightower* (June 30, 2000) ("*Bradley* Expert Rep.")) at 3.[22] Just over a decade later, a group of female inmates challenged

[21] Dr. Burns is an expert witness for the Plaintiffs in the present matter.

[22] Dr. Burns and Dr. Haddad described deficiencies in ADOC's mental health program: "Every type of what goes by the name 'treatment' or 'treatment unit' is seriously deficient in some critical aspect. Rounds that are designed to assess inmates and provide inmates with access are rapid 'drive-throughs.' Brief encounters at the cell or in a 'pill line' are termed 'psychotherapy.' Inmates with serious mental illness are locked-down under primitive conditions, and, if thought suicidal, stripped and made to sleep on the floor on a thin plastic mat. Medications are distributed in an unprofessional and dangerous fashion. Psychotropic medications are administered without prior consent and the policy and procedures for the forcible administration of medications are not followed. The 'treatment plans' that exist do not meet the most basic requirements for such plans

conditions and the provision of mental health care for women in ADOC facilities. *Laube v. Haley*, No. CV-02-T-957 (M.D. Ala.). Dr. Jane Haddad, one of the experts in *Bradley* and then a consultant for ADOC, noted that "Improved services for female inmates appeared compromised by inadequate mental health staffing; the lack of adequate mental health office space; and the lack of physical plant resources for intensive and long-term mental health services." Monitoring Report of Jane Haddad, *Bradley v. Haley* (Dec. 12, 2003)) at 8, available at http://www.clearinghouse.net/chDocs/public/PC-AL-0013-0001.pdf.

Nearly two-and-a-half decades after the *Bradley* litigation was filed, the same deficiencies remain. As a result of the agreement in *Bradley*, MHM Correctional Services, Inc. ("MHM") entered into a contract to provide mental health services throughout ADOC in 2001. Ex. 190 (excerpt of 2013 MHM Response to Request for Proposal), at MHM025964. The contract was renewed in 2008. *Id*. The current contract went into effect in 2013. Ex. 153 ("Mental Health Contract") at ADOC000323.

According to the Mental Health Contract, "[t]he ADOC is responsible, through the services of MHM, for the provision of inmate mental health care that meets constitutional standards, to include comprehensive mental health services and related support services for the inmates in the custody of the ADOC." Ex. 153

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and the medical records as a whole are professionally unacceptable." Ex. 222 (*Bradley* Expert Report) at 82-83.

(Mental Health Contract) at ADOC 000327. Under the contract, ADOC requires MHM to carry out "the State's constitutional duty to provide mental health care to state inmates" through "specialized mental health programming that conforms with correctional and constitutional standards." *Id*. at 323. Inadequate mental health and corrections staffing, inadequate identification of mental illness, and inadequate treatment options and space prevent constitutional treatment for people with serious mental illness incarcerated in ADOC. Despite charging MHM with meeting the requirements of ADOC's constitutional duty to provide care, ADOC routinely fails to ensure that MHM provides even minimally adequate mental health care, further exacerbating the problem.

ADOC itself also employs limited mental health staff to supplement the treatment provided by MHM. System-wide, ADOC directly employs a Chief Psychologist, two psychologists who oversee testing at intake, and psychological associates who provide limited mental health services, primarily to persons not on the mental health caseload. Ex. 21 (excerpt of Naglich, Dec. 8, 2015 ("Naglich Dep. I")) at 142:2-144:18. These ADOC staff have almost no role in the provision of mental health services for prisoners with serious mental illness in ADOC custody.

Under the Mental Health Contract, ADOC agreed to pay MHM a flat rate of $36,109,660 between October 1, 2013 and September 30, 2016. Ex. 153 (Mental

Health Contract) at ADOC 000323. The contract pays MHM the same amount regardless of the level of care that MHM provides to individuals held in ADOC custody. *See* Ex. 153 (Mental Health Contract) at ADOC 000342. [23] This structure creates an incentive to reduce costs by providing only a minimum level of care. In turn, individuals in ADOC custody face suffer from constitutionally inadequate mental health services.

**1. Inadequate Mental Health and Correctional Staff Are a Barrier to Providing Constitutional Mental Health Care**

**a. ADOC Mental Health Staffing Levels are Insufficient to Provide Constitutionally Adequate Treatment**

In *Bradley*, to bring the ADOC into compliance with its obligation to provide constitutionally adequate mental health care, ADOC agreed to mental health staffing levels for the 20,619 male prisoners in its custody at the time. Doc. 555-5 (Report of Dr. Kathryn Burns ("Burns Rep.") at 9-10. As of April 2016, the population has increased to more than 24,000 prisoners. (ADOC Monthly Report, April 2016) at 3.[24] As the population has increased, so has the size of the mental health caseload. As of March 2016, the mental health caseload was approximately 2,700 prisoners across the system. Ex. 16 (excerpt of Deposition of Robert Hunter,

[23] If the ADOC average monthly population is below 26,499 or above 26,500, the contract price changes at a rate of $3.71 per prisoner during the first year of the contract, $3.76 during the second year, and $3.73 during the third year. Ex. 153(Mental Health Contract) at ADOC 000342.
[24] The ADOC monthly report is available at http://www.doc.state.al.us/docs/MonthlyRpts/2016-04.pdf. The population number includes approximately 1,313 women, who were not included in the *Bradley* figures. Women in prisons are widely recognized as requiring a higher level of mental health services than men in prison. Doc. 555-5 (Burns Rep.) at 10.

Apr. 21, 2016) at 42:19-43:3; *see also* Ex. 15 (excerpt of Deposition of Teresa Houser, April 22, 2015 ("Houser Dep. II") at 21:20-22:6; Ex. 173 (Email from T. Houser to R. Naglich, June 24, 2015 (MHM045221)) (noting that REDACTED ); Ex. 180 (Multidisciplinary Meeting Minutes, Easterling Correctional Facility, June 9, 2014) at MHM 030039 ("REDACTED ").

Despite the increased population since the *Bradley* agreement, staffing levels have not increased at the same rate.

Starting in 2009, ADOC *reduced* the size of the mental health staff and developed a plan to transfer some of the prisoners on the mental health caseload to ADOC-employed psychological associates ("psych associates"). Ex. 15 (Houser Dep. II) at 84:5-86:12. However, the transfer of patients to the psych associates never really worked. Ex. 15 (Houser Dep. II) at 86:13-89:1. But the staffing cuts remained, and deepened with the 2013 contract.

In 2013, ADOC released a Request for Proposals in which it stated that it needed at least 144.95 full-time-equivalent mental health positions to provide constitutionally adequate mental health care. Ex. 153 (Mental Health Contract) at ADOC 000477. MHM submitted a bid for the contract, proposing the same

number of positions. Ex. 158 (excerpt of 2013 MHM Response to Request for Proposal), at MHM026351-26357. Nonetheless, ADOC agreed to fund only 126.50 positions, as reflected in the signed agreement. Ex. 153 (Mental Health Contract) at ADOC 000359. These staffing ratios did not come close to the *Bradley* staffing levels.

According to MHM Program Director Teresa Houser, ADOC made the reason to lower its costs by cutting staffing levels: "We were told in a meeting with the department that they wouldn't be able to fund that many employees and we should take that into consideration when we bid." Ex. 14 (excerpts of Deposition of Teresa Houser, Nov. 20, 2015 ("Houser Dep. I")) at 298:20-23. Ms. Houser explained that MHM's proposal contemplated providing the same services but with far fewer staff. *Id.* at 300:22-301:7. According to Ms. Houser, mental health services at numerous facilities – including all facilities housing the most seriously mentally ill prisoners – would benefit from additional staff. Ex. 15 (Houser Dep. II) at 33:5-41:5, 42:14-23, 47:18-48:1 (testifying that Limestone, Bullock Inpatient, Donaldson, Tutwiler, Easterling, and Kilby could all benefit from additional mental health staff and that Bibb, Draper, Staton, Elmore, and Bullock Outpatient could all benefit from additional time from a psychiatrist or certified nurse practitioner).

Starting in early 2015, MHM asked to amend the contract to add mental health staff. MHM could not provide the services required under the contract with the staff funded under the contract. *See* Ex. 15 (Houser Dep. II) at 48:15-49:17. Despite these requests, Ms. Houser has been repeatedly told that state budget issues prevent the staffing increases and as of April 2016, ADOC had not agreed to increase the funding for staff under the contract. Ex. 15 (Houser Dep. II) at 79:19-82:16.

Although there are staff shortages for all mental health positions, they are particularly acute at the highest levels, including licensed doctors and counselors. Ex. 169 (ADOC Clinical Contract Compliance Review, March 2015) at MHM 041833 (noting REDACTED "); Doc. 555-5 (Burns Rep.) at 9-11 (between 2000 and January 2012, "[t]he number of psychologists had been cut in half so that institutions were left with only part-time psychology coverage."). These positions are typically the most difficult and expensive to fill. *See* Ex. 10 (excerpts of Deposition of Felicia Greer, [DATE]), at 122:19-123:7, 126:4-14 (describing vacancies in psychiatrist and certified registered nurse practitioner positions); Ex. 28 (excerpts of Deposition of Dr. Charles Woodley) at 39:8-43:22 (describing turnover in the psychologist position at Donaldson, including two doctors who held the position no more than a few months, and acknowledging that it takes "any person working in corrections one or

two years to really get up to speed"); Ex. 2 (excerpts of Deposition of Dorothy Coogan), at 51:7-52:10 (same). Despite the expense, these practitioners are necessary – only licensed doctors have the training necessary to make certain diagnostic and clinical judgments.

ADOC proscribes minimum staffing levels, divided by facility and position. Ex. 153 (Mental Health Contract) at 5, Ex. A. Under the Mental Health Contract, MHM must repay ADOC for each hour below 85% of the required hours that MHM cannot fill for particular positions (psychiatrists and certified registered nurse practitioners). Ex. 153 (Mental Health Contract) at 5.[25] MHM frequently fails to fill the required psychiatrist and CRNP hours:

REDACTED

[25] In the same negotiation process that resulted in reducing total contractual mental health staff requirements from 144.95 FTE to 126.50 FTE, the threshold for having to pay for missed hours was lowered from 87% to 85% and the positions covered by the pay-back provision were narrowed, thereby reducing the actual staffing requirements further. *Compare* ADOC000329 *with* ADOC000450 in Exhibit 153.

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The caseload increases, combined with vacancies and contractual staff reductions has limited the availability of care for mentally ill prisoners throughout ADOC. MHM's Medical Director, Dr. Robert Hunter, testified that increased caseload without corresponding staffing increases affects care:

> [The increased caseload is] starting to tax our ability to adequately do what we do. I know more and more of our facilities are having more inmates to deal with. We haven't had much in the way of any increase in staffing, our staffing patterns, not in a comprehensive way. . . . I think we could definitely benefit from more staff to handle our increasing caseload.

Ex. 16 (Hunter Dep.) 44:4-18, 162:14-18.

The effect of the staffing deficiencies are evident in MHM's everyday functioning. Staffing shortages affect the timely delivery of mental health services. Ex. 14 (Houser Dep. I) at 22:7-22:20 ("If you don't have enough staff then it's difficult to see the number of inmates on a daily or weekly basis in order to provide them the services.") Insufficient numbers of psychiatrists and CRNPs leads to delays in psychiatric treatment. Because of increases in the number of prisoners requiring mental health treatment without corresponding increases in mental health staff, some MHM counselors have seen their caseloads nearly double over the last few years, making it difficult to allocate sufficient time for counseling sessions. Doc. 555-6 (Haney Rep.) at ¶251. According to MHM's Director of Training Dr.

Charles Woodley, under *Bradley* counselors were supposed to carry a caseload of no more than 75 prisoners in an outpatient facility or 25 prisoners in an inpatient facility or stabilization unit. Ex. 28 Deposition of Charles Woodley, March 8, 2015) at 210:2-211:8. REDACTED . Ex. 192 (emails regarding REDACTED ). Similarly, REDACTED . *See* Ex. 177 (Blending of Mental Health Services Audit (Sept. 13, 2011)) at ADOC046210. Caseloads for psychiatrists and nurse practitioners ("CRNPs") have also increased dramatically, causing a reduction in services. *See, e.g.*, Ex. 54 (Declaration of REDACTED ) at ¶ 39 ("[Dr. Posey] said he only had a few minutes and was putting me back on monthly counseling sessions. He said, because of the size of his case load, that is what everyone gets."). Those increased caseloads lead to prolonged wait times and missed appointments. Ex. 192 (REDACTED ); Ex. 77 (Declaration of REDACTED ) at ¶ 7. REDACTED

Ex. 169 (ADOC Clinical Contract Compliance Review, March 2015) at MHM 041833 (stating that REDACTED ). REDACTED

REDACTED *See* Ex. 9 (excerpts of Deposition of Brenda Fields, Feb. 5, 2016) at 126:21-127:21; Ex. 89 (Patterson Rep.) at 50 (REDACTED

); Ex. 45 (Declaration of Plaintiff Robert Dillard) at ¶ 13; Ex. 41 (Declaration of Plaintiff Howard Carter) at ¶ 9. Defendants' mental health expert, Dr. Patterson, found that REDACTED

Ex. 89 (Patterson Rep.) at 50-51. At some facilities, mental health staff forgoes multidisciplinary team meetings with medical and custody staff because of increased caseloads. Vacancies, particularly at the highest levels, exacerbate these problems. Ex. 28 (Woodley Dep.) at 271:16-272:6 (stating that vacancies cause MHM to "modify [its] programming to provide the best services or to provide the services to the most needy as determined by the treatment team").

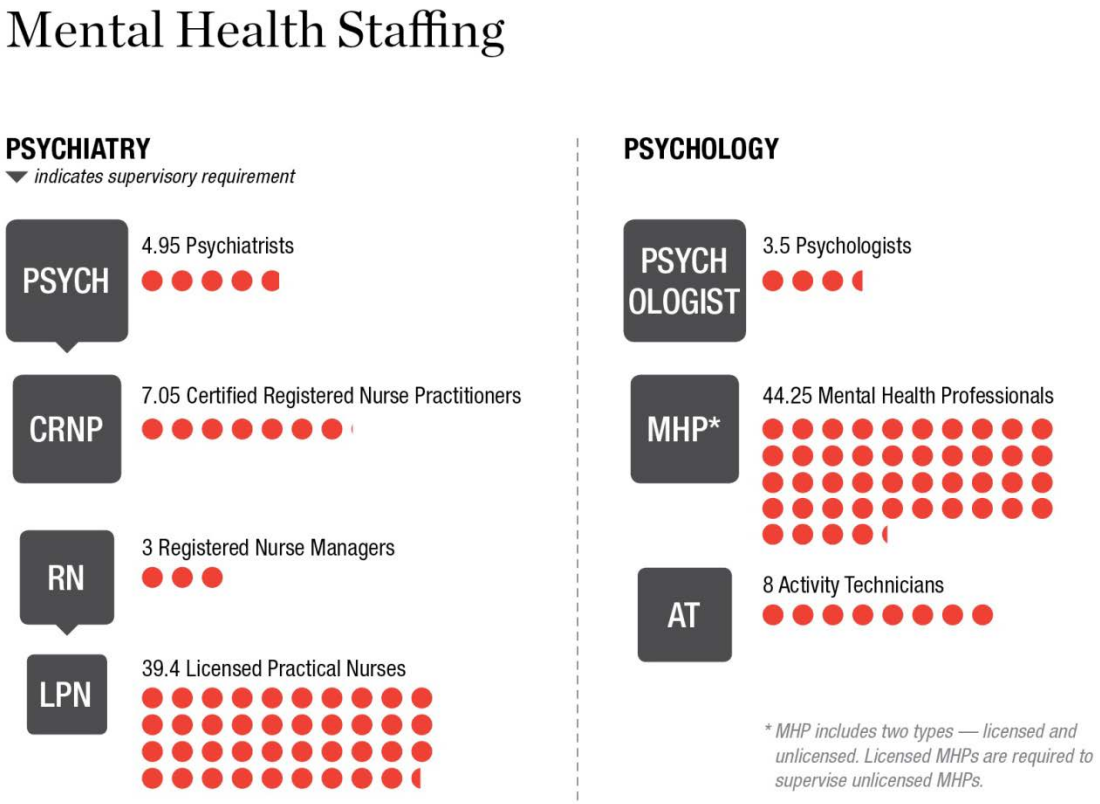
### b. Underqualified Staff Hinder the Provision of Mental Health Care

Under the Mental Health Contract, MHM provides mental health staff in both the psychiatry and psychology disciplines, as well as administrative staff. In psychiatry, MHM provides psychiatrists as well as CRNPs who are required to work under a psychiatrist's supervision.[28] In addition, MHM provides both registered nurses ("RNs") and licensed nurse practitioners ("LPNs"). RNs must supervise LPNs according to Alabama code.[29] In the psychology discipline, MHM staffs ADOC facilities with psychologists and mental health professionals ("MHPs"). MHPs may be licensed (typically in social work, therapy, or a related discipline) or unlicensed. Finally, MHM provides activity technicians and support staff for ADOC facilities.

According to the Mental Health Contract, each MHM provider should be licensed, certified, or registered in their field of expertise. Ex. 153 (Mental Health Contract) at 6. Despite the contractual requirement, MHM frequently relies on unlicensed MHPs to provide counseling services. Doc. 555-5 (Burns Rep.) at 15, 18. Even in disciplines where MHM requires licensure, ADOC has increasingly relied on less-credentialed staff. By January 2012, the number of psychiatrists provided under the 2008 contract had decreased from at least 8 at the time of the

[28] Under Alabama law, each CRNP must partner with a collaborating psychiatrist. The collaborating psychiatrist must provide on-site supervision and review a portion of the CRNP's records. Each psychiatrist may formally collaborate with up to four CRNPs. Burns Rep. at 13.
[29] *See generally* Burns Rep. at 16.

*Bradley* agreement to 6.75, while the use of CRNPs had increased from no more than 3 (to substitute for psychiatrists) to 12.2. Doc. 555-5 (Burns Rep.) chart at 12. As of February 2016, psychiatrists filled less than five full-time positions while CRNPs fill more than 7. *Id*. Psychologists, licensed versus unlicensed MHPs, and RNs versus LPNs have followed similar trends. Doc. 555-5 (Burns Rep.) at 10-12.



Although Alabama law requires supervision of CRNPs, RNs, and unlicensed MHPs, MHM routinely does not provide, and ADOC does not require, that oversight. Ex. 6 (excerpts of Deposition of Anna Davis-Walker, March 1, 2016 ("Davis-Walker II")) at 285:19-287:4 (acknowledging that, as the CQI manager for MHM, Ms. Davis-Walker does not do anything to evaluate the supervision offered in collaborative practice agreements); Ex. 9 (Fields Dep.) at 42:4-43:14 (REDACTED

); Doc. 555-5 (Burns Rep.) at 13 (stating that Dr. Burns did not find evidence of psychiatrists properly supervising CRNPs and that documenting such supervision is standard practice) and 15-16 (stating that a licensed psychologist is required to supervise unlicensed professionals in the community but not within ADOC's system). CRNPs are essentially functioning independently of psychiatrists. Doc. 555-5 (Burns Rep.) at 14 ("CRNPs now outnumber physicians in the system – no longer being utilized as physician extenders but replacements.") As MHM's Chief Psychiatrist, Dr. Robert Hunter, explained, MHM's CRNPs in the prisons are "psychiatrist[s] by proxy." Ex. 16 (Hunter Dep.) at 23:16-17. Moreover, they receive essentially no guidance from their purported supervisors. Ex. 2 (excerpts

of Deposition of Dorothy Coogan) at 85:1-86:5 (stating that CRNP Coogan was not aware of her collaborating psychiatrist Dr. Hunter changing or making suggestions regarding her work during the time Dr. Hunter has supervised her.) Ex. 12 (excerpts of Deposition of Cheryl Harvey) at 44:7-23 (REDACTED

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LPNs are performing functions that they are not qualified to fill. Doc. 555-5 (Burns Rep.) at 16. In his discussion of REDACTED ,

even Defendants' expert Dr. Patterson REDACTED

." Ex. 89

(Patterson Rep.) at 47. And unlicensed MHPs regularly provide treatment without supervision. Doc. 555-5 (Burns Rep.) at 15-16.

This overreliance on less-credentialed staff results in treatment that is below the standard of care. Doc. 555-5 (Burns Rep.) at 13, 16, 19-20. Such overreliance leads to heightened risk of inaccurate or missed diagnoses, improper treatment techniques, inadequate treatment plans, problematic medication management practices, and delays in care. Doc. 555-5 (Burns Rep.) at 14, 16-18; Ex. REDACTED

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### c. Inadequate Custody Staff Prevents Access to Mental Health Treatment

Inadequate numbers of ADOC custody staff compounds the problems with accessing care. Despite complaints and requests from MHM (see Doc. 555-6 (Haney Rep.) at ¶¶248-49), custody staffing levels continue to limit mental health services. Doc. 555-2 (Vail Rep.) at 35 ("ADOC is insufficiently staffed to perform the basic functions of keeping the inmates safe and secure"); Doc. 555-5 (Burns Rep.) at 20-21 (describing how ADOC staffing shortages impact mental health services); Doc. 555-6 (Haney Rep.) at ¶¶248-250 (describing the effects of staffing shortages through ADOC facilities).

On a regular basis, the lack of adequate ADOC custody staff results in prisoners missing counseling appointments and groups because no custody staff is available to transport them. Doc. 555-2 (Vail. Rep. at 60-66 (discussing how shortages in custody staff lead to missed medical and mental health appointments); Ex. 12 (Harvey Dep.) at 75:17-77:20 (REDACTED

"). Plaintiff Robert Dillard, who suffers from schizophrenia, has repeatedly been told by custody staff that he could not go see his counselor, although he later learned the counselor was in the mental health office and available. Ex. 45 (Dillard Decl.) at ¶ 11. At certain facilities, group therapy has been canceled altogether because of inadequate staffing levels. Doc. 555-6 (Haney Rep.) at ¶¶ 248-49 (noting that MHM staff report that ADOC

"staffing problem[s] resulted in the termination of certain forms of treatment" at Donaldson, Fountain, St. Clair, Holman, and Bibb); Ex. 9 (Fields Dep.) at 128:5-8 ("REDACTED

."). Inadequate custody staffing levels in treatment hubs not only affect counseling, but also undermine the availability of other types of therapeutic activity, including structured out of cell time. Doc. 555-5 (Burns Rep.) at 20-21; Ex. 15 (Houser Dep. II) at 73:20-74:6 (explaining that ADOC does not always provide enough officers in the SU or RU to allow programming to proceed) and 70:12-71:2 (noting that ADOC is not always able to provide sufficient staff to allow prisoners "structured out of cell time" on the SUs).

The inadequate number of custody staff has a particularly dramatic effect on prisoners in segregation or on death row. Because of their security status, these prisoners typically spend 23 hours a day or more in their cells and are able to access mental health services only if mental health staff visit the unit or if the prisoners are escorted to mental health individually. Ex. 41 (Declaration of Plaintiff Howard Carter) at ¶ 8; Ex. 7 (excerpts of Deposition of Lesleigh Dodd) at

62:7-20 (noting that prisoners in segregation or on death row at Holman must be brought to mental health by a two-man escort and mental health staff "can't always get to them" if "there's not enough staff"); *see generally* Doc. 555-2 (Vail Rep.) at 68 (describing officer shortages as a barrier to mental health staff completing segregation rounds). REDACTED

. Ex. 12 (Harvey Dep.) at 223:11-224:6, 228:17-231:6; Ex. 164 (Multidisciplinary Minutes, St. Clair Correctional Facility, Sept. 25, 2014) at [MHM029962] ("REDACTED

."). For those prisoners receiving medications, this can result in delayed or missed doses. *See, e.g.*, Ex. 7 (Dodd Dep.) at 151:9-21 (stating that nurses had been delayed in providing injections to prisoners in segregation or on death row within the month preceding her deposition).

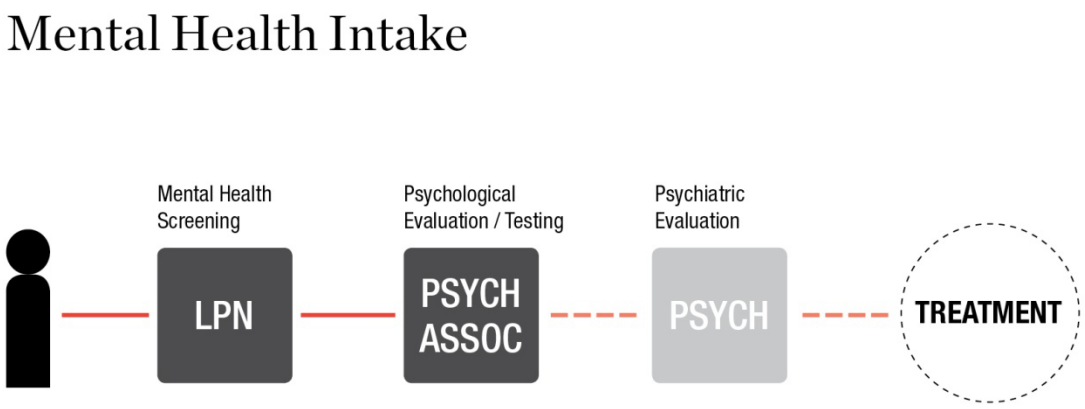
**2. ADOC's Identification and Classification System Fails to Adequately Identify the Existence and Acuity of Prisoners' Mental Illness**

As prisoners enter into ADOC custody, each person is screened for mental health issues during the reception or intake process. Both MHM and ADOC staff are involved in those screenings. Aside from this initial encounter, prisoners can access the mental health care system in two ways: they can request help (self-

referral)[30] or medical, mental health, or custody staff can refer them (staff referral). Each mechanism to access the mental health system is deficient in ways that result in under-identification of mental health illness and delays in providing care.

**a. ADOC's Mental Health Receiving Screening Fails to Identify Prisoners with Mental Illness**

The ADOC intake process overlooks inmates who require mental health treatment. Although each prisoner entering ADOC has some contact with mental health services, that contact is often limited to a short interview with an LPN and an evaluation by a psych associate.




As an initial step, an MHM LPN assesses each prisoner as they come through intake. Ex. 16 (Hunter Dep.) at 90:9-91:12. This screening is supposed to

[30] Prisoners can also refer one another but that process mirrors the self-referral process.

occur within 48 hours of arrival. Ex. 14 (Houser Dep. I) at 63:17-22. That assessment involves questioning the prisoner about his or her current mental health status, mental health history, and substance abuse, using a general screening tool. Ex. 187 (Reception Mental Health Screening Evaluation/ADOC Form MH0-011). During this initial screening, the LPN is also tasked with determining whether the prisoner is on psychotropic medications. If so, the LPN must verify the prescription and ensure that the prisoner has enough medication available until a psychiatrist can complete an evaluation. Administrative Regulation 610, Reception Mental Health Screening, May 14, 2004, http://www.doc.state.al.us/docs/AdminRegs/AR610.pdf.

Based on this cursory assessment, the LPN can make one of three decisions. First, the LPN can determine that the prisoner does not require further follow up and assign the prisoner a code of MH-0. Ex. 14 (Houser Dep. I) at 66:14-21. Second, the LPN may decide that the prisoner requires further evaluation at a later date. Ex. 14 (Houser Dep. I) at 66:22-67:08. Finally, the LPN may decide that the prisoner a psychiatric evaluation immediately. *Id*.

The LPN acts as a gatekeeper to mental health services by making the initial determination of whether or not a prisoner requires *any* mental health care. This is an inappropriate role for LPNs who require supervision by registered nurses for a task of this nature. Doc. 555-5 (Burns Rep.) at 16-17. This critical judgment

requires a higher level of specialized skill and diagnostic knowledge that an LPN possesses. Doc. 555-5 (Burns Rep.) at 22. The use of an LPN at this early screening stage contributes to the under-identification of prisoners with mental health illness. *Id.*; *see also* Ex. 89 (Patterson Rep.) at 47.

In addition to the LPN screening, each prisoner is also screened by an ADOC psych associate. The psych associate's screening consists of completing a screening tool (Ex. 186, ADOC Psychological Evaluation form) and administering three tests: intelligence screening (BETA), education evaluation (WRAT), and a personality inventory (MMPI-II). Doc. 555-5 (Burns Rep.) at 22. Although ADOC collects these test results, the information is not used to inform treatment. *Id*. The psych associate does not assign a mental health code based on their assessments. Ex. 14 (Houser Dep. I) at 84:8-19. They can, however, refer a prisoner back to MHM for a psychiatric assessment. Ex. 14 (Houser Dep. I) at 73:8-15. This referral process serves as the only way in which a prisoner that has been coded as an MH-0 by an LPN can nonetheless receive further evaluation.

If either an LPN or the psych associate refers a prisoner for further evaluation, the prisoner will eventually receive a psychiatric evaluation. For non-emergencies, that evaluation is scheduled "at the next available appointment time," which is supposed to occur within 14 days. Ex. 14 (Houser Dep. I) at 69:10-

70:08.[31] At that appointment, a psychiatrist determines whether the prisoner should be placed on the mental health caseload and what level of treatment he or she requires. Ex. 14 (Houser Dep. I) at 84:8-19.

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Ex. 89 (Patterson Rep.) at 47. The size of the mental health caseload has grown since the *Bradley* agreement. Ex. 16, (Hunter Dep.) 43:4-10. However, the percentage of the population receiving mental health services has remained roughly the same and has stayed consistently below REDACTED. Ex. 155 (MHM Monthly Report, February 2016) at [ADOC 0319152].[32] A total of

REDACTED Those percentages have remained roughly consistent over the past few years. Doc. 555-5 (Burns Rep.) at 23.

These numbers are considerably lower than national averages. *Id.* According to the Bureau of Justice Statistics, 73% of female prisoners and 55% of male prisoners report mental health problems. *Id.* A 2014 report by the Treatment

[31] The LPN may also decide a prisoner requires an urgent mental health intervention and refer the person for crisis care.

[32] As of March 2016, MHM's medical director estimated that there were 2,700 prisoners on the mental health caseload. Ex. 16 (Hunter Dep.) at 42:19-43:3.

Advocacy Center noted that 15% of all state prisoners nationwide have serious mental illness. *Id.* at 23-24.[33]

**b. ADOC Does Not Require MHM or ADOC to Respond to Self Referrals or Staff Referrals in a Timely Manner**

In addition to intake, prisoners are supposed to be able to access mental health care by submitting a written request (or verbal request in case of emergency). Staff can similarly submit a written request on a prisoner's behalf. Ex. 14 (Houser Dep. I) at 19:7-20:2. These requests are then triaged by an MHM nurse, who, on the basis of the single document, decides whether the prisoner should see someone, and with what urgency. Ex. 14 (Houser Dep. I) at 25:10-28:18. Frequently it is an unsupervised LPN making this decision. *Id*. Each request presents three options – schedule an appointment with the prisoner, respond in writing, or file the request without any formal response.[34] The requests must be responded to within 5 working days.

Once the nurse makes that initial determination, the response time is recorded in a log. Audits of these logs have found that the response times often cannot be determined, because the date of the request is not recorded. Doc. 555-5 (Burns Rep.) at 28-29). For those instances where the response time could be

[33] Serious mental illness include, for example, schizophrenia, schizoaffective disorder, bipolar disorder, major depression and disorders with symptoms of psychosis. Doc. 555-5 (Burns Rep.) at 23.
[34] In her review of records, Dr. Burns noted "many instances in which MHM was unresponsive to prisoner self-referrals." Burns Rep. at 27.

determined, many responses took longer than 5 working days. *Id*. Moreover, the level of urgency of the request is not noted on the log.

Prisoners report that it can take days or even weeks for their requests to result in actual face-to-face contact with mental health staff, if contact occurs at all. Ex. 8 (excerpts of Deposition of Joshua Dunn); Ex. 36 (Declaration of REDACTED ) at ¶ 8 ("If I need to see [my counselor] I can drop a request slip. But I might not see her for a week."); Ex. 34 (Declaration of REDACTED ) at ¶¶ 9-10 ("I put in a sick call slip… to talk to someone from mental health. I did not hear anything for two weeks."). This is the case even when the requests are urgent. Ex. 63 (REDACTED Decl.) at ¶ 22 (3 hours to see a counselor if having crisis in segregation). The delays in responding for requests for mental health care frequently prompt prisoners to engage in destructive or self-injurious conduct designed to catch the attention of mental health staff. Doc. 555-5 Burns at 27. Prisoners frequently beat on the walls, scream, set fires to property, and threaten to or actually do harm themselves in efforts to get the mental health care they require. Ex. 36 (REDACTED Decl.) at ¶ 9 ("beat on the walls to get the attention" of mental health staff); Ex. 41 (Carter Decl.) at ¶10 "the only way to get mental health to see me was to cut myself"); Doc. 555-6 (Haney Rep.) at ¶ 55 ("prisoners resort to setting fires to get attention"); Doc. 555-6 (Haney Rep.) Exhibit 4 at ¶ 55 ("KLZ "threw water out of his cell to get staff's attention"); Doc. 555-6 (Haney Rep.) Exhibit 4 at ¶ 60/CEJ

"you have to cut up to get attention."). As Dr. Burns identified, "[i]ronically, these behaviors often result in disciplinary action, including placement in segregation, where mental health care is more difficult to access." Doc. 555-5 (Burns Rep.) at 27; *see also* Ex. 89 (Patterson Rep.) at 47.

**c. ADOC's Mental Health Classification System Fails to Ensure that Prisoners Are Provided Adequate Treatment**

A psychiatrist assigns each person placed on the mental health caseload a mental health code. Ex. 16 (Hunter Dep.) at 88:17-89:12. The codes range from MH-1 through MH-6. Prisoners that are not referred for further screening at intake are coded as MH-0 by default. Ex. 16 (Hunter Dep.) at 93:06-13.

ADOC "classif[ies] prisoners by their presumed housing needs (outpatient or residential treatment – dormitory or cell)." Doc. 555-5 (Burns Rep.) at 25-26; *see also* Ex. 16 (Hunter Dep.) at 75:7-82:5. For example, a code of MH-1 is assigned to someone who can be placed in general population, while an MH-3 is assigned to someone who has to be placed in an RTU. This classification system does not permit tracking of prisoners with serious mental illness. Doc. 555-5(Burns Rep.) at 25. That deficiency "has a direct bearing on the number of professional staff required to care for inmates with serious mental illness." *Id.* at 26.

Prisoners are assigned inappropriate codes based on their level of illness. *Id.* at 26-27. Codes are changed when individuals are transferred between inpatient

and outpatient facilities, despite there being no changes in a prisoner's mental health status.[35] Additionally, prisoners with significant mental health illnesses are frequently coded MH-1. For example, a prisoner prescribed three antipsychotics and two antidepressants who was frequently on suicide watch was classified as an MH-1. Burns at 27. The misclassification is apparent from reviewing individual records, but also population data. In February 2016, REDACTED

. Ex. 155 (MHM Monthly Report, Feb. 2016) at ADOC0319152. REDACTED

. *Id.* REDACTED

(*Id.*),

REDACTED

[35] See, e.g., Moncrief Decl. at ¶¶ 5-9 (code changed to MH-3 after transfer to RTU, no perceived change in MH status); REDACTED Decl. at ¶ 4—dropped from MH-3 to a 2 and eventually a 1 when moved to main camp/had no counseling or change in MH status)

#### d. Mentally Ill Inmates Are Improperly Removed from the Mental Health Caseload, Despite Needing Care

In light of the increasing caseload and insufficient staffing levels, MHM actively removes inmates from the mental health caseload in an effort to "manage" the population. Doc. 555-5 (Burns Rep.) at 29. For example, at one multidisciplinary meeting, REDACTED

" Ex. 163 (Bullock Multi Disciplinary Meeting Minutes, June 5, 2014) at MHM029855. The discussion ended with the CRNP stating REDACTED

*Id*. at MHM029856.

Prisoners are taken off the caseload despite feeling they need to be on it and even when they have recently engaged in self-harm. *See, e.g.*, Ex. 34 (Declaration of REDACTED ) at ¶¶ 6-7 (describing being taken off the caseload although he had recently attempted suicide 4 times).

### 3. ADOC Fails to Provide Meaningful Mental Health Treatment to Prisoners in ADOC Custody

Under the Mental Health Contract, ADOC has charged MHM with "all duties required in the management of a system to deliver comprehensive mental health care to inmates assigned to the ADOC." Ex. 153(Mental Health Contract) at ADOC000325. Those duties include providing mental health care at five distinct

levels: Reception Evaluations, Intensive Stabilization Units (SU), Residential Treatment Units (RTU), Outpatient Services, and In-patient Psychiatric Care. Ex. 153 (Mental Health Contract) at ADOC000420. The care consists of individual counseling, group counseling, psycho-educational groups, and pharmacological interventions. Ex. 14 (Houser Dep. I) at 132:7-11. Although the contract mandates that all mental health treatment meets the standard of care, treatment is deficient at each level. As a result, REDACTED

Ex. 89 (Patterson Rep.) at 47 (REDACTED

REDACTED .")

According to Dr. Hunter, REDACTED

. Psychotropic medication is the only treatment that is consistently available. Doc. 555-5 (Burns Rep.) at 37. Prisoners on the mental health caseload, particularly those in the RTUs and SUs, "receive no more than the barest minimum of individual and group therapy (if they receive any at all) . . . [I]t is not remotely enough treatment to address the complicated needs of this vulnerable population." Doc. 555-6 (Haney Rep.) ¶ 23.

### a. Use of Outdated Psychotropic Medications, Combined with Inadequate Monitoring and Follow Up, Creates a Risk for Those Prisoners Prescribed Psychotropic Medications

#### i. MHM Overrelies on Long-Acting "Typical"[36] Antipsychotics

MHM has adopted a pattern of prescribing "long-acting haloperidol (Haldol) and fluphenazine (Prolixin) injections" for inmates with mental health disorders despite the severe side effects which "impact normal movement and can cause severe restlessness (akathisia) and painful muscle spasms (acute dystonic reaction) and also lead to permanent, irreversible movement disorders that include tremor, involuntary movements of the tongue and mouth (tardive dyskinesia) and Parkinsonism." Doc. 555-5 (Burns Rep.) at 38. Dr. Burns reported that "Many of the inmates interviewed displayed these types of movement disorders, but their prescriptions were continued rather than changed to medications less likely to cause these problems." *Id.* Many prisoners report side effects and that that they generally dislike the way the injections make them feel. Ex. 38 (Declaration of Plaintiff Quang Bui) at ¶¶ 9-10 ("At Donaldson, they began giving me shots of Haldol. Since then, I've been getting monthly shots of Haldol. The Haldol made my hands and head shake. The Haldol makes me very sleepy."); Ex. 69 (Declaration of REDACTED ) at ¶¶ 3-7 (Haldol "makes my head and hands shake

[36] Antipsychotic medications are frequently described as either typical or first generation, or as atypical or second generation.

[and] makes me restless and affects my sleep."); Ex. 56 (Declaration of REDACTED ) at ¶¶ 7-8 (takes Prolixin shot every two weeks; he states "I don't want to take the shot. It made me l[o]se weight and my arms lock up. I am currently 158 lbs.").

Overreliance on these first generation antipsychotics presents additional clinical concerns. Doc. 555-5 (Burns Rep.) at 39. "[I]t takes 6 weeks to 3 months after a dosage adjustment to see a response to the adjustment because they are so long-acting. Using them to make dose adjustments is therefore impractical when the adjustment is made in response to worsening symptoms or when a dose reduction is necessary to reduce or eliminate side effects. Dosage adjustments are most often made with oral medications for this reason in other systems, but this is not the case in ADOC." *Id.*

**b. MHM Fails to Adequately Respond to Side Effects of Psychotropic Medications**

Severe side effects are not limited to long-acting typical antipsychotics; the oral forms of these medications also case side effects. Despite the significant side effects experienced by inmates on Haldol, Prolixin and other psychiatric medications, prisoners who experience these side effects are regularly maintained on the same medications rather than being switched to medications less likely to cause problems. Doc. 555-5 (Burns Rep.) at 38 (discussing specific instances of

prisoners who were maintained on Haldol and Proxilin despite side effects). Prisoners who attempt to refuse their medications because of the side effects are subjected to disciplinary measures. Prisoners are often "threatened with forcible medication injections if they refuse[]" medications and some have "actually been subjected to the use of force to be given an injection of a refused medication." Doc. 555-5 (Burns Rep.) at 39; Ex. 45 (Dillard Decl.) at ¶ 16 ("I used to take a Haldol shot. I didn't want to take it because it made me shake and my vision was blurry. They told me if I didn't take it, they would write me up."); Ex. 57 (RE DA Decl.) at ¶¶ 5-7 ("I take one pill daily. I do not know what it is called. A psychiatrist at Limestone told me it was to help me sleep. I do not want to take the pill. I did not take it before coming to prison. It makes me sick. I don't think I need it. I take it because if I don't take it, they put you in lockup. I have been put in lockup at Bullock for not taking my medication. I also got a disciplinary. This happened twice."); Ex. 77 (REDACTED Decl.) at ¶ 13 ("I have been told I was non-compliant with former medication. I told my doctor it made me feel zombie-like; I was threatened with a disciplinary if I didn't take it anyway."); Ex. 32 (REDACTE D Decl.) at ¶¶ 10, 12 ("I have been coerced and intimidated into taking Haldol shots in the past. When I refused Haldol in the past because I was experiencing severe side effects, I was threatened with segregation. . . . I have been threatened with physical violence if I don't take Haldol."); Ex. 50 (REDA CTED Decl.) at ¶ 7 ("When I was at

Donaldson, I told the mental health staff, I think Ms. Coogan, that I did not want to take the [Haldol] shot because it makes me feel funny. I don't feel like myself. . . . I did not think the medicine was helping me so I was not going to take the shot. The police, a sergeant and some officers, held me down and forced the shot on me. Then they sent me to [segregation] for about a week.").

Although ADOC has recognized that "[i]nmates have the right to refuse and withdraw their consent for medications," MHM's own audits have acknowledged that "inmates were threatened with disciplinary actions if not compliant with medications."

**c. Inappropriate Cost Considerations**

This overreliance on first generation antipsychotics despite complaints about their side effects may be explained by the higher cost of certain second generation atypical antipsychotics. Dr. Hunter has repeatedly expressed concern about the costs of atypical, second generation antipsychotics. REDACTED

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. *See*,

*e.g.*, Ex. __ (MHM CQI Meeting Minutes, Feb. 5, 2013) at MHM031155 REDACTED

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.”). In MHM’s monthly reports to ADOC it includes information REDACTED

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**d. ADOC Fails to Ensure that Prisoners on the Mental Health Medications Are Adequately Monitored**

MHM acknowledges the importance of monitoring medication compliance and side effects. Dr. Hunter has noted the importance of psychiatric medication monitoring regarding certain medications, like monitoring “second generation atypical antipsychotics, which can affect blood sugar, which can affect lipids, like cholesterol, triglycerides, and we have to monitor those things,” and monitoring for the ‘Abnormal Involuntary Movement Scale’ (AIMS) caused by antipsychotics,

which "which can impact or cause certain movement disorders, that's a way to monitor their progression over time. And were required to do that at baseline and at intervals while they're on that medication . . . ." Ex. 16 (Hunter Dep.) at 293:23-294:15. The monitoring is, however, inadequate within ADOC. MHM's own audits demonstrate significant gaps in monitoring for side effects.

Similarly, MHM routinely fails to monitor prisoners' compliance with their medications. An annual audit by MHM in 2014 found that REDACTED

REDACTED

The failure to monitor medication also limits prisoners' access to their medications. REDACTED

REDACTED

. Ex. __

(Patterson Rep.) at 47 (REDACTED

.”); Ex. 63 (REDACTED Decl.) at ¶¶ 7, 12

(“REDACTED

.”); Ex. 77 (REDACTED Decl.) at ¶ 10 (“My doctor changes my medication every few months without explaining why. I go without medication for two days each time this happens.”); Ex. 37 (REDACTED Decl.), at ¶¶ 14-15 (“During my incarceration, there have been approximately 6 times my required medication was unavailable, or ‘out.’ I have gone weeks without necessary medications and suffered withdrawals. I have been given wrong medications approximately 10 times in just the last 2 years.”); Ex. __ (REDACTED Decl.) at ¶¶ 4, 7, 10, 12-13 (stating he had been on medication for depression and anxiety, and despite suicide attempts, was not given any medication for months); Ex. 32 (REDACTED Decl.) at ¶¶ 13, 15 (“Every time I am transferred, I go about a week without my medications. . .

. Last month, when I was transferred and temporarily off meds, I cut myself."); Ex. 67 (Declaration of REDACTED ) at ¶ 10 ("When I received the wrong medication the nurse would take it and never return with the right medication."); Ex. 46 (REDACTED Decl.) at ¶ 5 ("On many occasions my Ha[l]dol and Benadryl shots are late by two weeks."). MHM Program Director Houser noted that during a site visit, Regional Director of Nursing Candace Hanzes "learned that some of the meds were not being refilled in a timely manner in the RTU." Ex. 14 (Houser Dep. I) at 131:15-18.

Prisoners report that their medications are changed without anyone telling them why, or for non-clinical reasons. Ex. 77 (REDACTED Decl.) at ¶ 10 ("My doctor changes my medication every few months without explaining why."); Ex. 57 (RE DA Decl.) at ¶ 5 ("I take one pill daily. I do not know what it is called."); Ex. 41 (Carter Decl.) at ¶¶ 4-6 ("Around 2011, I was transferred to Donaldson Correctional Facility. At that time, Ms. Coogan discontinued all my mental health medications. While at Donaldson, I repeatedly asked the mental health staff for mental health medications. When I was transferred to St. Clair, Ms. Coogan refused to see me or prescribe the mental health medication I needed. I am currently on the mental health caseload and still do not receive any medications to treat my depression, anxiety and hallucinations.")

Problems with the administration of "pill call" create additional barriers for prisoners to receive and comply with their medications. Pill call is often plagued by missing doses, long wait times between doses, prohibitively long wait lines, waiting areas outside in extreme climates, MHM has long been aware of these problems.

Prisoners complain about the difficulties with pill call. Ex. 55 (REDACTED Decl.) at ¶¶ 16-17 ("I got to pill call twice a day and it lasts about an hour each time. A few times at Bibb I've had to wait four hours for pill call."); Ex. 77 REDACTED Decl.) at ¶ 12 (noting that she has waited up to one and half hours at pill call); Ex. 42 (RED ACT Decl.) at ¶¶ 7-8 ("Sometimes I miss pill call because the line is too long. . . . the wait can be over an hour and a half."); Ex. 63 (REDACTED Decl.) at ¶ 11 ("When I was being given medication, I would wait outside in the pill call line, often for over two hours. I was not allowed to sit down during those periods."). One prisoner explains that he has stopped taking medications completely because withdrawal is too difficult when he cannot get his medications because of administrative problems. Ex. 82 (Declaration of REDACTED ) at ¶¶ 8-10.

**c. Mental Health Treatment Other than Medication Is Inadequate**

**i. Treatment at Outpatient Facilities is Deficient**

**ii.**

According to ADOC's Administrative Regulations, prisoners receiving outpatient mental health services must be provided individual counseling no less

than once a month, psychiatric appointments no less than every 90 days, and access to therapeutic or activity groups. ADOC Administrative Regulation 623, Outpatient Mental Health Services, June 5, 2007, http://www.doc.state.al.us/docs/AdminRegs/AR623.pdf.) Despite these requirements, "virtually the only treatment being provided is psychotropic medication." Doc. 555-5 (Burns Rep.) at 35.

Although prisoners on the mental health caseload are assigned a counselor (MHP), turnover, security vacancies, and excessive caseloads lead to brief, infrequent and unproductive counseling sessions. Ex. 77 (REDACTED Decl.) at ¶¶ 7-8 ("When I see my MHP, I sometimes wait up to 2 hours. I spend 10-15 minutes with my MHP. She is unresponsive when I express feelings of violence or unhappiness."); Ex. 45 (Dillard Decl. ) at ¶¶ 7, 9 ("Ever since I've been at Bullock, since 2004, the counselors change all the time. It's hard for me to trust the counselors because it's always someone new. . . . I sometimes have to wait 30 minutes or one hour to see my counselor. I just have to sit on the bench and wait."); REDACTED

Counseling sessions that do occur generally last no more than 10-20 minutes. Doc. 555-5 (Burns Rep.) at 35; Ex.7 (Dodd Dep.) at 64:21-65:11; Ex. 72 (REDACTED Decl. ¶ 7)(stating that counseling sessions at

Holman were about five minutes once a month and an officer remained in the room during those sessions); Ex. 67 (REDACTED Decl. ¶ 5)("While at St. Clair, I saw nurse Coogan once a month for 5 minutes. I saw the counselor 1 x month for 5 to 10 min."); Ex. 63 (REDACTED Decl. ¶ 26)("When I see my counselor, it is only for 5-10 minutes."); Ex. 57 (REDACTED Decl. ¶¶ 9-10 ("When I see my counselor, we talk for about one minute. He asks, 'are you taking your meds?' I say yes. He asks 'are you hearing voices?' I say no. He asks 'are you going to hurt yourself or someone else?' I say no. Then the meeting is over. These are the same 3 questions my counselor asks me every time we meet."); Dillard Decl. ¶ 5 ("Right now, I see my counselor every two months or so. Those counselors meet with me for about 15 minutes."); Ex. 46 (REDACTED Decl. ¶¶ 7-8)("When I meet with my counselor it is only for about ten minutes. I always request to see her and I am never scheduled. I have seen my counselor aprox. [sic] 10 times since arriving at Holman in 2014."). These brief and infrequent encounters do not constitute individual counseling. Doc. 555-5 (Burns Rep.) at 35.

Prisoners in outpatient facilities report having no access to mental health groups. Ex. 67 (REDACTED Decl.) at ¶ 9 ("While at St. Clair, I did not have the opportunity to go to any mental health groups."); Ex. 57 (REDACTED Decl.) ¶ 13 ("I am not in any groups right now. If I could be in a group, I would want to be in a group."); Ex.46 (REDACTED Decl.) ¶ 10 ("I have not taken any mental health groups

but I have not been given any information about when or where they take place."). On REDACTED

. Ex. 172 (February 19, 2016 email chain) at MHM044092.

Yet another reason for the lack of mental health group counseling is the lack of adequate treatment space. REDACTED

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; see also Ex. 15 (Houser Dep. II) at 280:7-17 (discussing inadequate space for group sessions).

REDACTED

." Ex. 9 (Fields Dep.) at 14:23-15:2, 55:11-56:17 (REDACTED

). Even when groups are offered, there are only a small number of number of groups that are offered over and over to the same population . *See* Ex. 45(Dillard Decl.) ¶ 12 ("Since I've been on the after-care side [general population at Bullock], I have not been to any groups. I was going to be on honor camp but they told me I had to take three groups that I had already done three or four times. I asked if there were any new groups I could do and they said I had to complete the same groups

again. Because I did not want to repeat the same groups, I did not go to honor camp.").

The lack of adequate mental health staff means that individual mental health counselors are saddled with burdensome caseloads, and patients are taken off the mental health caseload to accommodate increased needs. Ex. 170 (Email chain from November 19, 2015 to December 3, 2015) at MHM042077-78 ("REDACTED

"); Ex. 164 (MHM Multidisciplinary Meeting Minutes for Bullock, June 26, 2014) at MHM029857 (REDACTED

"). REDACTED

").

Counselors do not adhere to treatment plans; the plans themselves are "superficial, often times boilerplate prescriptions that are only occasionally changed" and not kept up-to-date. Doc. 555-56 (Haney Rep.) at ¶35; Ex. 89 (Patterson Rep.) at 50-51 (REDACTED

); Ex. 9 (Fields Dep.) at 126:21-127:21 (REDACTED

); Ex. 174 (email chain from January 5, 2016) at MHM048867 (REDACTED

); Ex. 171 (email chain from June 29, 2015) at MHM042090-91 (REDACTED

"). The clinical insufficiency of treatment plans and MHM's failure to implement the plans is reflected in the experiences of mental health patients—who don't recall meeting with a treatment team and don't know anything about their treatment plan. Ex. 45 (Dillard Decl.) ¶¶ 13, 15 ("Since I've been on the after care side, I have not seen my treatment team. I do not know whether I have a treatment plan right now. About two or three months ago, my counselor told me to sign something about redoing my medications. I told her that someone stole my glasses so I could not see what I was signing. I asked her to read it to me but she

just told me basically what it said and told me to sign. . . . Last night, the nurse told me that she needed to reorder my other med. She mentioned a different med that I have never heard of and never saw a doctor about."); Ex. 67 (REDACTED Decl.) ¶ 8 ("I did not see a treatment team while at St. Clair. I was never told what was on my treatment plan. I was only told to sign the paper."); Ex. 46 (REDACTED Decl.) ¶ 9 ("I have never met with a treatment team and I have not seen my treatment plan since my initial appointment at Holman in 2014.").

### iii. Treatment at Residential Facilities is Inadequate

Residential Treatment Units (RTUs) are intended to provide "supportive therapeutic environment for treatment of inmates with serious mental illness who are unable to function in the general prison population." Admin. Reg. 633) at ADOC0141644. According to ADOC policy, treatment interventions for individuals in RTUs should progress from cell-front interactions with the psychiatrist and mental-health nurse to multiple group counseling sessions per week and daily structured activities. *Id.*; see also Doc. 555-5 (Burns Rep.) at 32.

Yet, psychotropic medication is the primary treatment provided in RTUs. Doc. 555-5 (Burns Rep.) at 33. Individuals in Donaldson RTUs are "locked in their cells with minimal opportunity to participate in treatment interventions" and those in Bullock RTUs have some social interaction but do not receive treatment other than medication. Doc. 555-5 (Burns Rep.) at 33. Notably, individuals housed

in RTUs receive little if any individual or group counseling. Doc. 555-6 (Haney Rep.) at Ex. 4 ¶¶ 30-333, 47, 58, 59, 60, 63, 68, 71, 72, 74, 75, 77, 78, 82, 83, 85, 86 (lack of treatment in RTUs described in interviews with X.L.I., C.D.B., F.W.B., C.S.Q., P.D.L., L.L.Z., N.I., D.T.I., T.L.B., T.P.Z., X.J.I., Q.B. , E.E.S., C.E.J., K.C.Q., C.A., Q.S., X.B.X., E.P.C. Ex. 82 (REDACTED Decl.) ¶¶ 19-27 (describing that he thought he would die in a "time-out cell"—a small room with a glass wall with a toilet, sink, and a mattress—where he spent more than two months at the Bullock RTU after being beaten by guards for refusing to go back to general population because he feared for his life); Ex. 80 (REDACTED Decl.) ¶ 6 (describing his treatment: "I see my psychiatrist once a month with a gaurd [sic]/officer present. I do not like this."); Ex. 50 (REDACTED Decl.) ¶ 13 ("I remember seeing a counselor here at Bullock and before at Donaldson and St. Clair. I think I saw a counselor about every four months at Donaldson and St. Clair. I think those meetings lasted about 20 minutes. At Bullock, my meetings with my counselor are shorter."); Ex. 60( Moncrief Decl.) ¶ 14 ("Two months ago, they stop the groups [at Bullock RTU] for no reason."); Ex. 50 (REDACTED Decl.) ¶¶ 15-16 ("I try to participate in mental health groups and have been trying to participate since I got to Bullock in September. I have told the activity techs that I want to participate. I also put request slips in the box saying that I want to sign up. One AT . . . told me that she keeps forgetting to sign me up. Another AT . . . told me I need to talk to

my counselor if I want to participate. I have asked my counselor how to participate in mental health groups. She says she doesn't know. I also told my treatment team that I have not been able to get into groups . . . They write it down in their notes, I don't know if they have done anything.").

The February 2016 MHM Monthly report shows that only 79% of the male RTU beds and 57% of the Tutwiler beds were actually filled, and that there were "only 9 inmates in the 30-bed Bullock SU and no women in the 8-bed Tutwiler SU." Doc. 555-5 (Burns Rep.) at 34; Ex. __ (MHM Monthly Report, Feb. 2016) at ADOC0319155-56. The failure to use the available SU and RTU space reflects a trend of improperly classifying individuals for outpatient care who need a higher level of care. *See, e.g.*, Doc. 555-5 (Burns Rep.) at 34-35 (discussing, among others, a "seriously mentally ill inmate" with functional impairment and medication side effects requiring "placement on watch in infirmary but not considered for transfer to higher level of care"; another inmate who "presented with garbled, mumbling speech and appeared to have an intellectual disability in addition to serious mental illness but kept at St. Clair").

d. Suicide Prevention and Suicide Watch is Inadequate

Mental health and correctional staff respond to individuals at risk for suicide with indifference and punishment. Ex. 8 (Dunn Dep.) at 162:8-163:11 (discussing testifying that guards delayed taking him to medical, then beat and threatened him after he attempted suicide in segregation); Ex.77 (REDACTED Decl.) ¶ 18 ("Twice I

have expressed suicidal thoughts and was laughed at; nothing else happened."). Staff often assume that prisoners who hurt themselves do so for non-mental health reasons. Ex. __ (MHM CQI Meeting Minutes, Feb. 5, 2014) at MHM029579 ("REDACTED

"); *Id*. at MHM029583 (REDACTED

."); [37] Ex. __ (Multidisciplinary Meeting, Bullock Correctional Facility, November 18, 2013) at MHM029841 ("REDACTED

[37] Most CQI meeting minutes contain REDACTED . See, e.g., Ex. __ (MHM CQI Meeting Minutes, April 22, 2015) at MHM029594-596; MHM CQI Meeting Minutes, July 22, 2015) at MHM029600-602; MHM CQI Meeting Minutes, January 28, 2015) at MHM029618.

REDACTED

.”); *Id.* at MHM029840 (REDACTED

”).

Inmates are frequently disciplined for self-harm. Ex. 69 (REDACTED Decl.) at ¶ 21 (“I received a disciplinary for cutting myself and served 30 days in segregation”); Ex. 63 (REDACTED Decl.) at ¶ 18 (“I have received disciplinary write-ups for cutting myself and hanging myself.”); Ex. REDACTED Decl.) at ¶ 17 (“I have been written up for cutting myself.”); Ex. 46 (REDACTED Decl.) at ¶ 12 (“When I got a disciplinary two months ago, I was not given a mental health consultation to the mental health process during my hearing and there was no mental health staff present.”).

While failing to prevent suicides and other acts of self-harm, ADOC operates safe cells that are far from safe. MHM and ADOC staff barely monitor individuals in the crisis cells, if at all. Ex. 77 (REDACTED Decl.) ¶ 19 (“When I went to a suicide cell, I was left there for 72 hours. No one checked on me during that time.”); Ex. 69 (REDACTED Decl.) ¶ 11 (describing interactions with his counselor while on suicide watch at Kilby as “two times a week for 20 minutes at cell front”); Ex. 46 (REDACTED Decl.) ¶ 11 (“When I was in suicide watch during the

summer of 2014, I went to the suicide cell on Friday and was not seen by any MH until Monday. Five minute safety checks were not completed by MHM staff on the weekend."); Ex. 63 (REDACTED Decl.) at ¶ 17 ("Sometimes I am placed in a conference room while waiting for a crisis cell. I have been left in the conference room for up to 3 hours with no one checking on me."). Little or no treatment is provided. Ex. 83 (Williams Decl.) ¶ 11 ("I was in a safe cell for about three days before I saw Ms. Burden who asked me if I was suicidal. I told her No, and she released me."); Ex. 8 (Dunn Dep.) at 156:19-157:13, 159:14-160:18 (testifying that while in suicide watch, mental health staff came by on third day to ask if he was suicidal).

Custody staff do not check on prisoners regularly. For example, during one inspection at Holman, the sheet outside an occupied suicide watch cell on which the correctional officer is supposed to record 15-minute checks was blank from 9:00 a.m. until 11:15 a.m. and thereafter. Ex. 191 (Photo of Mental Health Watch Restraint Procedure form). Further, MHM Corporate Associate Brenda Fields noted REDACTED

. Ex. 9 (Fields Dep.) at 100:9-101:12,109:21-110:8.

Individuals who are placed in safe cells commit further self-injury in those cells—including with razors found in the cells. Ex. 8 (Dunn Dep.) at 153:10-19

(cut himself with a razor he brought into suicide watch); Ex. 84 (Williams Decl.) at ¶ 7 (cut herself in safe cell at Fountain Correctional Facility); Ex. 69 (REDACTED Decl.) at ¶ 20 ("While on suicide watch I took out the staples [from cutting myself] and cut myself again with a razor I received from the segregation runner."); Ex. 81 (Wallace Decl.) at ¶ 6 ("I was in the crisis cell because I bit myself. I bit myself because I was going through it and it is the only way to get attention. They always ignore me."); Ex. 63 (REDACTED Decl.) at ¶¶ 16, 23 ("I do not believe the suicide cells are searched before I am placed there. Sometimes, I have been placed in a suicide cell when I have a razor with me, and I was not searched. . . . I have hurt myself by cutting while in a crisis cell multiple times.").

There are also inadequate numbers of crisis cells, resulting in people being placed in inappropriate locations rather than a safe cell. Ex. __ (MHM emails from 4/6/16) (regarding three prisoners spending much of the weekend in the shift office, rather than a crisis cell); Ex. __ (MHM emails from 10/2/15 to 10/5/15) at MHM044618 (regarding placement of prisoner who attempted to hang himself in library at Staton); Ex. 63 (REDACTED Decl.) at ¶ 17 ("Sometimes I am placed in a conference room while waiting for a crisis cell.").

**e. ADOC's Disciplinary Process and Segregation Policies Have a Dramatic Effect on Prisoners' Mental Health**

The mental health services provided to individuals in segregation is even less than those offered to individuals housed elsewhere. Counseling, when it happens, is generally limited to a few minutes at cell-block, where the counselor asks if everything is okay. Ex. 63 (REDACTED Decl.) at ¶¶ 20-21 ("Mental health will talk to me in segregation for about 5 minutes. When I am concerned about privacy, I have asked to talk to mental health outside of the seg cell. More than half the time, I am not taken out of the cell and I speak to no one from mental health."); Ex.74 (REDACTED Decl.) at ¶ 16 ("I have been on the mental health caseload since I entered ADOC. When I was in lock-up, the counselor would come by once a week, look in the window through my door and ask me 'Are you alright?' The counselor would [stay] no longer than a minute or two and would ask nothing more than 'How are you doing' or 'Are you alright'?"); Ex. 76 (REDACTED REDACTED Decl.) at ¶¶ 8-10 ("While in lock-up [at Bullock], . . . Ms. Collins, the psychologist, would come around every Friday. She just talks through the window to ask if you're okay, and I didn't feel comfortable talking to her with people around. Ms. Collins stays for 3-4 minutes at the most. It's like she don't have no patience."); Ex. 77 (REDACTED . Decl.) at ¶¶ 15-16 ("In segregation, mental health makes rounds where they speak to me for less than a minute. They do nothing when I tell them I have a problem. I have asked to see a mental health professional several times while in seg and nothing ever happened."); Doc. 555-6 (Haney Rep.) at Ex. 4 ¶¶ 2-

4, 6-7, 23, 96, 105 (describing interviews with H.A., H.L.I., U.I., T.L.Z., F.D.Z., O.E.J., Q.V.Q., E.P.Q., D.C.G., K.J.I.). Further, the shortage of mental health and custody staff mean that segregated inmates often receive no mental health counseling at all. Ex. __ (Multidisciplinary Minutes, St. Clair Correctional Facility, September 25, 2014) at MHM029962 ("ADOC continues to have officer shortages in segregation which delays inmates being seen."); Ex. __ (Multidisciplinary Meeting, Tutwiler Prison, February 25, 2014) at MHM030106 ("Ms. Greer reported that the officers expressed some challenges they are having with moving the seg. inmates for mental health appointments. Some times security will get the inmate ready for the appointment time that is in the newsletter but mental health cannot see them right then. Also some times mental health tries to get the inmate at their appointment time but they are unable to come at that time due to security issues..."); Ex. 46 (REDACTED Decl.) ¶ 13 ("When I was recently in seg, no mental health staff came to provide counseling services to me.").

This dearth of mental health services exacerbates the deterioration caused merely by placing mentally ill individuals in segregation. Plaintiff Robert "Myniasha" Williams experienced the harm caused by several placements in segregation. In March 2014, after being placed in segregation at Holman, Williams cut herself. The nurse called Dr. Hunter, who declined to put Williams in a safe cell; Williams was sent back to segregation where she cut herself again with a

razor that was sitting on her sink. Ex. 83 (Williams Decl.) at ¶¶ 6, 10, 12, 16-17. Many other prisoners have decompensated while in segregation, engaging in self-harm. See, e.g., Ex. 76 (REDACTED ) at ¶ 11 ("In March 2016, after about 4 months in lock-up, I attempted to commit suicide."); *see generally* Doc. 555-6 (Haney Rep.) at ¶¶ 24-28, 138.

**4. ADOC Fails to Implement Adequate Quality Assurance Programs**

**a. ADOC fails to maintain a regular and effective audit process**

OHS is responsible for monitoring MHM's performance under the contract. Ex. 153 (Mental Health Contract) at ADOC 000330. However, OHS oversight over mental health services is practically nonexistent and thus, ineffective.

OHS does not appear to have ever set a regular auditing schedule for mental health audits, nor does one exist currently. Ex. 21 (Deposition of Ruth Naglich I) at 98:23-99:02; 99:13-100:06. OHS admits it has conducted just two formal audits of any mental health care unit or program since 2013. Ex. 22 (Naglich Dep. II) at 166:21-23, 168:15-169:02; *see also* Ex. 15 (Houser Dep. II) at 293:02-18 (testifying to three audits).

OHS audited the Donaldson RTU in the April and May 2013. Ex. 162 (2013 MHM Corrective Action at Donaldson) at ADOC045464-471. The audit showed significant problems with, among other things: access to mental health care, partly due to a shortage of officers; hygiene; treatment planning; availability of groups;

medication administration; persons not in need of RTU-level care being housed in the RTU; lack of access to medical care; and the presence of rodents. *Id*. The OHS did not work with MHM to develop a plan to resolve these problems. Ex. 17 (Kinard Dep.) at 166:4-8. Nor did OHS re-audit the RTU. *Id*. at 166:22-167:2. OHS staff met once to discuss the results of this audit, but no one from Donaldson or MHM was present. Ex.17 (Deposition of Brandon Kinard) at 167:13-168:21. There was no follow up after that. *Id*. at 169:03-17. REDACTED

. Ex. 9 (Fields Dep.) at 126:21-134:1.

The next time OHS conducted a formal mental health audit was in December 2015. Ex. 22 (Naglich Dep. II) at 168:15-169:02. The results of this audit were not produced in discovery.

**b. ADOC fails to monitor and address issues identified through MHM's internal CQI processes**

MHM appears to have a more comprehensive quality assurance program in place than does ADOC. MHM's CQI program includes an annual contract performance review, formal audits, CQI meetings and conference calls, and various other data-gathering. Ex. 5 (Deposition of Anna Davis-Walker, February 12, 2016) at 26:13-30:15. MHM regularly identifies and reports on performance shortcomings. See, e.g., Ex. 192 (emails reporting mental health caseload analyses for Ventress, Bibb, Easterling, Bullock, and Donaldson and finding problems with

delinquent MHP or provider appointments, outdated treatment plans, or medication issues at each facility).

These quality assurance processes identify problems, but they are inadequate for correcting problems. One reason for this is that findings are often reported without recognition that the issues are recurring. Doc. 555-5 (Burns Rep.) at 43. MHM's Corrective Action Plans created in response to annual contract compliance reports are illustrative. For example, the MHM corporate team audited MHM's performance at Donaldson in 2014 and 2015. Most of the Corrective Action Plan from 2014 appears to have been copied any pasted into the Plan for 2015, with no acknowledgement that the problems were recurring. Compare Ex. __ (2014 Donaldson Corrective Action Plan) at MHM031582-584 with Ex. __ (2015 Donaldson Corrective Action Plan and email) at MHM046077-081. The deficiencies identified and corrective plans for the following aspects of care are identical[38]:

- Treatment Plans (Outpatient)
- Medication Compliance/Medication Education/(Outpatient)
- Medication Changes (Outpatient)
- Weight Monitoring (Outpatient)
- Nursing Assessments/Treatment Plans (Inpatient)

[38] The sole difference is that in 2015, MHM staff set an earlier target date for resolving the problems than they did in 2014.

- Treatment Plans (Crisis)(Inpatient)
- Informed Consents/AIMS/BMI (Inpatient)
- Group Activity Log

*Id*.

REDACTED

OHS is ultimately responsible for ensuring that contract compliance issues are addressed. As is the case with OHS direct auditing, OHS monitoring of MHM's CQI processes is ineffective. The person at OHS who is responsible for looking at mental health care does not receive or request copies of the corrective

action plans created by MHM following MHM's performance audits in ADOC. Ex. 15 (Houser Dep. II) at 199:12-200:7. Defendant Naglich does not receive the contract compliance report each year. Ex. 22 (Naglich Dep. II) at 182:06-08. Furthermore, while an OHS staff member does attend CQI meetings, Defendant Naglich does not receive reports from these meetings and has not requested any such reports. *Id*. at 185:11-21. Even if her staff calls her to discuss problems they learned of, Defendant Naglich has never been asked to reviewed CQI meeting minutes, despite her ability to do so. *Id*. at 191:02-06. Most critically, Defendant Naglich has little knowledge about what corrective actions are taking place to ensure that identified errors are corrected— or even how many corrective action plans have been created— explaining that she does not believe it is her role to review every action plan. Ex. 22 (Naglich Dep. II) at 173:4-177:1.

**c. Suicide reviews fail to meaningfully assess the causes of suicide, preventing identification of adequate preventative measures**

In every instance of prisoner suicide, MHM conducts a "psychological reconstruction" examining the deceased prisoner's mental health, medical, and social histories. Ex. 178 (MHM Psychological Reconstructions). The psychological reconstruction ends with a summary and recommendations. . REDACTED

*Id.* at MHM 040810, 812, 815, 820, 041812. REDACTED

REDACTED

*Compare Id.* at MHM 040811 *with Id.* at MHM 040814.

REDACTED

REDACTED

*Id.* at MHM040808. Segregation rounds continue to be done through the cell front doors. Doc. 555-6 (Haney Rep.) at ¶ 303. REDACTED

Ex. 178 (MHM Psychological Reconstructions) at MHM040825. REDACTED

*See* Ex. 89 (Patterson Rep.) at 47.

Although it has failed to implement the recommendations that come the psychological reconstructions, MHM has seemingly recognized that there is a connection between placement in segregation and suicide rates. Ex. 555-6 (Haney Report) at ¶ 257-303; Ex. 16 (Hunter Dep.) at 96:16-97:17. Like with all other CQI processes, MHM has been able to identify an issue but not meaningfully address it. In October 2015, MHM and ADOC met to discuss suicide prevention measures, discussions of restrictive housing use. Despite the meeting being a "starting point" for discussing the issue, no subsequent meetings occurred and there is no evidence

that anything is being done to address the mental health implications of placement in suicide. Ex. 16 (Hunter Dep.) at 184:20-185:12, 191:15-19; 200:18-201:12.

ADOC has the right under the contract to review any and all documents relating to the provision of care in the ADOC. Ex. 153 (Mental Health Contract). However, as discussed above, ADOC has decided not to exercise that right. *See also* REDACTED MHM's CQI process identifies serious problems with the provision of mental health care. ADOC has chosen not to look.

**5. ADOC's Involuntary Medication Policy Results in Violations of Prisoners' Constitutional Rights**

Prisoners have the choice whether or not to take their medications. Ex. 16 (Hunter Dep.) at 229:22-230:3. If a prisoner refuses to take their medications,[39] ADOC allows MHM to involuntarily medicate the person under ADOC's policy concerning Involuntary Psychotropic Medication. The policy allows ADOC to prescribe and administer psychotropic medications against the will of a particular prisoner. Administrative Regulation 621, Administrative Review for Involuntary Psychotropic Medication(s), Sept. 20, 2014, http://www.doc.state.al.us/docs/AdminRegs/AR621.pdf.[40] Since 2002 or 2003, the

[39] Prisoners may generally refuse medications either in writing or by verbally refusing at pill call. Ex. 16 (Hunter Dep.) at 230:4-233:7.

[40] Medical staff at the facilities question the practice. Ex. __ (Lovelace Dep.) at 131:11-32:7 ("It's against the law to force people to take medication.")

number of prisoners receiving medications involuntarily has grown from "a handful" to around 70 or 80. Ex. 16 (Hunter Dep.) at 239:9-239:22.

Before administering medication involuntarily, the ADOC policy requires extensive procedures. *Id*. Despite the procedures laid out in the policy, implementation is deeply flawed. Doc. 555-5 (Burns Rep.) at 39-42. Under the contract, MHM is charged with implementing the involuntary medication policy. Ex. 153 (Mental Health Contract) at 37. ADOC's oversight of MHM's implementation consists entirely of interviewing and reviewing the records of prisoners who are on involuntary medications. Ex. 22 (Naglich Dep. II) at 47:7-48:15.

Prisoners who refuse their medications are transferred to the SU for "a deeper, more in-depth look" and to be "evaluated in detail." Ex. 16 (Hunter Dep.) at 235:8-36:8. If a prisoner sent to the SU after refusing medications indicates that "there's nothing wrong," he "do[es not] need medicine," or he is "not going to take it," *Id*. at 236:2-5, MHM views those statements as an indication that the prisoners is "in denial about how dysfunctional they've become." *Id*. at 236:5-6. Because of the dysfunction and the denial, the person is considered for involuntary medication. *Id*. at 236:6-8.

By contrast, the policy requires that prisoners may not be prescribed involuntary medication unless they dedicate symptoms of serious mental illness, a

"high likelihood of serious harm to self, others or property," are "unable to perform basic life sustaining functions," and "[m]anifest severe deterioration in routine functioning." A.R. 621 at 2. The petitioner must also consider and document any "history of side effects, including severity, from the proposed involuntary medication." *Id*. at 3. Yet prisoners are maintained on the same medications despite the side effects. Doc. 555-5 (Burns Rep.) at 41; Ex. 50 (REDACTED Decl.) at ¶ 9; *see also* Ex. 56 (REDACTED Decl.) at ¶ 8 ("I don't want to take the shot. It made me loose [*sic*] weight and my arms lock up. I am currently 158 lbs."); Ex. 38 (Bui Decl.) at ¶¶ 9, 10 ("The Haldol made my hands and head shake. The Haldol makes me very sleepy."); Ex. 1 (Bui Dep.) at 42:12-19 (""[T]hey give me a shot and I don't want it. I want to quit taking it, so I don't have to be shaking no more.").

The policy also requires that the prisoner refuse voluntary treatment and be transferred to the SU for less intrusive treatment before the involuntary administration of psychotropic medication begins. *Id*. Although the policy does not specify which SU,[41] *Id*. at 2, all prisoners who are being considered for initial placement on involuntary medication are transferred to Bullock. Ex. 16 (Hunter Dep.) at 236:18-21.[42] This transfer is at least partially for administrative convenience. *Id*. at 237:11-14, 238:7-15; Ex. 28 (Woodley Dep.) at 66:2-6.

[41] Donaldson also has an SU.
[42] *But see* Ex. __ (Greer Dep.) at 226:18-28:3 (Question: "[P]ending the [involuntary medication] hearing, is the inmate placed in the SU?" Answer: "No.")

In ADOC, the process for considering an involuntary medication petition often stretches on for weeks or months. According to Dr. Hunter, typically three or four weeks pass between the time a treating provider petitions for involuntary medications and the Involuntary Meds. Committee actually issues the order. Ex. 16 (Hunter Dep.) at 237:15-38:6. These delays and transfers harm prisoners' mental health: they are disruptive to the continuity of care and relationships with the medical provider. Doc. 555-5 (Burns Rep.) at 41.

The treating psychiatrist, *Id*. at 236:8-17, or any member of the treatment team, A.R. 621 at 2, may petition the Involuntary Medication Review Committee for a formal order that the prisoner be placed on medication involuntarily. The policy requires that the petition involve a psychiatric evaluation, a DSM IV diagnosis, and a consideration of less intrusive alternatives. *Id*. at 2-3. The policy also requires that the prisoner present either a "substantial likelihood of serious physical harm," a substantial likelihood of significant property damage," or is "unable to perform basic, life sustaining functions." *Id*. at 2. Additionally, the policy requires that the petitioner describe "methods used to motivate the inmate to accept medication and the inmate's responses to these efforts" along with "[a]ny recognized religious objection to the medication. *Id*. at 3.

Despite these requirements, the petitions are typically deficient. They frequently include identical language copied and pasted from one petition to another. *See* Ex. 2 (excerpts of Quang Bui Medical Records, Coogan Dep. Ex. 6).

Once a petition is complete, the prisoner is referred to the Involuntary Medication Review Committee ("Involuntary Meds. Committee"), who is responsible for making a final determination. A.R. 621 at 3. The Involuntary Meds. Committee is required to meet within one day of receiving the paperwork for a preliminary review. *Id*.

The Involuntary Meds. Committee is also responsible for notifying the prisoner of his or her due process rights at least one day working day before the hearing. A.R. 621 at 3. Despite this requirement, prisoners often don't learn about the hearings in advance. Doc. 555-5 (Burns Rep.) at 40.

Dr. Hunter convenes the three-person panel that is responsible for conducting the hearing. The panel typically includes Dr. Hunter, Dr. Woodley, and an RN. Ex. 16 (Hunter Dep.) at 238:16-239:2. The psychiatrist on the panel, typically Dr. Hunter, is the ultimate decision-maker for the panel. Ex. 28 (Woodley Dep.) at 79:21-81:20. During the hearing, prisoners are supposed to be informed of their due process rights, have the opportunity to present testimonial evidence opposing the involuntary medication request,[43] and be given the opportunity to

[43] An inmate's right to be present may be limited by the Chair for specific reasons. A.R. 621 at 4.

question witnesses who support the involuntary medication order. A.R. 621 at 4. Yet because the psychiatrist or CRNP requesting the involuntary medication order is often not present at the hearing, prisoners typically do not have the opportunity exercise their rights. Doc. 555-5 (Burns Rep.) at 40.

Even prisoners who are given the opportunity to speak on their own behalf are quickly dismissed. Ex. 50 (REDACTED Decl.) at ¶ 10 ("When I say why I don't want the meds, they say that I am doing good and should just keep taking the meds."); Ex. __ (REDACTED Decl.) at ¶ 18 ("At the hearing, Dr. Hunter does all the talking. They are talking to each other but they are talking about me."); Ex. __ (REDACTED Decl.) at ¶ 14 ("I tell Dr. Hunter I do not want to be on the shots during these meetings. He tells me I need to give it more time."); Ex. 38 (Bui Decl.) at ¶ 12 ("At every meeting, I ask them to stop giving me the shots. They have never stopped giving me the shots. I am still getting the shots."); *see also* Ex. __ (Coogan Dep.) at 250:8-53:13 ("Mr. Bui states that he does not need [the medication]. . . He said the medication did nothing for him.").

Additionally, the policy requires that the Involuntary Meds Committee assign a "staff advisor" to assist the inmate before and during the hearing. A.R. 621 at 3.[44] "Staff advisors" are often not appointed or prisoners are not made aware or their identity. Ex. __ (REDACTED Decl.) at ¶ 19 ("I don't feel like there is anyone to

[44] Although Defendant Naglich testified that a prisoner can bring any advocate he chooses to an involuntary medication hearing, Ex. __ (Naglich Dep.) at 51:2-21, the policy only allows for a "staff advisor" assigned by the Involuntary Meds. Committee. A.R. 621 at 3.

help me at the hearings."); *see also* Ex. 29 (Kern Dep.) at 93:12-94:14 ("The medical records clerk . . . informs the inmate prior to the hearing . . . . And she officers practical assistance to them in terms of answering very basic administrative questions . . . . But to my knowledge, they are not afforded any . . . counsel beyond that.").

The hearing itself is "primarily a paper review of the request." Doc. 555-5 (Burns Rep.) at 40. The result is almost always an involuntary medication order. Ex. 16 (Hunter Dep.) at 240:20-42:6 (stating that approximately 95% to 97% of involuntary medication requests are approved).[45]

The policy requires that the Involuntary Meds. Committee notify the prisoner of the order and his right to appeal a unfavorable decision by the committee with the assistance of the staff advisor. A.R. 621 at 4-5. Although the policy does not require that the appeal be in writing, *Id.*, in practice written appeals are required. Ex. 16 (Hunter Dep.) at 269:6-11; Ex. 28 (Woodley Dep.) at 87:1-14. Similarly, the policy does not impose any limits on the subject matter of the appeal. A.R. 621 at 4-5. Yet Dr. Hunter testified that appeals are

> supposed to be based on procedural problems as opposed to I'm appealing because nothing is wrong with me and I don't want meds or I don't need meds, and that's typically what the appeal says when we get it. But it's supposed to be on procedural grounds; we weren't given appropriate due process, you weren't notified in a timely manner, you weren't allowed to be

[45] At the renewal stage, between 92% and 95% of requests are approved. Ex. __ (Hunter Dep.) at 242:20-43:7.

> present at the hearing. . . . Supposed to be based on a procedural defect. . . . [T]hat's my understanding of how the appeals process is supposed to go [based on t]he regulations.

Ex. 16 (Hunter Dep.) at 269:11-270:10. All appeals must be submitted within 24 hours. A.R. 621 at 4; Ex. 28 (Woodley Dep.) at 67:15-17.

Although the process exists to appeal an involuntary medication order, those appeals are almost never successful. Ex. 16 (Hunter Dep.) at 271:2-72:4; Ex. __ (REDACTED Decl.) at ¶ 11; Ex. 1 (Bui Dep.) at 79:8-18. In Dr. Hunter's tenure as medical director for MHM, he does not remember a single successful appeal. *Id*.

Under the policy, an initial order for involuntary medication expires after 30 days. Administrative Regulation 621, Administrative Review for Involuntary Psychotropic Medication(s), Sept. 20, 2014, http://www.doc.state.al.us/docs/AdminRegs/AR621.pdf at 4.[46] Yet MHM does not require reauthorization of the initial involuntary medication order until 90 days have lapsed. Ex. 16 (Hunter Dep.) at 253:2-10; Ex. 28 (Woodley Dep.) at 60:21-61:2; Ex. 2 (Coogan Dep.) at 236:12-15; see generally http://doc.alabama.gov/Regulations.aspx, 600 Series Administrative regulations. The policy lays out a procedure for extending the order for an additional 180 days. A.R. 621 at 5. Involuntary medication orders are often maintained for years. Ex. 52 (REDACTED Decl.) at ¶ 6 (five years).

[46] "The decision to medicate the inmate requires a majority of the committee, with the Psychiatrist among the majority, and remains in effect for thirty days."

According to that procedure, the Involuntary Meds. Committee (comprised of the same members as the initial panel) must review a continuation request before the existing order expires. *Id*. at 5. Despite that requirement, MHM does not consider an order expired after 180 days have lapsed. Ex. 16 (Hunter Dep.) at 247:20-48:21. Instead, MHM "tr[ies] to give [itself] a two, maybe four week at the max cushion for" renewing orders by extending them for a few weeks informally pending a formal renewal. *Id*. 248:5-7.[47] The result is that prisoners are administered medication involuntarily even after orders have expired. Doc. 555-5 (Burns Rep.) at 40.

Although the factors for initiating or continuing an involuntary medication order are clearly defined in the policy, *Id*. at 2,[48] a "big important" indicator that the Involuntary Meds. Committee relies on is "insight." Ex. 16 (Hunter Dep.) at 245:11-46:5. A relevant determination, according to Dr. Hunter, is whether the prisoner is "now coming around to the realization that they had a problem; are they more accepting of that; are they no longer in denial." *Id*. at 245:20-23; Ex. 2 (Coogan Dep.) at 238:9-239:12 ("You would look at their acknowledgement . . . they're likelihood to take oral medications when you have asked them about

[47] According to Dr. Hunter, if "a guy had a six-month approval that was done in January, and he's due in June, and we can't get to -- . . . It will expire without renewing in June . . . We try to get that done before July is out, within thirty days of that date." *Id*. at 248:7-15.

[48] Key indicators include "a substantial likelihood of serious physical harm towards self or others, a substantial likelihood of significant property damage or who is incapacitated to the extent that he/she is unable to perform basic, life sustaining functions such as eating and drinking or manifests severe deterioration in routine functioning by repeated and escalating loss of cognitive or volitional control over personal actions as a result of the serious mental illness."

coming off an injection."); *see also* Ex. 28 (Woodley Dep.) at 82:10-83:1 (describing that an involuntary medication order was not reviewed because the prisoner was "compliant with the treatment, both the pharmacotherapy as well as the psychosocial treatment, and they had a clear understanding of their illness, insight was evident").

The consequences of refusing an involuntary medication administration can be dramatic. Prisoners who refuse their injections have been physically restrained while the injection is administered. Ex. 56 (REDACTED Decl.) at ¶¶ 9, 11-12 ("I refused to take my shot. They tried put the handcuffs on me, throw me on the ground and gave me my shot."). Refusing an involuntary medication administration can have drastic consequences. *Id*. at ¶ 10 (60 days in segregation for refusing an involuntary medication injection); Ex. 38 (Bui Decl.) at ¶ ("The Captain said that if I wouldn't take the shot, they would put me in lockup."). Defendant Naglich testified that such threats are not permissible. Ex. 22 (Naglich Dep. II) at 55:6-13.

Beyond the involuntary medication process described in the regulations, a second, less formal process exists. Although prisoners technically have the right to refuse their medications, Ex. 16 (Hunter Dep.) at 229:22-230:3, prisoners in ADOC cannot always exercise that right. *See* Doc. 555-5 (Burns Rep.) at 39 ("[I]nmates consistently reported being subjected to being threatened with forcible

medication injections if they refused either oral medications or a scheduled injection; and some said they had actually been subjected to the use of force to be given an injection of a refused medication."). Some prisoners are threatened with segregation sentences or other disciplinary sanctions if they refuse their medications. *See* Ex. 57 (RE DA Decl.) at ¶ 7 ("I take it because if I don't take it, they put you in lockup. I have been put in lockup at Bullock for not taking my medication."); Ex. 37 (REDACTE D Decl.) at ¶ ("While in suicide watch in the past, I refused Haldol because it gave me lockjaw and muscle spasms. I was threatened with segregation if I didn't take the drug."); Ex. 32 (REDACTE D Decl.) at ¶¶ 10, 12 ("When I refused haldol in the past because I was experiencing severe side effects, I was threatened with segregation. . . . I have been threatened with physical violence if I don't take haldol."); Ex. 45 (Dillard Decl.) at ¶ 16 ("I used to take a Haldol shot. I didn't want to take it because it made me shake and my vision was blurry. They told me if I didn't take it they would write me up."). Others are told that they will be forcibly medicated if they don't take the prescriptions voluntarily. Ex. 63 (REDAC TED Decl.) at ¶¶ 13-14 ("In the past I have been told I was non-compliant with medication. During noncompliance, I was told I would be locked up a [*sic*] forcefully medicated"); Ex. 77 REDACTED Decl.) ¶ 13 ("I have been told I was non-compliant with former medication. I told my doctor it made me feel

zombie-like; I was threatened with a disciplinary if I didn't take it anyway."). Such consequences are not permissible. Ex. 22 (Naglich Dep. II) at 55:14-57:4.

### C. ADOC Violates the ADA Rights of Prisoners with Mental Health Disabilities

The ADOC maintains prisons throughout Alabama in which it systemically discriminates against many of the most vulnerable people in its custody, specifically prisoners with mental health disabilities, by denying them the access, accommodations, and services required by federal law. These ongoing actions of the ADOC violate the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, (collectively, the "Acts").

The ADOC's failures to meet its obligations under the Acts are system-wide and affect incarcerated men and women with mental health disabilities throughout its prisons. Upon information and belief, the ADOC's refusal to provide accommodations and services required under the Acts currently harms hundreds and possibly thousands of prisoners with mental health disabilities in its custody. Rather than addressing each failure individually, which would be impracticable, inefficient, costly and arguably impossible, Plaintiffs seek to represent a subclass consisting of any current or future inmate in the physical custody of ADOC who

has a disability as defined in 42 U.S.C. § 12102 and 29 U.S.C. § 705(9)(B) relating to or arising from mental disease, illness, or defect.

The following Named Plaintiffs are exemplary for the purposes of class certification of the proposed ADA Mental Health Subclass and if so certified, would be members of the ADA mental health subclass themselves:

**A. Robert Dillard**

Plaintiff Robert Dillard is incarcerated at Bullock Correctional Facility. Ex. 45 (Dillard Decl.) at ¶ 1. He has been diagnosed with schizophrenia, a serious mental illness. Plaintiff Dillard understands he is ineligible for an "honor camp" due to the dosage of his medication. R. Dillard Dep. 9:5-11.

**B. Leviticus Pruitt**

Plaintiff Leviticus Pruitt is incarcerated at Holman Correctional Facility. Ex. 68 (Pruitt Decl.) at ¶ 3. Plaintiff Pruitt has a serious mental illness due to his diagnosis of Depression. *Id*. at ¶ 6. While housed in segregation at Holman, Plaintiff Pruitt was unable to attend chapel. Additionally, he could not complete GED program because he was sent to segregation.

**C. Jamie Wallace**

Plaintiff Jamie Wallace has been incarcerated at Donaldson Correctional Facility and is presently incarcerated at Bullock Correctional Facility. Ex. 81 (Wallace Decl.) at ¶¶3-4. Plaintiff Wallace has been diagnosed with serious

mental illness and an intellectual disability. *Id*. at ¶ 7. While incarcerated, he has received several disciplinary citations for cutting himself. Plaintiff Wallace never had a job while he was at Donaldson due to being in lockdown (on the mental health unit). Plaintiff Wallace gets to spend time out in the yard only "once in a blue moon."

## I. THE ADOC HAS FAILED TO FULFILL ITS OBLIGATIONS UNDER THE ACTS[49]

Over an almost twenty-five (25) year period, the ADOC has not met its obligations under the Acts with respect to prisoners with mental health disabilities incarcerated in its facilities. The ADOC's inattention to its federal statutory obligations towards prisoners with mental illnesses, intellectual disabilities, traumatic brain injuries, learning disabilities, and other mental health disabilities pervades the department through every level of its administrative and facility staff, as well as its third-party service providers. As set forth below, the ADOC lacks basic operational standards to ensure its compliance with the provisions of the Acts with respect to prisoners with mental health disabilities.

### A. The ADOC Has No Disability Related Accommodations Request or Grievance System.

[49] Pursuant to the terms of the Phase I Settlement Agreement which is still pending final approval from the Court, the ADOC has agreed to implement processes through which it will identify and track prisoners with disabilities, prisoners can request accommodations for their disabilities and submit disability related grievances, and personnel working in ADOC prisons will receive ADA training, among other provisions. (Doc. 518) However, under the explicit language of the Settlement Agreement, prisoners with mental health disabilities are excluded from these protections unless specifically referenced in the Settlement Agreement.

The implementing regulations for the ADA require the establishment of grievance procedures providing for prompt and equitable resolution of complaints alleging any violations of the ADA. 28 C.F.R. §35.107(b). Commissioner Dunn does not know whether ADOC has an ADA grievance procedure in place. *See* Doc. 434-11 (Dunn Dep.) at 275:9-12. Associate Commissioner Ruth Naglich is not aware of an ADOC ADA grievance procedure at any of its facilities. *See* Doc. 426-3(Naglich Dep.) at 314:20-23.

Medical personnel working in the ADOC's prisons, who are familiar with the medical grievance process and who are the primary actors in determining whether a prisoner will get an accommodation, do not know of an ADOC ADA grievance procedure. *See e.g.* Doc. 427-2 (Baker Dep.) at 176:6 – 177:12; Doc 427-5 (Guice Dep.) at 118:21 – 119:3; and Doc. 435-4 (Patterson Dep.) at 109:16-110:23.

A functioning ADA grievance process would allow a prisoner like Plaintiff Pruitt to grieve his lack of access to chapel services or GED courses in segregation where he was placed due to his mental health. Such a process also would allow a prisoner like Plaintiff Dillard to grieve his inability to access the "honor camp" due to the dosage of his medication which he receives in the course of his mental health treatment.

**2. The ADOC Has No Functional ADA Coordinators.**

Pursuant to 28 C.F.R. §35.107(a), ADOC is required to designate a responsible employee to coordinate its efforts to comply with and attend to its responsibilities under the ADA. In its responses to Plaintiffs' interrogatories regarding whether ADOC had designated such responsible employees, ADOC identified several individuals it asserted were facility "ADA Coordinators." *See* Doc. 423-4 (ADOC Resp. to Pls. Interrogs.) at 15. However, none of these individuals actually performed work as ADA Coordinators nor had they received any ADA training from the ADOC.

For example, Aaron Billups was designated as the ADA Coordinator for Elmore Correctional Facility. However, for the last five years, Aaron Billups has worked as the maintenance supervisor at Elmore Correctional Facility. *See* Doc. 435-5 (Billups Dep.) at 15:1-10.. Mr. Billups does not believe he has any job responsibility with respect to inmates with disabilities housed at Elmore Correctional Facility. *Id.* at 15:16-17:6. One week prior to his deposition, Mr. Billups met with a lawyer for the ADOC and was informed that he was the ADA Coordinator for the Elmore Correctional Facility. *Id.* at 17:7-19. Accordingly, Mr. Billups admits that he knows nothing about the ADA, how the ADA relates to the ADOC, and that his only knowledge of the ADA was from television commercials he may have seen that show people "with disabilities, wheelchairs, things of that nature, crutches." *Id.*at 17:20-19:1.

Billups does not know the responsibilities of an ADA coordinator and had never heard of an ADA Coordinator at Elmore Correctional Facility prior to his deposition. *Id.* at 22:17-24:1. He further admits he has never had any ADA training. *Id.* at 26:1-4. He also is unaware of how many inmates at Elmore Correctional Facility have qualified disabilities under the ADA, and he does not know who is responsible for identifying inmates with disabilities at Elmore. *Id.* at 27:2-13.

Other ADA Coordinators identified by ADOC were similarly deficient. Ernest Claybon is the ADA Coordinator at Staton Correctional Facility. Mr. Claybon is unaware as to whether his facility has an ADA transition plan and does not even know what an ADA transition plan is. *See* 435-6 (Claybon Dep.) at 56:19 – 57:18. Mr. Claybon stated that, as ADA Coordinator, he has no responsibility to ensure that the prison's programs are accessible to prisoners with disabilities. *Id.* at 84:12-16.

Similarly, Joel Gilbert has been employed at Donaldson Correctional Facility for eighteen (18) years and learned via an email that he had been designated as the ADA Coordinator for the facility. *See* Doc. 435-7 (J. Gilbert Dep.) at 18:12-19, 39:10-12. He has received no training on how to identify prisoners with disabilities or how to effectively communicate with prisoners with disabilities. *Id.* at 54:8-17. Gilbert has not been informed of his job duties as ADA

Coordinator at Donaldson Correctional Facility. *Id.* at 56:13-57:11. He is not aware of any ADOC policies that relate to inmates with disabilities. *Id.* at 61:17-62:11.

Likewise, Adrienne Givens was identified as the ADA Coordinator at Tutwiler Prison for Women. In spite of her title, Ms. Givens has never received any ADA training. *See* Doc. 435-8 (Givens Dep.) at 37:3-22. She does not know her job responsibilities as ADA Coordinator. *Id.* at 39:13-15. Ms. Givens agreed that her only job responsibility as ADA Coordinator to date was to attend a deposition as ADA Coordinator. *Id*. at 115:4-16.

Furthermore, Kenneth Peters was named the ADA Coordinator for St. Clair Correctional Facility. *See* Doc. 435-9 (Peters Dep.) at 10:16-22. Mr. Peters does not recall receiving any ADA training in the twenty-five (25) years he has been employed with the ADOC, nor is he aware of any ADOC policies and procedures regarding the ADA. *Id*. at 13:5-14:20, 17:2-21.

Tellingly, no one working in ADOC's administration or its prisons could identify any of these purported ADA Coordinators or whether such positions even existed. For example, Commissioner Dunn does not know whether the ADOC has a statewide ADA coordinator. Doc. 434-11 (Dunn Dep.) at 273:12-22. Commissioner Dunn also does not know whether there are ADA coordinators at any ADOC facilities and has no knowledge of what an ADA coordinator is. *Id*. at

273:23-274:8. Associate Commissioner Naglich has been told there are ADA coordinators at ADOC facilities, but does not know whether every facility has one or who serves as an ADA coordinator. Doc. 426-3 (Naglich Dep.) at 300:12-16, 301:9-12, 301:16-19.

Medical personnel did not know of any ADA Coordinators working in ADOC prisons. *See e.g.* Doc. 426-10 (Darbouze Dep.) at 132:11 – 133:7; Doc. 427-3 (Duffell Dep.) at 221:5–11, 264:6–13; Doc. 427-4 (Ergle Dep.) at 240:6–21; Doc. 426-8 (Gams Dep.) at 44:5 – 44:17; Doc 427-5 (Guice Dep. at 119 :15-20; Doc. 427-6 (C. Johnson Dep.at 214:9 – 215:3; Doc. 435-3 (Lovelace Dep.) at 233:19-234:11; Doc. 427-1 (Odom Dep.) at 100:2-9; Doc. 435-4 (Patterson Dep. at 112:3-13. Presumably, if the ADA Coordinators actually had responsibilities, the medical staff at each facility would know who the designated ADA Coordinator is.

The ADOC's failure to designate functioning ADA Coordinators in its facilities negatively affects prisoners with mental health disabilities and disregards applicable law. A trained, properly functioning ADA Coordinator could, for example, assist Plaintiff Pruitt with finding appropriate housing that both accommodates his mental health disability and provides him with access to programming.

### 3. Personnel Working in ADOC Prisons Have Not Received Meaningful Training on the ADA

ADOC is responsible for ensuring that its employees receive appropriate training. Nevertheless, Commissioner Dunn has no knowledge of whether ADOC employees receive any training on the ADA. *See* Doc. 434-11 (Dunn Dep.) at 269:5-8, 270:4-13) Associate Commissioner Naglich has not received any ADA training from the ADOC in her time as Associate Commissioner. *See* Doc. 426-3 (Naglich Dep.) at 306:9-12. ADOC facility Wardens are similarly uncertain about whether they have ever received ADA training. Warden Holcomb does not recall whether any of his annual training provided by ADOC included information on the ADA. *See* Doc. 434-12 (Holcomb Dep. at 14:3-6. Employed by the ADOC since 1983, Warden Estes does not recall receiving any training on the ADA or on accommodating prisoners with disabilities at any time. *See* Doc. 435-1 (Estes Dep.) at 15:1-14, 17:18-18:15.

Medical personnel working in ADOC facilities also have never received or cannot recall receiving any training on the ADA from Corizon or the ADOC. *See e.g.* Doc. 427-3 (Baker Dep.) at 170:22 – 173:18 and 175:13 – 176:5; Doc. 426-10 (Darbouze Dep.) at 131:9 – 132:10; Doc. 427-3 (Duffell Dep.) at 62:20 – 63:8; Doc. 427-4 (Ergle Dep.) at 216:18 – 218:3; Doc. 426-8 (Gams Dep.) at 10:13 – 11:4; Doc. 427-6 (C. Johnson Dep.) at 207:1 – 207:13; Doc. 435-3(Lovelace

Dep.) at 173:13-23; Doc. 427-1 (Odom Dep.) at 100:10–20; Doc. 435-4(Patterson Dep.) at 105:19 – 107:3 and Doc. 426-9 (Pavlakovic Dep.) at 154:6–18.

ADA training would teach ADOC employees effective ways to communicate with prisoners disabilities like Plaintiff Johnson. All prisoners with mental health disabilities in the custody of ADOC would benefit from ADOC furnishing training to its staff on the ADA.

**4. The ADOC Does Not Have an ADA Transition Plan or ADA Policies and Procedures.**

Commissioner Dunn has no knowledge of whether the ADOC has an ADA transition plan. *See* Doc. 434-11 (Dunn Dep.) at 270:17-19. Wardens at ADOC facilities are also uninformed about whether ADOC or their own facilities have a transition plan, except for the few who are aware that their facilities do not have one. *See* Doc. 426-4 (K. Jones Dep.) at 21:20-23 and 22:1-5; Doc. 434-12 (Holcomb Dep.) at 24:11-23, 25:1-6; Doc. 435-1 (Estes Dep.) at 23:5-21; Doc. 426-7 (Barrett Dep.) at 28:15-21, 28:22-23, and 29:1-23.

Commissioner Dunn does not know whether ADOC has policies and procedures relating to accommodations for prisoners with disabilities who desire to participate in programs offered at ADOC. *See* Doc. 434-11(Dunn Dep.) at 291:9-292:10. Other ADOC administrators are also uninformed in this regard. Warden Jones, the Warden for Bullock Correctional Facility, has no knowledge of ADOC policies regarding accommodations for prisoners with disabilities. *See* Doc. 426-4

(K. Jones Dep.) at17:6-22. Likewise, medical personnel working onsite at ADOC facilities do not know specifically whether the ADOC or Corizon have any policies or procedures relating to inmates with disabilities. *See e.g.* Doc. 427-3 (Baker Dep.) at 173:19 – 176:5; Doc. 426-8 (Gams Dep.) at 24:4–19, and Doc. 426-9 (Pavlakovic Dep.) at 164:12 – 165:20. Mental health personnel employed at the ADOC's prisons also do not know whether the ADOC or MHM have any policies or procedures regarding prisoners with disabilities.

Instead of these deficiencies the ADOC should have a written transition plan as well as policies and procedures that comply with the ADA and address accommodating prisoners with mental health disabilities.

**5. The ADOC Has Created Discriminatory Eligibility Criteria for Programming and Services.**

By failing to act in the numerous ways described herein, ADOC creates discriminatory eligibility criteria. If the ADOC does not know which prisoners in its custody have mental health disabilities and the personnel working in ADOC prisons have not been trained on the ADA, then the ADOC necessarily engages in discrimination because it has no basis from which to evaluate the extent and the needs of its population of prisoners with mental health disabilities. Furthermore, the overall lack of ADA policies and procedures unfairly discriminates against

prisoners with mental health disabilities in ADOC custody, because effectively there are no criteria of any kind to apply to eligibility determinations.

## III. Argument.

### A. Legal Standard.

Plaintiffs seek certification of a class of "all prisoners in the custody of ADOC who are now, or who in the future will be, subjected to Defendants' medical, mental health, and dental care policies and practices." As the United States Supreme Court explained in *Estelle v. Gamble*, 429 U.S. 97, 103 (1976), the deprivation of medical care, to which Plaintiffs and class members allege they have been subjected, amounts to cruel and unusual punishment prohibited by the Eighth Amendment to the United States Constitution.

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce "torture or a lingering death," the evils of most immediate concern to the drafters of the Amendment. In less serious cases, the denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose . . . . We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain" proscribed by the Eighth Amendment. This is true

whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care, or intentionally interfering with the treatment once prescribed. *Estelle*, 429 U.S. at _____ (citations omitted). *See also Brown v. Plata*, ____ U.S. ____, 131 S. Ct 1910, 1928 (2011)("Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care.").

There can be no doubt that it is proper to certify a class seeking injunctive relief pursuant to Rule 23(b)(2) where pervasive, systemwide deficiencies threaten an entire class of prisoners. The Supreme Court in *Brown v. Plata* approved a grant of relief to a state-wide class of tens of thousands of prisoners in multiple facilities. As did the plaintiff class in *Brown*, plaintiffs here "rely on systemwide deficiencies in the provision of medical and mental healthcare that, taken as a whole, subject sick and mentally ill prisoners [] to 'substantial risk of serious harm' and cause the delivery of care to fall below the evolving standards of decency that mark the progress of a maturing society.'" *Id*. at 1926 n. 3 (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)).

Consistent with the principles enunciated in *Brown*, plaintiffs seek declaratory and injunctive relief, for themselves and on behalf of all prisoners who reside or who will reside in Alabama prisons, to prevent the continuation of inadequate care rendered by ADOC on a systemic basis. When prisoners seek

injunctive relief from unconstitutional conditions of confinement, they need not prove that the challenged conditions have resulted in actual injury (although plaintiffs and many class members here have suffered, and are continuing to suffer, actual injury); it is the unreasonable risk of harm to which they are subjected that entitles them to prospective relief under the Eighth Amendment. *Farmer*, 511 U.S. at 837 (holding that prison officials violate the Eighth Amendment when they have actual knowledge of a substantial risk of serious harm to prisoners and fail to act reasonably to address that risk).

The Ninth Circuit recently affirmed certification of a class virtually identical to the one sought here. In *Parsons v. Ryan*, 754 F.3d 657 (9th Cir. 2015), the Circuit Court approved certification of a class of "all prisoners who are now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the [Arizona Department of Corrections]." Similar classes of prisoners have been certified by courts in other jurisdictions. *See, e.g.*, *Henderson v. Thomas*, 289 F.R.D. 506 (M.D. Ala. 2012)(certifying class of HIV-positive prisoners regarding discrimination in prison conditions); *Decoteau v. Raemisch*, No. 13-cv-3399-WJM-KMT, 2014 WL 3373670 (D. Colo. July 10, 2014) (class of prisoners in administrative segregation); *Redmond v. Bigelow*, No. 2:13CV393DAK, 2014 WL 2765469 (D. Utah June 18, 2014) (class of prisoners); *Ashker v. Governor of California*, No. C 09-5796 CW, 2014 WL 2465191 (N.D.

Cal. June 2, 2014) (class of prisoners confined in isolation); *Lyon v. United States Immigration and Customs Enforcement*, No. C-13-5878 EMC, 2014 WL 1493846 (N.D. Cal. Apr. 16, 2014) (class of immigration detainees at several facilities); *Hughes v. Judd*, No. 8:12-cv-568-T-23MAP, 2013 WL 1821077 (M.D. Fla. Mar. 27, 2013) (class of juveniles in custody); *Chief Goes Out v. Missoula Cnty.*, No. CV 12-155-M-DWM, 2013 WL 139938 (D. Mont. Jan. 10, 2013) (class of juveniles, both pre-trial and convicted, confined in jail); *Indiana Protection & Advocacy Servs. Comm'n v. Comm'r, Indiana Dep't of Corr.*, No. 1:08-cv-01317-TWP-MJD, 2012 WL 6738517 (S.D. Ind. Dec. 31, 2012) (class of mentally ill prisoners confined in segregation at multiple prisons); *Rosas v. Baca*, No. CV-12-00428 DDP (SHx), 2012 WL 2061694 (C.D. Cal. June 7, 2012) (class of jail detainees challenging practice and custom of use of excessive force); *Rasho v. Walker*, No. 07-1298-MMM (C.D. Ill. Aug. 14, 2015)(certifying a class of mentally ill prisoners); *Dockery v. Epps*, No. 3:13cv326-TSL-JCG (Sept. 29, 2015)(certifying a general medical class and three subclasses of prisoners subject to defendants' healthcare policies).

Plaintiffs' evidence, as summarized above, clearly establishes that plaintiffs, and many other prisoners, have already suffered grievous harm due to defendants' provision of inadequate care and/or complete failure to provide clearly needed care. Defendants' pattern and practice of deficient care subjects plaintiffs,

and all others who are or will be incarcerated in Alabama prisons, to an ongoing substantial risk of serious harm in violation of established Eighth Amendment standards.

### B. The requirements of Fed. R. Civ. P. 23(a) and (b) are satisfied.

Plaintiffs' evidence also satisfies the requirements of Rules 23(a) and (b), Fed. R. Civ. P., for certification of a class. The proposed class of thousands of ADOC prisoners is more than sufficiently numerous to render joinder impracticable. The ADOC healthcare system is controlled through Defendants' centralized policies, procedures and practices applicable to all facilities, which place every prisoner at substantial risk of serious harm. Plaintiffs' claims are therefore common to, and typical of, those of the class. Plaintiffs and their counsel satisfy the requirement of adequacy of representation. The proposed class representatives seek relief that will benefit the entire class, and their counsel are experienced in civil rights and class action litigation. Defendants' maintenance for many years of a profoundly broken system demonstrates that they have "acted or refused to act on grounds that apply generally to the class, such that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole."

Rule 23(a) provides:

> One or more members of a class may sue . . . as representative parties on behalf of all members only if:
>
> (1) the class is so numerous that joinder of all members is impracticable;
>
> (2) there are questions of law or fact common to the class;
>
> (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
>
> (4) the representative parties will fairly and adequately protect the interests of the class.

Plaintiffs proposed class satisfies each of these requirements.

**1. <u>Numerosity</u>.**

A class may be certified only if it is "so numerous that a joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). Although there is no fixed number required to demonstrate numerosity, "generally less than twenty-one is inadequate, more than forty adequate, with numbers in between varying according to other factors." *Cox v. Am. Cast Iron Pipe Co.*, 784 F.2d 1546, 1553 (11th Cir. 1986).

As of April 2016, ADOC houses 24,120 prisoners in its 28 facilities. On any given day, thousands of those prisoners suffer from one or multiple serious healthcare needs. [insert specifics here]

Those who do not suffer from such a need on any particular day are virtually certain to do so on some other day while in ADOC custody.[50] They remain at substantial risk of serious harm as long as they remain in custody and at the peril of ADOC's inadequate system of care. All prisoners either require dental care or are likely to require dental care in the future.

As of February 2016, there were 3,416 prisoners on the mental health caseload. While that is more than a sufficient number to satisfy the requirement of numerosity, it significantly understates the number of prisoners who are actually in need of mental health care because Defendants' policies and practices result in frequent failures to identify prisoners' mental illnesses.

In addition to the sheer number of prisoners, other factors weigh in favor of finding numerosity, "including the fluidity of prison populations and [individual] prisoners' lack of access to counsel." *Kilgo v. Bowman Transp., Inc.*, 789 F.2d 859, 878 (11th Cir. 19876)(affirming certified class of 31 present members and future members who could not be identified); *Riker v. Gibbons*, No. 3:08-cv-00115 LRH-RAM, 2009 WL 910971 at *2 (D. Nev. March 31, 2009). *See also Clarke v. Lane*, 267 F.R.D. 180, 195 (E.D. Pa. 2010)(numerosity requirement satisfied by class of residents of facility holding up to 300 prisoners at a time); *Lambertz-Brinkman v. Reisch*, No. CIV-07-3040, 2008 WL 4774895, at *1 (D.S.D.

[50] As the Supreme Court observed in *Brown v. Plata*, "prisoners with no present physical or mental illness may become afflicted, [and p]risoners in the general population will become sick, . . . with routine frequency." *Id.* at _____.

Oct. 31, 2008)("Because the class includes future inmates, . . . joinder of all members would be impracticable."); *Dean v. Coughlin*, 107 F.R.D. 331, 332-33 (S.D.N.Y. 1985)("The fluid composition of a prison population is well-suited for class status, because, although the identity of the individuals involved may change, the nature of the wrong and the basic parameters of the group affected remain constant.").

**2. Commonality.**

To establish commonality pursuant to Fed. R. Civ. P. 23(a)(2), plaintiffs must show that there are "questions of law or fact common to the class." In *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct 2541, 2551 (2011), the Supreme Court explained that the commonality prong of Rule 23(a) requires plaintiffs to show that class members' claims "depend upon a common contention" that is "capable of classwide resolution." *See also Cooper v. Southern Co.*, 390 F.3d 695, 714 (11th Cir. 2004); *Fla. Businessmen for Free Enter. v. Florida*, 499 F. Supp. 346, 350 n.3 (N.D. Fla. 1980)("There is one question of law, and it is common to all members of the class."). What is required for class certification is "the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation." *Wal-Mart*, 131 S. Ct at 2551. What Rule 23(a)(2) does not require is that every member of the class have an identical claim. Some degree of factual variation will not defeat commonality where common questions yielding

common answers can be identified. *Cooper*, 390 F.3d at 714. *See also* 7a Charles A. Wright, et al., Fed. Prac. & Proc. Sec. 1763, at 226 (3d ed. 2005)("[C]lass suits for injunctive or declaratory relief by their very nature often present common questions satisfying Rule 23(a)(2).").

Common solutions to the systemic deficiencies that underlie the provision of constitutionally inadequate care in ADOC prisons, across facilities and without regard to the details of any particular ailment, are precisely what plaintiffs seek. Plaintiffs assert constitutional challenges to defendants' policies and practices that deprive all proposed class members of access to adequate healthcare and put all class members at risk. The basic questions in this case do not vary among class members, even though the particulars of their individual healthcare needs may differ. Common questions of law include (1) whether systemic and pervasive deficiencies in care have placed ADOC prisoners at unreasonable risk of suffering new or worsening mental or physical injury or illness, and/or the prospect of premature death, and (2) whether defendant's policies, practices and procedures reflect deliberate indifference to the serious healthcare needs of ADOC prisoners, resulting in violation of their right to be free from cruel and unusual punishment.

Allegations of common policies or procedures that treat the class at large unlawfully, such as are alleged here, easily satisfy the commonality requirement. *Cox*, 390 F.2d at 1557-58. Common questions of fact include (1)

whether ADOC fails to provide appropriate oversight and monitoring for healthcare providers; (2) whether ADOC's contracts permit improper costs considerations to interfere with treatment; (3) whether adequate staff (both in number and qualification) are maintained for the provision of healthcare; and (4) ultimately, whether ADOC systematically provides inadequate care and treatment to its prisoners.

Defendants' contract with systemwide providers for medical and dental care (Corizon), and for mental health care (MHM). Those contracts permit, and indeed cause, cost considerations to improperly interfere with treatment. Because they require the contractors to provide care at an unreasonably low cost, and to bear the risk of loss if healthcare costs are higher than predicted, Defendants' contracting policies create a clear incentive for the contractors to provide less care, or lower quality care, in order to maximize profits. Defendants' also fail to adequately oversee and monitor the performance of its contractors, or to meaningfully address deficiencies in the delivery of care. These failures are common themes running through the systemic deficiencies detailed above.

Many other common questions of fact exist across any variation in the specifics of an individual illness. Question of fact common to the entire class include:

- Whether inadequate numbers of custody staff render care inadequate by creating barriers to accessing health care
- Whether defendants provide inadequate training for custody staff, resulting in inadequate responses to health care crises
- Whether Defendants' sick call and pill call processes render care inadequate by creating barriers to accessing treatment for medical and dental problems
- Whether Defendants' intake screening processes render care inadequate by failing to properly identify medical and dental health care needs
- Whether Defendants' policies and practices result in delays in or failures to make or respond to referrals, creating a likelihood that acuity increases before treatment is provided
- Whether Defendant's policies and practices with respect to overuse and custody understaffing of segregation increase risk of delay in response to medical emergencies in segregation
- Whether Defendants' chronic care policies and practices result in inadequate treatment of serious chronic medical conditions
- Whether Defendants' policies and practices regarding sending prisoners to off-site medical providers, hospitals or emergency rooms create a substantial risk of serious harm to prisoners

Questions of fact common to all members of the Mental Health Subclass include:

- Whether Defendants' deficient classification system for mental health ensures inmates don't receive adequate treatment
- Whether Defendants' policies and practices result in delays in or failures to make or respond to mental health referrals, creating a likelihood that acuity increases before treatment is provided
- Whether Defendants' policies and practices result in overreliance on medication as the sole treatment for mental health conditions that require additional treatment
- Whether Defendants' policies and practices result in overreliance on outdated mental health medications, creating increased risk of harm through side effects or lack of efficacy
- Whether Defendants' policies and practices result in inadequate monitoring of medications and testing for side effects, creating increased risk of harm
- Whether Defendants' policies and practices result in inadequate counseling services (both time and frequency) for prisoners with mental illness, causing them to deteriorate without adequate care
- Whether Defendants' policies and practices result in inadequate group treatment and structured activities for prisoners with mental illness, causing

them to deteriorate and increasing risk that they are unable to function in any less restrictive environment

- Whether Defendant's policies and practices with respect to overuse of segregation increase risk for mental health crises
- Whether Defendants' policies and practices in providing inadequate monitoring of prisoners in segregation increase the risk of mental health crisis or self harm
- Whether Defendants' policies and practices with respect to the use of mental health crisis cells as overflow for segregation (or general lack of crisis cells) increase the risk of harm to prisoners in mental health crisis by preventing them from receiving necessary care
- Whether Defendants' policies and practices result in under-identification of prisoners in mental health crisis, increasing the risk of self-harm and suicide
- Whether Defendants' policies and practices result in inadequate observation of prisoners in mental health crisis, increasing risk of self-harm and suicide
- Whether Defendants' policies and practices result in inadequate follow up of prisoners after a mental health crisis has subsided, creating increased risk of relapse or self-harm
- Whether Defendants maintain crisis cells that are unsafe, creating increased risk of self harm

- Whether underutilization and unavailability of stabilization services in the stabilization units leads to increased risk that mental health crisis have long-term or permanent effects
- Whether Defendants' failure to track and remedy medication errors creates increased risk of harm

Rebuking the contention that claims of inadequate systemwide prison care failed to meet the commonality standard under *Wal-Mart*, the Ninth Circuit Court of Appeals in *Parsons* explained that:

> what all members of the putative class . . . have in common is their alleged exposure, as a result of specified statewide ADC policies and practices that govern the overall conditions of health care services and confinement, to a substantial risk of serious future harm to which the defendants are allegedly deliberately indifferent. As the district court recognized, although a presently existing risk may ultimately result in different future harm for different inmates - ranging from no harm at all to death - every inmate suffers exactly the same constitutional injury when he is exposed to a single statewide ADC policy or practice that creates a substantial risk of serious harm.

*Parsons*, 754 F.3d at 678-79. The reasoning of *Parsons* was later expressly adopted by the district court in *Scott v. Clarke*, 61 F.Supp. 569 (W.D. Va. 2014), in certifying a class of female inmates challenging inadequate medical care, and other district courts have similarly recognized that *Wal-Mart*'s holding concerning commonality does not bar certification of class actions in cases where prisoners allege a pattern and practice of conduct resulting in unconstitutional conditions of

confinement. *E.g.*, *Jones v. Gusman*, 296 F.R.D. 416, 465-67 (E.D. La. 2013)(action by residents of Orleans Parish Prison challenging unlawful conditions with respect to security, healthcare, environmental conditions, fire safety, and language translation services); *Hughes v. Judd*, 2013 WL 1821077, at *19-25 (M.D. Fla. Mar. 27, 2013)(action by parents and guardians of juvenile detainees over deliberate indifference to violence and unlawful policies regarding use of pepper spray); *Butler v. Suffolk Cnty*, 289 F.R.D. 80, 96-101 (E.D.N.Y. 2013)(action challenging systemic adverse environmental conditions resulting from County's policies and practices and deliberate indifference to health).

**3. Typicality.**

Fed. R. Civ. P. 23(a)(3) mandates that the claims of the named plaintiffs must be "typical of the claims or defenses of the class." To establish typicality, the named plaintiffs must show that there is a "nexus between the class representative's claims or defenses and the common questions of fact or law which unite the class." *Kornberg v. Carnival Cruise Lines, Inc.*, 741 F.2d 1332, 1337 (11th Cir. 1984). "A sufficient nexus is established if the claims or defenses of the class and the class representative arise from the same event or pattern or practice and are based on the same legal theory." *Id.*

The claims of the named plaintiffs are typical of those of the class as a whole, in that those claims arise from the same set of policies, practices and

procedures. The named plaintiffs and the proposed class also seek the same injunctive relief - namely, reform of the systemic deficiencies in the provision of medical, mental health and dental care provided in ADOC. Classwide resolution of these claims "will resolve an issue that is central to the validity of each one of the [plaintiffs' ] claims in one stroke. *Wal-Mart*, 131 S. Ct at 2551. That the injuries plaintiffs have suffered as a consequence of various of those deficiencies are not identical injuries does not weigh against a finding of typicality. *See Parsons*, 754 F.3d at 685-86 ("It does not matter that the named plaintiffs may have in the past suffered varying injuries or that they may currently have different healthcare needs; Rule 23(a)(3) requires only that their claims be 'typical' of the class, not that they be identically positioned to each other or to every class member."). Like the plaintiffs in *Scott v. Clarke*, plaintiffs here "have alleged a broad variety of medical problems . . . that are generally representative of the adverse health issues experienced by the entire prison population" of ADOC. *Id.* at 589. Similarly, the plaintiffs seeking to represent the Dental Subclass have alleged a variety of harms that are generally representative of the harms caused by the dental policies and practices experienced throughout ADOC. The plaintiffs seeking to represent the Mental Health Subclass and Mental Health ADA Subclass have alleged similar problems to those experienced by all mentally prisoners in the ADOC. Because the risk of injury arises from the same systemwide policies and

practices, and the relief sought with respect to those policies and practices would benefit the entire class, plaintiffs' claims are typical of those of the class.

**3. Adequacy.**

*a. The representative parties have no conflicts with the class as a whole.*

A class may be certified only where the representative parties "will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). In determining whether named plaintiffs have the ability to appropriately represent the class members, courts consider both whether the named plaintiffs have a sufficient interest to ensure vigorous representation, and whether the interests of the named plaintiffs are in any way antagonistic to those of the class as a whole. *E.g., Valley Drug Co. v. Geneva Pharm, Inc.*, 350 F.3d 1181, 1189 (11th Cir. 2003). Named plaintiffs here are mostly individuals who are currently incarcerated in ADOC facilities, so they have a genuine and urgent desire for a successful outcome in this action.[51] Their interests are directly aligned with those of other ADOC prisoners who are or will eventually become subject to the same system of care. The requested relief - that defendants implement a constitutionally adequate system of care - will benefit all members of the class. No named plaintiff will receive any form of relief not afforded to all class members.

[51] A small number of named plaintiffs have been released from custody since the filing of the lawsuit, but remain very interested in remedying the conditions under which they suffered harm on behalf of their fellow prisoners whom they left behind. The relief they seek is the same as that sought by named plaintiffs who remain in custody.

*b. Proposed class counsel are qualified, experienced, and able to conduct the proposed class action litigation.*

Class counsel are qualified and prepared to adequately prosecute this action on behalf of the class. *See Kirkpatrick v. J.C. Bradford & Co.*, 827 F.2d 718, 726 (11th Cir. 1987) ("The inquiry into whether named plaintiffs will represent the potential class with sufficient vigor to satisfy the adequacy requirement of Rule 23(a)(4) most often has been described to involve questions of whether plaintiffs' counsel are qualified, experienced, and generally able to conduct the proposed litigation . . . .") (quotations, citations, and alterations omitted). The attorneys representing the Named Plaintiffs are experienced in handling class actions and civil rights litigation, and have expertise in issues relating to the rights of prisoners. Class counsel are employed by two nationally recognized and highly regarded organization - Southern Poverty Law Center and Alabama Disabilities Advocacy Program - and a respected law firm - Baker Donelson, that possess the experience and resources to litigate this matter. See Docs. 428-5, 428-6, 428-7.

**4. <u>Rule 23(b)(2) is satisfied</u>.**

In addition to meeting the numerosity, commonality, typicality and adequacy requirements of Rule 23(a), plaintiffs seeking class certification must also show that the case properly falls within one of the requirements of Rule 23(b). This case fits comfortably within the provisions of Rule 23(b)(2), which authorizes

certification where "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." "Two basic requirements must be met" to satisfy Rule 23(b)(2): "(1) the class members must have been harmed in essentially the same way by the defendant's acts; and (2) the common injury may properly be addressed by class-wide injunctive or equitable remedies." *Williams v. Nat'l Sec. Ins. Co.*, 237 F.R.D. 685, 693-94 (M.D. Ala. 2006) (citing *Holmes v. Continental Can Co.*, 706 F.2d 1144, 1155 (11th Cir. 1983)). Both requirements are satisfied here.

Plaintiffs allege that defendants have placed the class and subclasses at an unreasonable risk of grave harm through their deliberate indifference to ADOC's inadequate medical, mental health and dental care policies, practices and procedures, and seek injunctive relief that addresses the systemic factors creating these risks. Class certification is appropriate here because "a single injunction or declaratory judgment would provide relief to each member of the class." *Wal-Mart*, 131 S. Ct at 2257. Plaintiffs seek no individual relief for themselves or for any individual class member. If plaintiffs prevail, the resulting injunction will apply to and benefit all members of the proposed class and subclass.

The term "generally applicable" does not require "that the party opposing the class . . . act directly against each member of the class." *Anderson v.*

*Garner*, 22 F. Supp. 2d 1379, 1386 (N.D. Ga. 1997) (quotation and citation omitted). Rather, the key is whether the defendants' actions "would affect all persons similarly situated so that [their] acts apply generally to the whole class." Certification pursuant to Rule 23(b)(2) is particularly appropriate where, as here, the class action is brought to vindicate civil or constitutional rights, [CITATIONS] such as cases challenging prison or jail conditions. [CITATIONS]

Defendants have acted or refused to act on grounds generally applicable to the class through many of their policies and procedures, including:

- Contracting for the provision of care in a manner that creates incentive for the providers to delay or deny care, or to provide lesser care, in order to cut cost and maximize profits;
- Delaying or denying needed medical care based on cost considerations;
- Failing and refusing to refer prisoners to outside providers when necessary care cannot appropriately be provided internally;
- Failing and refusing to provide adequate numbers of medical staff to provide necessary care for all of the prisoners who require care;
- Failing and refusing to provide medical staff who are qualified to perform the duties to which they are assigned, resulting in the provision of inadequate care;
- Failing and refusing to require appropriate supervision of medical staff;

- Failing and refusing to adequately oversee and monitor the provision of care by their contracted vendors;
- Failing and refusing to adequately address deficiencies in the care provided by their contracted vendors;
- Failing and refusing to employ sufficient custody staffing to facilitate the provision of necessary medical care;
- Failing and refusing to maintain an adequate intake process, resulting in failure to properly identify and diagnose illnesses;
- Failing and refusing to maintain a sick call process that facilitates the timely and effective treatment of illnesses;
- Failing and refusing to maintain an adequate system of medication administration, resulting in prisoners not receiving needed medications, having medications delayed, or receiving the wrong medications; and
- Failing and refusing to provide adequate physical facilities for the provision of care.

Defendants have acted or refused to act on grounds generally applicable to the Dental Subclass through many of their policies and procedures, including:

- Contracting for the provision of care in a manner that creates incentive for the dental providers to delay or deny care, or to provide lesser care, in order to cut cost and maximize profits;

- Delaying or denying needed dental care based on cost considerations;
- Failing and refusing to refer prisoners to outside dental providers when necessary care cannot appropriately be provided internally;
- Failing and refusing to provide adequate numbers of dental staff to provide necessary care for all of the prisoners who require dental care;
- Failing and refusing to require appropriate supervision of dental staff;
- Failing and refusing to adequately oversee and monitor the provision of dental care by their contracted vendors;
- Failing and refusing to employ sufficient custody staffing to facilitate the provision of necessary dental care;
- Failing and refusing to maintain an adequate intake process, resulting in failure to properly identify and diagnose illnesses;
- Failing and refusing to maintain a sick call process that facilitates the timely and effective treatment of dental conditions;
- Failing and refusing to maintain an adequate system of taking radiographs resulting in inadequate and dangerous dental care; and
- Failing and refusing to provide adequate equipment for the provision of dental care.

Defendants have acted or refused to act on grounds generally applicable to the Mental Health Subclass through many of their policies and procedures, including:

- Contracting for the provision of care in a manner that creates incentive for the providers to delay or deny mental health care, or to provide lesser care, in order to cut cost and maximize profits;
- Delaying or denying needed mental health care based on cost considerations;
- Failing and refusing to refer prisoners to psychiatric hospital when necessary care cannot appropriately be provided internally;
- Failing and refusing to provide adequate numbers of mental health staff to provide necessary care for all of the prisoners who require care;
- Failing and refusing to provide mental health staff who are qualified to perform the duties to which they are assigned, resulting in the provision of inadequate mental health care;
- Failing and refusing to require appropriate supervision of mental health staff;
- Failing and refusing to adequately oversee and monitor the provision of care by their contracted mental health vendor;
- Failing and refusing to adequately address deficiencies in the care provided by their contracted mental health vendor;

- Failing and refusing to employ sufficient custody staffing to facilitate the provision of necessary mental health care;
- Failing and refusing to maintain an adequate intake process for mental health, resulting in failure to properly identify and diagnose illnesses;
- Failing and refusing to maintain a referral process that facilitates the timely and effective treatment of mental health needs;
- Failing and refusing to maintain an adequate system of medication administration, resulting in prisoners not receiving needed mental health medications, having mental health medications delayed, or receiving the wrong mental health medications; and
- Failing and refusing to provide adequate physical facilities for the provision of mental health care.

Defendants have acted or refused to act on grounds generally applicable to the Mental Health ADA Subclass through many of their policies and procedures, including:

- Failing and refusing to establish an ADA accommodation or grievance process to address the ADA needs of persons with mental health disabilities;
- Failing and refusing to provide ADA coordinators to address the ADA needs of persons with mental health disabilities;
- Failing and refusing to provide ADA training to ADOC personnel;

- Failing and refusing to create an ADA transition plan or ADA policies and procedures;

- Creating eligibility criteria for programs, services and benefits that discriminate against prisoners with mental health disabilities.

## IV. Conclusion.

For the foregoing reasons, plaintiffs satisfy all the requirements of Rule 23(a) and (b)(2). Accordingly, plaintiffs respectfully request that this Court certify this case as a class action under Rule 23(b) and that plaintiffs not be required to give notice to absent class members.

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Respectfully Submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that I have on this 19th day of August, 2016, electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which will send a notice of electronic filing to the following:

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