UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

JOSEPH LEWIS, JR., KENTRELL PARKER, FARRELL SAMPIER, REGINALD GEORGE, JOHN TONUBBEE, OTTO BARRERA, CLYDE CARTER, CEDRIC EVANS, EDWARD GIOVANNI, RICKY D. DAVIS, LIONEL TOLBERT, and RUFUS WHITE, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

BURL CAIN, Warden of the Louisiana State Penitentiary, in his official capacity; STEPHANIE LAMARTINIERE, Assistant Warden for Health Services, in her official capacity; JAMES M. LEBLANC, Secretary of the Louisiana Department of Public Safety and Corrections, in his official capacity; and THE LOUISIANA DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS,

Defendants.

CIVIL ACTION NO. 3:15-cv-00318

CHIEF JUDGE: Hon. Shelly D. Dick

MAGISTRATE JUDGE: Richard L. Bourgeois, Jr.

PLAINTIFFS' FINDINGS OF FACT AND CONCLUSIONS OF LAW

TABLE OF CONTENTS

FINDINGS OF FACT

BACKGROUND

I. CLASS MEMBERS

1. Louisiana State Penitentiary at Angola ("Angola" or "LSP") is a maximum-security men's prison in Angola, Louisiana that houses approximately 6400 inmates.[1] While the number of individuals incarcerated at Angola fluctuates, it housed between approximately 6200 and 6400 people throughout the discovery period.[2]

2. In the Court's February 26, 2018 Ruling, the Court certified a class consisting of "all inmates who [are] now, or will be in the future, incarcerated at LSP," and a subclass of "all qualified individuals with a disability, as defined by the [Americans with Disabilities Act ("ADA") and Rehabilitation Act ("RA")], who are now, or will be in the future, incarcerated at LSP."[3]

II. DEFENDANTS

3. Defendant Louisiana Department of Public Safety and Corrections ("DOC") is a division of the State of Louisiana charged with overseeing the custody and care of individuals in state prisons, including Angola.[4]

4. Defendant Darrel Vannoy is the current Warden of Angola and has served in that position since approximately January 1, 2016. From February 1, 1995 to December 31, 2015, Burl Cain served as Warden. The Warden is responsible for, among other things, assigning people to manage the medical care and then being sure that they do what the policies and procedures say.[5]

5. Defendant Randy Lavespere is the current Medical Director of Angola and has served in that position since approximately May 2014. This position is responsible for managing, among other things, Angola's doctors, nurses, patients, relationship with headquarters, and

---

[1] Undisputed Facts ("UF") ¶ 1, First Amended Joint Pretrial Order ("JPTO"), Rec. Doc. 242-2.
[2] PX 6 at 0017; DX 14 at 5.
[3] Rec. Doc. 394 at 30.
[4] UF ¶ 2.
[5] UF ¶ 3; *see also* JX 4, B. Cain Depo. at 6:13-25; JX 4, D. Vannoy Depo. at 16:19-20:6. Per the Court's Order, Defendants filed the Joint Exhibits with Bates numbering on behalf of both parties on October 2, 2018. As of 2:00 pm on the day of the filing of Plaintiffs' Findings of Fact and Conclusions of Law, Defendants have not produced the Bates stamped versions of the Joint Exhibits to Plaintiffs, despite Plaintiffs' repeated requests. As a result, Plaintiffs were not able to reference the Bates numbers for the Joint Exhibits cited to herein, but can supply these numbers to the Court in a supplement whenever requested.

relationships with administration. Prior Medical Directors of Angola have included Jason Collins and Raman Singh.[6]

6. Defendant John Morrison is the current statewide Chief Medical and Mental Health Director ("Statewide Medical Director") of the DOC and has held that position since approximately April 2018. He was preceded by Raman Singh, who held the position from November 2007 to November 2017. The Statewide Medical Director's job is to "run healthcare operations ... find out the challenges and to go and find the solutions."[7]

7. Defendant James LeBlanc is the Secretary of the DOC. He supervises the Statewide Medical Director and is "responsible for whatever goes on in this department."[8]

8. Defendant Tracy Falgout is the Assistant Warden for Health Services at Angola and has served in that position since approximately November 2016. He was preceded by Stephanie Lamartiniere, who held the position from June 2013 until approximately November 2016. Prior to Ms. Lamartiniere's tenure, Kenneth Norris held the position. The Assistant Warden has "operational control over the medical unit at LSP. This includes, among other responsibilities, budgeting, hiring, medical records, and any kind of staffing issues."[9]

9. Defendant Stacye Falgout is the Chief Nursing Officer for the DOC and has held that position since approximately October 2011. Until sometime in 2017, she reported directly to the Statewide Medical Director (then Dr. Singh) and served as the "No. 2 in the headquarters realm." Prior to becoming Chief Nursing Officer, she served as Assistant Director of Nurses at Angola.[10]

10. Defendant Sherwood Poret has been the Director of Nursing at Angola since January 2013 and was the Infection control supervisor before that. He supervises all nurses working at Angola.[11]

III. OVERVIEW OF MEDICAL CARE PROVIDED BY DEFENDANTS

11. Class members are housed in the following locations:[12]

---

[6] UF ¶¶ 4-7; *see also* JX 4, R. Lavespere Ind. Depo. at 10:9-15; JX 4, J. Collins Depo. at 10:17-11:7; JX 4, R. Singh Depo. at R. Singh Depo. at 8-15:20.
[7] UF ¶ 4; *see also* JX 4, R. Singh Ind. Depo. at 9:5-18; 24:15-22; 37:15-17.
[8] JX 4, J. Leblanc Depo. at 23:9-24:5.
[9] UF ¶ 6; JX 4, S. Lamartiniere Depo. at 9:4-20; Anticipated Trial Testimony of Stephanie Lamartiniere.
[10] JX 4, S. Falgout Depo. at 7:12-22, 9:4-5; Anticipated Trial Testimony of Stacye Falgout; *see also* UF ¶ 8.
[11] UF ¶ 9; *see also* JX 4, Poret Depo. at 4:17-19.
[12] PX 6 at 0011, 17-18.

a. The main prison, which houses Class members in cell blocks as well as dormitories and has approximately 3216 beds.

b. Inside of main prison, three "medical dormitories," named Ash 2, Cypress 2, and Hickory 4, which generally house persons with significant disabilities or major ongoing medical needs.

c. Two infirmaries, named Nursing Unit 1 and Nursing Unit 2. Nursing Unit 1 is an infirmary for acute care patients. Nursing Unit 2 is an infirmary for patients requiring long-term nursing care and hospice patients. They house approximately 44 beds between the two.[13]

d. Four remote "outcamps," named Camps C, D, F, and J. The outcamps house approximately 3401 individuals.

e. Death row and closed cell restriction, which houses approximately 116 individuals.

12. DOC is responsible for providing or arranging medical care for all Class members. Due to their incarcerated status, Class members have no ability to obtain medical care other than that which DOC provides or arranges.

13. DOC provides medical care through DOC personnel, as well as by contracting with third-party medical professionals to provide specialty services on-site at Angola, via telemedicine, and off-site at Louisiana hospitals.[14]

14. The principal places that DOC delivers on-site medical care are:[15]

a. The R.E. Barrow Treatment Center ("REBTC" or "TC"), which contains seven clinical examination rooms; a procedure center in which telemedicine and certain procedures or specialty visits occur; the Acute Treatment Unit ("ATU"); the two infirmaries; administrative offices; the laboratory; the pharmacy; and the medical records office.

b. Individual cells and dormitories, including the medical dormitories, where, as discussed below, Emergency Medical Services ("EMS") personnel perform sick call.

c. Pill call stations in each outcamp and cell block, where medication is distributed and administered, as discussed below. Pill call also occurs in the medical dormitories.

15. Medical staff at Angola includes the following personnel. Staffing numbers are current as of the Plaintiffs' medical experts' site visit, unless otherwise noted:

[13] PX 6 at 0080.
[14] *See* UF ¶ 10.
[15] PX 6 at 0011, 28-30; UF ¶¶ 11-14.

a. Medical providers:[16] Angola's table of organization allows Angola to have four physicians and one nurse practitioner, in addition to Dr. Lavespere, the Medical Director.[17] The exact number of providers fluctuated slightly during the discovery period due to the death of one physician and the resignation of another, but typically was comprised of Dr. Lavespere, four other physicians, and one nurse practitioner.[18]

b. Nurses: Angola has 53 permanent nursing positions and four temporary positions. This comprises 20 registered nurses ("RNs"), 34 licensed practical nurses ("LPNs"), two certified nurse assistants ("CNAs"), and one respiratory therapist.[19]

c. Emergency Medical Services ("EMS") personnel: Angola employs approximately 35 emergency medical technicians ("EMTs"). EMS personnel generally have three levels of training and licensure: basic EMTs; advanced EMTs; and paramedics.[20] EMTs at Angola are designated as security staff and report administratively to the Assistant Warden, although they are nominally under the clinical supervision of the Medical Director.[21]

d. Correctional officers: Defendants use correctional officers (i.e., prison guards) to administer medication in most housing units, including the so-called medical dormitories.[22]

16. As relevant to this case, Class members most commonly access medical care through the following methods:

a. "Routine sick call": Class members write their complaint on a Health Services Request form ("HSR," also called a "sick call form"). EMS personnel visit each housing unit, beginning around 4:30 a.m., to collect HSRs. EMS personnel typically review HSRs during sick call, examine patients at their cell or dormitory, or in a hallway outside their dormitory, and may prescribe treatment at that time. EMS personnel write observations on the sick call form and decide whether a patient should be transported at that time, and they then put the sick call form in a box for

[16] The term "providers" encompasses both physicians and nurse practitioners. For all purposes relevant to this case, nurse practitioners are qualified and licensed to provide the same types of care as physicians.
[17] JX 1.
[18] PX 6 at 0017; UF ¶ 10; JX 1 at 0002.
[19] PX 6 at 0018-19; JX 1 at 0002.
[20] Except where the Proposed Findings of Fact and Conclusions of Law specifically distinguish between EMS levels, Plaintiffs will use "EMT" to refer to all three levels together.
[21] PX 6 at 0015; DX 14 at 0007; JX 1 at 0002.
[22] PX 6 at 0015; JX 4, D. Cashio 30(b)(6) Depo. at 73:18-74:18.

the provider responsible for the relevant housing unit. Class members are typically charged $3.00 for routine sick call.[23]

b. "Self-declared emergency" ("SDE" or "emergency sick call"): Class members can inform a correctional officer or EMT that they believe they have an emergency medical need, or, if they reside in the prison and are both permitted and able to travel to the ATU, can present themselves for emergency treatment at the ATU. Class members declaring an SDE are initially, and often only, examined and treated by an EMT. Class members are often charged $6.00 for an SDE.[24] Class members risk discipline if EMTs do not believe that their complaints are actually emergent.[25]

c. Chronic disease clinics: Class members with diagnosed chronic illnesses are seen by providers in chronic disease clinics with varying frequency.[26]

d. Specialist care: Angola providers can refer Class members to specialists. Specialist appointments occur in three ways:

    1) DOC has contracted with some specialists to hold occasional clinics at Angola.

    2) Some specialty appointments occur via telemedicine, in which a doctor in another location has a videoconference with a Class member, who may, or may not, be accompanied by an LPN.

    3) Some specialist appointments occur off-site. All referrals for off-site care, including all major surgical procedures, are scheduled through DOC headquarters in Baton Rouge, using a computer database called Eceptionist. All referrals in Eceptionist are approved by the Statewide Medical Director, who reviews referrals to determine whether the provider has adequately substantiated that the referral is "medically necessary." DOC does not maintain any official definition of "medically necessary."[27]

e. Infirmary care: When there is space available in the infirmary units, providers can assign patients to one of those units. In theory, the infirmary allows for heightened observation, nursing care, and provider evaluation. In practice, the actual care delivered at the infirmaries is wholly inadequate.[28]

---

[23] PX 6 at 0031-32; DX 0014 at 12; JX 4, D. Cashio Depo. at 29:15-30:22, 44:20-45:8, 54:8-55:8, 60:4-6 (describing sick call process); JX 5-a at 0023.
[24] PX 6 at 0033; JX 5-a at 0005.
[25] JX 4, A. Cowan Depo. at 43:21-25.
[26] PX 6 at 0042-47.
[27] PX 6 at 0071-79; JX 4, R. Singh Depo. at 151:3-25.
[28] PX 6 at 0079-84.

17. While Defendants use the ATU to provide emergency care, it lacks several diagnostic and treatment capabilities necessary in an emergency room. Accordingly, for actual emergency care, Defendants must transport patients to an outside hospital.[29]

18. Angola is approximately 150 miles from University Medical Center in New Orleans ("UMC" or "UMC-NO"), 60 miles from Our Lady of the Lake Hospital in Baton Rouge ("OLOL"), 50 miles from Lane Regional Medical Center in Zachary ("Lane"), and 25 miles from West Feliciana Parish Hospital in St. Francisville ("West Feliciana"). Prior to the opening of UMC, Defendants sent patients to Interim LSU Hospital ("ILH") in New Orleans. Defendants use UMC as their hospital of choice.[30]

IV. THE PARTIES' EXPERTS

A. Plaintiffs' Experts

19. Plaintiffs submitted testimony and joint expert reports from three medical experts:

a. Dr. Michael Puisis: Dr. Puisis is a board-certified internist who has worked as a physician, health care administrator, or consultant in correctional environments for over 30 years. He served as Assistant Medical Director, Medical Director, and Chief Operating Officer for Cook County Jail, one of the largest jails in the country. He served as Regional Medical Director for the state of New Mexico prison system, working through a contract medical vendor called Correctional Medical Services. He was the Medical Director of correctional facilities for a private company called Addus Health Care. He edited both editions of *Clinical Practice in Correctional Medicine*, the only textbook of correctional medicine, and has authored numerous other publications related to correctional and internal medicine. He has participated in the development or revision of numerous standards related to correctional medical care, including the American Diabetes Association's standards of care for diabetics in correctional facilities and the medical standards of the National Commission on Correctional Health Care ("NCCHC") and the American Public Health Association ("APHA"). He has been an expert, consultant, or monitor in numerous cases and for a wide range of parties, most notably serving as a Court-appointed expert in *Plata v. Davis*, which concerned the medical care provided throughout the California correctional system; as an expert for the Department of Justice; as a consultant to the Department of Homeland Security in reviewing its own facilities; and as a post-trial medical monitor in several correctional facilities.[31]

b. Dr. Susi Vassallo: Dr. Vassallo is a board-certified emergency room physician and medicine toxicologist. She actively practices as an attending physician in the emergency rooms of three hospitals. She is Clinical Professor of Emergency

[29] PX 6 at 0065.
[30] PX 6 at 0072; DX 14 at 10.
[31] JPTO at 9-10.

Medicine at the New York University School of Medicine, and previously taught emergency medicine at the University of Texas – Austin. She is certified as a correctional health professional by NCCHC. She has authored numerous publications related to correctional and emergency medicine. She has evaluated correctional health care systems in nine states, including Louisiana, Mississippi, Texas, Florida, New York, California, Arizona, Nevada, and Wisconsin. She has also been retained by the Department of Homeland Security to review medical care delivery at its detention facilities. Her opinions have been repeatedly relied upon by the Fifth Circuit.[32]

c. Nurse Practitioner Madeleine LaMarre: Ms. LaMarre is a nurse practitioner who has more than 30 years of experience working as a nurse practitioner, administrator, and consultant in correctional facilities. She worked in the Georgia Department of Corrections for more than two decades, serving as a nurse practitioner, Nursing Director, and Statewide Clinical Services Manager. She is the associate editor of *Clinical Practice in Correctional Medicine* and the author or coauthor of numerous other publications related to correctional medicine and nursing. She was a consultant to the Centers for Disease Control and Prevention ("CDC") regarding HIV testing implementation and the management of Hepatitis C in correctional settings. She has also served as an expert or monitor in numerous cases regarding correctional medicine, including serving as a Court-appointed expert in *Plata* and serving as a monitor at the Dallas, Cook County, and Passaic County Jails.[33]

20. Plaintiffs' medical experts conducted a four-day in-person site visit (two days in the case of Dr. Vassallo), during which they evaluated all relevant parts of Angola's facilities, interviewed numerous Angola staff members and patients, and observed Defendants' medical care in practice. They also reviewed the medical records of 42 patients, selected to represent a sample of patients who had died and/or had chronic medical conditions that required recurring medical care. Across these 42 patients, they reviewed thousands of encounters between Class members and Defendants' medical personnel. They also reviewed the medical records of several of the Named Plaintiffs, in response to Defendants' experts' reports.[34]

21. Plaintiffs' medical experts produced a 90-page principal report, accompanied by 183 pages of chart reviews, and two rebuttal reports, totaling 38 pages. All three experts testified at the trial, and Dr. Puisis testified at the class certification hearing as well.[35] Plaintiffs also submitted testimony and a report from Mark Mazz regarding the accessibility of Angola's facilities to individuals with disabilities. Mr. Mazz is a registered architect and architectural accessibility consultant with over 30 years of experience in accessible design, including three years in the Department of Justice's Disability Rights Section. Mr. Mazz's practice includes

[32] JPTO at 10; *Yates v. Collier*, 868 F.3d 354, 363-65 (5th Cir. 2017); *Ball v. LeBlanc*, 792 F.3d 584, 593 (5th Cir. 2015); *Gates v. Cook*, 376 F.3d 323, 339 (5th Cir. 2004).
[33] JPTO at 9.
[34] PX 6 at 0010-11.
[35] PX 6; PX 28; PX 244.

evaluating compliance with the program access requirements of Title II of the ADA and Section 504 of the Rehabilitation Act by identifying architectural barriers to access. His work includes reviews of correctional facilities in approximately ten states, as well as other Section 504 and Title II barriers assessment and transition plans.[36]

22. Mr. Mazz conducted a survey of various areas of the prison that are used by individuals with disabilities to access Angola's services, programs, and activities.[37] He identified programmatic access barriers by noting instances in which the architectural features in these areas deviate from the 1991 ADA Standards for Accessible Design.[38] He produced a 73-page report in which he identifies 190 architectural barriers impeding independent access to a range of programs, services, and activities, including housing, toilets, showers, phones, JPay stations, common areas, drinking fountains, recreation areas, transportation, the law library, visiting areas, medication administration, meals, medical services, and mail services.[39] Mr. Mazz also testified at trial.

B. Defendants' Experts

23. Defendants submitted testimony from two medical experts:

a. Dr. David Thomas: Dr. Thomas is an ophthalmologist who is currently a Professor at Nova Southeastern University.[40]

b. Dr. Jacqueline Moore: Dr. Moore holds a Ph.D in nursing and is semi-retired.[41]

24. Dr. Thomas conducted a one-day site visit to Angola during which, among other things, he reviewed an unknown set of medical records and allegedly spoke with 100 Class members. He also reviewed the Named Plaintiffs' medical records and the medical records of the patients in Plaintiffs' experts' sample. He testified at the class certification hearing and trial and produced a 74-page report. The Court previously excluded portions of his testimony under Federal Rule of Evidence 702.[42]

25. Dr. Moore conducted a three-day site visit and reviewed approximately one year of medical records for each of seven chronic care patients, five sick call encounters, and five sets of screening documents. She testified at trial and produced a 31-page report.[43]

26. Defendants also submitted testimony and a report from Brian Nolan, a licensed architect. Mr. Nolan reviewed Mr. Mazz's findings, including the photographs of each violation that

[36] PX 7 at 0007, 0012.
[37] *Id.* at 0009.
[38] *Id.* at 0008.
[39] *Id.* at 0018-39.
[40] JPTO at 11.
[41] *Id.* at 11-12.
[42] DX 14; Rec. Docs. 322, 343.
[43] DX 13; Rec. Doc. 321.

were attached to his report.[44] He testified at trial and produced a report in which he substantiated the violations identified by Mr. Mazz.[45]

EIGHTH AMENDMENT CLAIM

I. DEFENDANTS' POLICIES AND PRACTICES SUBJECT THE CLASS TO A SUBSTANTIAL RISK OF SERIOUS HARM

27. The evidence overwhelmingly establishes that Defendants' policies and practices subject the Class to a systemic and substantial risk of serious harm.

28. The medical care that Defendants provide is grossly deficient, falling below clinical standards of care and routinely denying Class members access to a timely professional medical judgment and timely receipt of the care that the medical professional orders.

29. Every Class member who has or develops a serious medical need faces an egregious and unacceptably high risk of receiving inadequate diagnosis or treatment, being denied meaningful diagnosis or treatment altogether. The evidence presented at trial shows that there is also a likelihood of affirmative medical mistreatment. This risk is present across all types of medical needs, from longstanding chronic diseases to newly developed illnesses to immediate emergencies. These failures to provide constitutional care have resulted in preventable death and needless suffering for countless Class members in the past, and will continue to do so into the future absent fundamental changes to Defendants' system of providing medical care.

30. Defendants' inadequate care and the risks to which it exposes Class members are the direct result of numerous deficiencies in Defendants' policies, practices, and procedures. Defendants' system is inadequate at all levels. Defendants do not provide sufficient provider and nursing staffing, and inappropriately use EMS personnel[46], correctional officers, and even Class members to make up for that understaffing. Defendants limit Class members' access to necessary specialists and emergency services, and systematically fail to ensure that personnel at Angola implement outside providers' recommendations. Defendants employ numerous practices that impede Class members' access to care, prevent identification and mitigation of problems, and even affirmatively harm patients. Each of these policies and practices directly contributes to the life-threatening risks that Class members face at all times.

---

[44] PX 18 at 0001.
[45] *Id.* at 0002.
[46] EMS has three levels: a basic EMT has between 3-6 months of training on top of high school or GED; an Advanced EMT has an additional 3-6 months; and a paramedic has an additional 14-18 months of training. JX4, D. Cashio Depo. 13:25-24:7.

A. Defendants' Medical System Creates a Substantial Risk of Delayed Diagnosis, Delayed Treatment or Mistreatment, Needless Pain and Suffering, and Preventable Death

31. Through compelling expert, documentary, and first-hand testimony, Plaintiffs have shown that Defendants' deficient medical system places Class members at a substantial risk of delayed diagnosis, non-treatment or mistreatment of serious medical needs, needless pain and suffering, and preventable death.

32. The "most basic and essential elements of adequate health care access" is "timely access to a qualified medical professional who is qualified to diagnose and treat their serious medical needs," "access to a professional judgment," and "timely diagnosis and treatment, including being sent to an outside hospital.[47] Defendants routinely deprive Class members of these fundamental necessities, with predictably tragic results.

(1) Findings of Plaintiffs' Medical Experts

33. Plaintiffs' medical experts reviewed medical records for 58 current and former Class members, 48 of whom were in their judgment sample and ten of whom were Named Plaintiffs. Each of the Class memebers had a chronic medical condition, passed away while at Angola, or required emergency medical treatment during Plaintiffs' medical experts' site visit.[48] The results were systematic and stark: they "identified preventable deaths and inadequate care in almost every medical chart [they] reviewed."[49] Of the 48 patients in the sample, they identify serious mistakes or omissions in the treatment of all but two patients. Many of these case studies exhibited prolonged, even years-long courses of under-treatment, non-treatment, and mistreatment.

34. As a whole, these case studies evinced "a similar pattern of inadequate medical evaluations and lack of timely monitoring and treatment."[50] Case after case follows a basic sequence: a patient reports symptoms that are indicative of chronic conditions or life-threatening emergencies, but is never properly examined by a medical provider or even a registered nurse. Instead, he is treated solely by Angola's EMTs, who provide superficial treatment for the patient's symptoms. When the patient sees a doctor, the doctor does not perform the basic steps necessary to diagnose the source of the patient's symptoms, including a focused physical examination, a relevant medical history, and medically indicated testing or referral. Diagnostic tests are delayed for months or years, and when they are performed they are not reviewed by a physician. Referrals to specialists are delayed, canceled by DOC headquarters,

---

[47] PX 6 at 0007-8.

[48] In addition to 41 Class members from the judgment sample, the experts' opening report also discussed four Named Plaintiffs using anonymized numbers (specifically, Patients # 23, 24, 25, and 27), bringing the total chart review in the opening report to 45. For purposes of their sample, these four are excluded.

[49] PX 6 at 0027.

[50] *Id.* at 0047.

or thwarted by Defendants' failure to provide necessary testing—and once a specialist appointment occurs, the specialist's recommendations are delayed or ignored, going unreviewed by the patient's primary provider at Angola as the patient's medical need progresses.

35. A similar pattern occurs in emergency situations. A patient presents with an emergent medical need, either a sudden onset — such as a broken rib—or the product of a long-standing, untreated illness. EMTs manage the patient's emergency with little if any participation by a medical provider, doing little if anything to diagnose the source of the emergency. Abnormal vital signs indicating life-threatening crises are recorded without any apparent recognition of their critical nature. Diagnostic testing is not timely performed or performed at all, or is performed and unreviewed by a provider, leading the emergency to escalate over the course of a day or a week. Transport to an outside hospital that would be able to properly diagnose and treat the condition is delayed by hours, days, or weeks, until the patient's condition is irreversible.

36. To be sure, not every patient examined by Plaintiffs' experts suffered from every misstep outlined above. But Plaintiffs demonstrated many or all of these critical errors and omissions in literally dozens of cases, at a rate high enough to prove that the problems are pervasive throughout the care that Defendants provide.

37. Most disturbingly, Plaintiffs found major medical errors in diagnosis and treatment leading up to nearly every death they examined. Their sample included 28 patients who passed away. In all but two cases, the deaths were preceded by serious medical negligence, including significant delays in diagnosis, failures to provide necessary medical treatment, and/or failures to timely transport for hospital care. Disturbingly, Plaintiffs' experts found major medical errors— many of which led to preventable deaths— in almost every chart they reviewed.

38. Plaintiffs' medical experts concluded that of the 28 people who died in the sample, 26 had significant medical errors leading up to their deaths.

39. While an exhaustive recitation of Plaintiffs' medical experts' case studies would be unduly lengthy and is unnecessary for the purposes of these Proposed Findings of Fact, a brief sample of synopses will convey the range and grotesque nature of Defendants' deficient care.

    a. Patient #20, a 37-year-old man with HIV/AIDS, was found in a fetal position complaining of severe and worsening abdominal pain. EMTs documented "grossly abnormal vital signs" and abdominal distention for several hours before notifying a physician. Eventually, Dr. Toce ordered medication and admission to the nursing unit without ever examining the patient. Because there was no room in the nursing unit, the EMTs continued to manage the patient in the ATU. Shortly thereafter, the patient became severely anemic, suggesting acute bleeding, but EMTs did not notify a physician and no physician ever signed the findings. As Plaintiffs' medical experts explained, "[a]t this point, EMTs should have recognized that the patient was

internally bleeding and at risk of death." Instead, they monitored his vital signs for the next six hours without performing a physical examination or evaluating his symptoms, which, according to Plaintiffs' medical experts, "is not clinically appropriate and falls below the standard of care." After admission to the nursing unit the following day, Patient #20 died of massive upper GI bleeding, a perforated large peptic ulcer, and bilateral bronchopneumonia. At some undocumented time that day (either before or after the patient's death), Dr. Toce wrote an admission assessment that overlooked the critical anemia finding.[51] Patients' medical experts conclude that "[t]he lack of prompt medical evaluation and treatment and failure to send the patient to the hospital when his vital signs were abnormal directly contributed to his death."[52]

b. Patient # 34 declared an emergency due to pain from a football injury he had received three days before. Although a physician ordered an X-ray to assess the injury, an entire week passed before the X-ray occurred. In the meantime, the patient declared yet another emergency and requested to be transferred to the ATU, but a physician denied that request. The patient's condition further deteriorated and, three days later, emergency medical personnel found him unable to leave his bed. The patient died the following day from fluid accumulation caused by his fractured ribs.[53]

c. Patient #31, who suffered from Hepatitis C, went to the ATU where he presented with abdominal pain and jaundice. Although the patient should have been evaluated for possible liver failure, he was discharged. On the following day, the patient complained to medical staff of vomiting and continued abdominal pain, but he was discharged once again. Two days later, the patient returned to the ATU complaining of worsening symptoms. Rather than hospitalizing the patient, medical staff requested that he sign a do-not-resuscitate order. He died the following day due to complications of liver disease.[54]

40. Stunningly, Defendants do not seriously dispute the findings from Plaintiffs' medical experts' sample. Of Defendants' experts, only Dr. Thomas responds to Plaintiffs' case studies at all—and he disputes just *three* of the 39 case studies in which Plaintiffs' medical experts identified serious medical error.[55] The other 36 findings of serious harm and medical error are simply unrebutted.

41. Even where Dr. Thomas does discuss Plaintiffs' experts' case studies, his comments underscore, rather than undermine, Plaintiffs' findings. He does not materially dispute any of Plaintiffs' medical experts' findings in any of them. Specifically:

[51] PX 6 at 0034-35, 46-47, 53, 56, 85, 216-27.
[52] *Id.* at 0035.
[53] *Id.* at 0063-0064, 0267-0268
[54] *Id.* at 0067, 0261-0264.
[55] DX 14 at 67-69.

a. Patient #15, a 40-year-old man who had severe, uncontrolled hypertension and passed away on January 25, 2014. According to Plaintiffs' medical experts, Defendants failed to provide adequate medical care for Patient #15's hypertension over a period of many years and in the months before his death. The day before his death, Patient #15 exhibited numerous signs and symptoms of acute coronary disease, including left-sided chest pain, rated 10 on a scale of 10, an EKG showing changes consistent with ischemia (inadequate blood supply to the heart), and an x-ray suggesting aneurysmal change. According to Plaintiffs' medical experts, this indicated immediate hospitalization. Instead, EMTs released Patient #15 to his housing unit. Less than three hours later, he presented with worsening symptoms, including hypoxia (oxygen deficiency) and tachycardia (abnormally rapid heart rate), but was not transported to a hospital until he became unresponsive some two and a half hours later. At that point, he was transported to Lane, where he was promptly diagnosed with a dissecting aortic aneurysm and airlifted to OLOL for emergency treatment. He died en route.[56]

b. Dr. Thomas does not dispute Plaintiffs' medical experts' finding that Defendants failed to provide adequate medical care for his hypertension for years. He also acknowledges that "[c]learly, in retrospect, this patient should have been sent to the hospital," but opines that "[t]his is at most a failure on the part of a single physician to recognize the seriousness of an internal abdominal hemorrhage from which the patient was suffering."[57] Far from controverting Plaintiffs' medical experts' findings in any material way, this corroborates their conclusion that Defendants' personnel erred in treating the patient.

c. Patient #16, a 45-year-old man who presented to the ATU with a self-declared emergency, complaining of pneumonia- and tuberculosis-like symptoms on December 14, 2013. EMTs recorded some of his vital signs and sent him back to his housing unit without notifying a physician. He returned on December 16, at which point his fever had worsened, his blood pressure had plummeted, and his pulse had spiked—"critical findings that indicate a life threatening condition," according to Plaintiffs' medical experts. Nonetheless, EMTs did not contact a physician, instead treating the patient themselves in accordance with an unidentified protocol, and released him back to his housing unit without even referring him to a physician. He did not see a physician at all until December 18, four days after his initial presentation. Even at that time, the physician merely reviewed an x-ray. The patient was sent to a hospital for emergency treatment six hours after arriving at the ATU on December 18, where he was diagnosed with pneumonia and acute renal failure, and subsequently passed away of respiratory failure.[58]

[56] PX 6 at 0046, 53, 69-71, 183-90.
[57] DX 14 at 67.
[58] PX 6 at 0035-37, 190-93; PX 28 at 23.

d. Plaintiffs' medical experts conclude that Patient #16 "did not receive timely and appropriate care when he first presented with fever and respiratory symptoms," and that "[t]he failure of a physician to timely medically evaluate the patient likely directly contributed to his death."[59] Dr. Thomas does not disagree with *any* of Plaintiffs' medical experts' findings, pointing out only that a physician provider was "involved in the care because of the chest x-ray."[60] He does not suggest that it was appropriate for a patient with Patient #16's symptoms to be treated solely by EMTs for four days, nor does he dispute that Patient #16 exhibited signs of "a life threatening condition" on December 16 that were ignored for another two days.

e. Patient #18, a 57-year-old man who requested an HIV test in August 2013 but didn't receive it for three months. By that time he was exhibiting abnormal vital signs, a six-month long cough, and 57-pound weight loss over the previous two years. The EMT who documented these signs and symptoms did not notify a physician, instead sending him back to his housing unit and referring him to the ATU the following day. Patient #18 tested positive for HIV twice, but no physician acknowledged these results for two weeks. During that time, he made several visits to the ATU, with no records of EMTs ever notifying doctors of his abnormal vital signs or of a physician clinically evaluating him. Dr. Lavespere saw Patient #18 almost two weeks after his positive tests, but he didn't examine him or note his new HIV diagnosis, instead simply sending him to the ATU. He was thereafter admitted to the infirmary. But even on the infirmary, where Defendants provide their highest level of care, medical providers did not perform virtually any physical examinations of the patient. Moreover, despite being severely immunosuppressed and exhibiting life-threatening vital signs, he was not started on antiretroviral therapy for another four days, and only inconsistently received medication. His fever rose to 101 on the infirmary, but nurses did not notify a physician and did not take his vital signs again until the following day. He was ultimately hospitalized, where he passed away.[61]

f. Plaintiffs' medical experts conclude that Defendants' failed to timely test, evaluate, and treat Patient #18—including their delays in providing an HIV test, addressing his two positive tests, providing antiretroviral therapy, and hospitalizing him. They further conclude that without these errors, "his death was likely preventable."[62] Here again, Dr. Thomas does not dispute any of Plaintiffs' medical experts' factual findings about the content, adequacy, or appropriateness of the patient's care. Instead, all he says is that Plaintiffs' experts "acknowledge no certainty when they use the term 'probably' to conclude that "his death would probably been preventable [sic]."[63] Of course, there is no requirement that Plaintiffs prove to a "certainty" that

[59] PX 6 at 0037.
[60] DX 14 at 67-68.
[61] PX 6 at 39-40, 53, 56, 83-84, 86, 200-208.
[62] *Id.* at 0039-40.
[63] While Dr. Thomas purports to be quoting from Plaintiffs' medical expert report, the purported quote does not actually appear. That said, Plaintiffs' medical expert's actual opinion—that "it is likely

> any particular death was caused by medical error; the point of the case studies is to show Defendants' recurrent delays and gross medical negligence.

42. In all three cases, Dr. Thomas's focus seems to be that a physician was involved in some way at some point during each patient's treatment, even if only by telephone and even if belatedly or without a recognition of the patient's needs. This does not in any way undermine Plaintiffs' compelling showing of deliberate indifference to Class members' serious medical needs. Plaintiffs have shown that physician involvement is inadequate in timeliness, frequency, and content.

43. In addition to being unrebutted in all material respects, Plaintiffs' medical experts' sample employs a standard, reliable methodology. As the experts explain, they "selected records of patients with chronic diseases and other serious medical conditions because these are the patients who use the health care system most regularly and are at risk of harm."[64] This methodology, sometimes referred to as a "judgment sample," has been recognized as reliable in numerous cases, including cases about correctional practices in particular.[65] These "non-randomized qualitative research methods are both 'accepted and mainstream in the scientific community,' and, in the view of some experts, 'more applicable to a proper evaluation of the delivery of health care at a prison.'"[66] As explained by an expert in a prior case:

> When sampling from people (patients, staff) and documents in qualitative research, random samples are to be avoided. Instead, the gold standard for sampling is "judgment sampling" or "purposeful sampling". Instead of using random number generators to select samples, a judgment sample is chosen based on the expertise and judgment of a subject matter expert with knowledge of the system or process being assessed. The goal is to obtain a sample which is as broad, rich, and representative of the diversity of operational conditions as possible. Such a process for collection of data usually requires appropriate expertise in the relevant disciple: "At the same time, the choice of which data to examine, or how best to model a particular process, could require subject matter expertise that a statistician lacks." Judgment samples are appropriate because ensuring that all potential observational units in a population and sampling time frame have equal probability of selection is often not the most desired or beneficial strategy. Rather, we look to the subject matter experts to guide which areas, times of day, or segments of the population are most important to study and understand.[67]

44. Moreover, Defendants themselves use, and have endorsed, the basic methodology underlying Plaintiffs' medical experts' sample. As Dr. Singh, then a defendant and the

---

his death would have been prevented," PX 6 at 0086—is similar in substance, even if Dr. Thomas's actual quotation is fictional.

[64] PX 6 at 0010.

[65] *See Braggs v. Dunn*, 317 F.R.D. 634, 645-46 (M.D. Ala. 2016) (collecting cases).

[66] *Id.* (quoting *Dockery v. Fisher*, 253 F. Supp. 3d 832, 844 (S.D. Miss. 2015)).

[67] *Dockery*, 253 F. Supp. 3d at 844.

Statewide Medical Director, explained when describing his approach to reviewing the quality of care at Angola:

> It's not random selection. … [I]t's about selecting the target population smartly. And this [is] not something we created … . The whole industry grapples with this question, how to make the random selection very efficient. But the target population cannot be the all population. You have to be wise in selecting your denominator, that is chronic patients with chronic diseases. … Because if we take good actions, good care is being delivered, then hopefully there will be less complications down the record. That's how you select[,] the chronic disease, not all offenders.[68]

45. This is exactly what Plaintiffs' medical experts did. They reviewed patients selected at random from within the population of patients with chronic diseases or who had passed away. This is, in Dr. Singh's words, "efficient" and "wise in selecting [the] denominator."

46. The sample is also more than robust enough to shed light on the care that Defendants provide at a systemic level. Plaintiffs' medical experts looked at hundreds or even thousands of pages of medical records for each patient in their sample. In some cases, the evidence they reviewed stretched back more than a decade. They reviewed thousands of encounters between patients and medical personnel—sick call examinations, chronic disease visits, diagnostic test results, emergency treatment, specialists' findings, and every other type of encounter that a patient has with medical care. They reviewed these thousands of encounters in context, chronicling patients' care from appointment to appointment and sick call to sick call. This allowed them to observe whether Defendants provided adequate care over multi-year periods or consistently made similar mistakes and omissions, as well as the impact that Defendants' care has on the course of patients' medical needs and conditions.

47. In summary, Plaintiffs' medical experts have compellingly and convincingly shown that Defendants provide grossly deficient care at a shockingly high rate. This inadequate medical care denied Class members timely access to a professional medical judgment from a qualified medical professional, denies them timely diagnosis and appropriate treatment of serious medical needs, and—most importantly—places them at a substantial risk of experiencing serious harm any time they have or develop a serious medical need.

(2) Corroborating Evidence of a Substantial Risk of Serious Harm

48. The findings of Plaintiffs' medical experts are corroborated by a significant amount of credible evidence. This includes the first-hand testimony of doctors who treat Class members and Class members themselves; the medical records of the Named Plaintiffs; and documentary evidence produced in discovery.

[68] JX 4, R. Singh Depo. at 228:24-231:16.

49. This evidence paints the same picture as Plaintiffs' medical experts' sample: a picture of pervasive and systemic medical neglect, causing serious harm to innumerable Class members and exposing all Class members to a substantial risk of serious harm.

50. Some of the most significant pieces of that evidence include:

a. Testimony from Treating Providers

51. The testimony of multiple doctors at UMC who have treated patients incarcerated at Angola. Dr. Jane Andrews, Dr. Monica Dhand, and Dr. Catherine Jones submitted sworn declarations in support of class certification and then testified at trial.[69] They credibly testified to the harm that this medical neglect and mismanagement has done to some of their patients, including rendering illnesses untreatable, causing significant unnecessary pain, and possibly shortening Class members' lives.

b. Named Plaintiffs' Medical Records

52. In addition to their sample, Plaintiffs' medical experts reviewed the medical records of numerous Named Plaintiffs to respond to the incomplete (and often inaccurate) summaries in Dr. Thomas's report.[70] These records show the exact same patterns of neglect, mistreatment, and harm as the sample. For example:

a. Shannon Hurd: From 2013 to 2015, Mr. Hurd made dozens of sick call requests for chest pain, lung symptoms such as shortness of breath, weight loss (more than 61 pounds, ultimately), left-sided pain, cough, numbness of his extremities, testicular swelling or rash, and coughing up blood. All of these symptoms are suggestive of renal cancer. Physicians never conducted a proper physical examination or took a relevant history, ignored urinalysis results showing trace blood consistent with renal cell carcinoma, and made numerous other errors preventing Mr. Hurd from receiving indicated testing and any diagnosis of the source of his symptoms. On many occasions, Mr. Hurd was seen only by medics, rather than physicians. On November 3, 2015, a blood test ordered seven months earlier showed potentially life-threatening anemia at a level typically prompting transfusion, but doctors did not address the finding for days and did not work up the anemia for weeks. Even after a chest x-ray on November 21, 2015, showed nodules in Mr. Hurd's lung and a positive fecal occult blood test—indicating severe anemia and active bleeding—an Angola physician did not review the x-ray for two days, then merely requested a CT scan and scheduled him for a two-week follow-up rather than providing treatment. The CT scan was not performed until December 16, 2015, and showed a large renal mass with multiple lung nodules consistent with metastases. Even after that critical diagnostic test, no physician saw Mr. Hurd for nearly a month. As Plaintiffs' experts summarize: "Mr. Hurd had many of these signs and symptoms [of renal cell

[69] Anticipated Testimony of Dr. Monica Dhand, Dr. Catherine Jones, and Dr. Jane Andrews.
[70] PX 28 at 0007-22; *compare* DX 14 at 23-50.

carcinoma] for an extended period before he was diagnosed. LSP physicians failed to review abnormal laboratory results, failed to identify longstanding weight loss, and failed to adequately evaluate the patient for years." This care was "was a significant departure from standard of care and demonstrates multiple systemic deficiencies that caused the patient harm. This patient could have had a much earlier diagnosis." As of the close of discovery, Mr. Hurd, just 41 years old, was in hospice care.[71]

b. Joe Lewis: Like Mr. Hurd, Mr. Lewis made years of sick call requests complaining of symptoms suggesting potential cancer, including a chronic cough, hoarseness, and loss of voice. Mr. Lewis's repeated sick call requests documented the same concerns and even informed medics that he had a history of cancer. In response, Mr. Lewis was typically treated symptomatically by medics; when he did see providers, they failed to properly document Mr. Lewis's medical history, conduct diagnostic testing, or follow up on past treatment. According to Plaintiffs' medical experts, these symptoms indicated "potentially serious medical conditions" that were "consistent with laryngeal cancer." In all, physicians' treatment of Mr. Lewis's concerns were "below standard of care."[72]

c. Ian Cazenave: Mr. Cazenave suffers from advanced sickle cell disease. Complications related to sickle cell disease may lead to heart disease, lung disease, retinal disease, and other illnesses. For two decades, Mr. Cazenave has suffered from leg ulcers, another common complication related to untreated sickle cell disease and an indicator of other concerns like anemia. In 2013, records indicated that Mr. Cazenave had an enlarged heart; despite this, physicians failed to provide adequate, competent care. Sickle cell disease is best managed in consultation with a hematologist, who specialized in treatment of blood diseases. Despite being imprisoned at Angola for 18 years, Mr. Cazenave did not meet with a hematologist until he was hospitalized in 2016. Plaintiffs' medical experts have noted that "[Mr. Cazenave] hadn't had a transfusion in 10 years and have never taken hydroxyurea both of which are . . . especially needed for persons with severe sickle disease and leg ulcers." Even after meeting with specialists, prison physicians failed to properly document and act upon the specialists' recommendations. This resulted in delays in wound care for Mr. Cazenave, despite numerous requests by physicians over a period of nearly six months.[73]

d. Lionel Parks: Defendants did not properly test Mr. Parks for peripheral artery disease ("PAD"), and failed to treat him with statin therapy. Mr. Parks had severe thrombocytopenia (i.e., abnormally low platelets) on multiple tests over two years without evaluation of this abnormality. On June 29, 2014, one week after an unaddressed thrombocytopenia finding, Mr. Parks had a stroke. But despite

[71] PX 28 at 0018-22; *see generally* JX 10-cc (Shannon Hurd medical records). Mr. Hurd passed away after the close of discovery. His preservation deposition is in the record before the Court, *see* JX 4.
[72] PX 28 at 0017; JX 10-gg (Joe Lewis sick call requests).
[73] PX 29 at 0008-10; *see generally* JX 10-k (Ian Cazenave medical records).

recording telltale signs of a stroke—including facial droop, weakness in his left arm, and slurred speech—and Mr. Parks' risk factors for stroke, EMTs sent Mr. Parks back to his housing unit without proper evaluation, diagnosis, and treatment. Physicians did not examine him for a day and a half, instead simply prescribing an IV and Benadryl by phone. It took three visits to the ATU over 42 hours before Defendants' medical personnel recognized Mr. Parks' stroke and sent him to a hospital. Plaintiffs' medical experts report that his "care was a significant departure from standard of care. Had Mr. Parks been properly and timely diagnosed and treated, his stroke may have been prevented; had he been timely sent to a hospital for stroke treatment, he might not have had severe deficits thereafter.[74]

c. Class Member Witnesses' Testimony

53. Defendants deposed numerous Class members in this case, many of whose depositions are in evidence through designations.[75] They recount similar experiences of delays, failures to diagnose, and an inability to get attention for serious issues. For example:

a. James Hacker: Mr. Hacker was repeatedly referred for cataract surgery by outside providers, with at least one doctor ordering immediate cataract removal. Providers at Angola delayed the surgery for years, rendering him legally blind. Angola forced him to work in the fields even after he was declared legally blind and injured himself.[76]

b. James Marsh: Mr. Marsh suffered bilateral knee injuries in 2005, days after Hurricane Katrina, including a torn right meniscus. As of the close of discovery more than a decade later, Defendants had not performed a knee replacement; he was not even sent for a surgical review for 10 years. At times, his anti-inflammatory medication for the resulting knee pain has been delayed for as long as a week. He also waited over a year for hernia surgery, and received it only after his daughter contacted the warden's office.[77]

c. Marvin Tarver: Mr. Tarver waited nearly two years for hernia surgery, as his hernia worsened to the point where he required a wheelchair. At one point, UMC providers were prepared to operate on the hernia, but Defendants refused to authorize the surgery. Mr. Tarver similarly waited years for rotator cuff surgery, cataract surgery, and a hearing aid—as long as 12 years for the hearing aid—as recommendations made by outside specialists were delayed or ignored. After receiving rotator cuff surgery, he never received physical therapy.[78]

---

[74] PX 28 at 0011-13; *see also* JX 10-qq (Lionel Parks ATU reports after his stroke); PX 12 at 0001-2 (warning Defendants of failure to timely send stroke victims to outside hospitals).
[75] JX 4a-u.
[76] JX 4-i, J. Hacker Depo. at 20:2-13, 26:7-13; 36:2-37:19; 58:4-58:10.
[77] JX 4-l, J. Marsh Depo. at 10:23-11:20, 14:7-15:1, 29:24-30:10, 40:7-41:19.
[78] JX 4-r, M. Tarver Depo. at 13:12-15, 16:2-30:25, 42:4-43:16, 44:25-46:21, 51:6-52:7, 54:16-65:6.

d. Derrick Woodberry: Outside specialists referred Mr. Woodberry for hemorrhoid surgery, but DOC providers told him it would not be provided due to budget cuts. He filed more than 20 sick call requests over four years for his hemorrhoid problems, but Defendants did not provide surgery until after he developed anal fissures.[79]

d. Contemporaneous Documentation of Deficiencies in Medical Care and Harm to Patients

54. These include:

a. In 2009, Defendants retained a private consulting company, Wexford Consulting Group ("Wexford") to review the care at Angola and two other facilities. Wexford found, among other things, that patients were "not being seen in a timely fashion" and that Angola, in particular, would need "intense intervention to bring it within standards."[80] Defendants widely shared the report, with Dr. Singh acknowledging its "salient points."[81]

b. In August 2014, the Stroke Program Coordinator at Interim LSU Hospital alerted Defendants that "in the last month and a half . . . I have had three inmates from Angola that presented with obvious stroke symptoms. All of them were out of the window because it either took them a while to get here or the medical staff at Angola did not think the inmate was having a stroke." One patient "had to go to the infirmary three days in a row until they believed that he was having a stroke." As the nurse explained, prompt emergent care for stroke victims was necessary to "prevent severe disability," and the failure to provide proper emergent care had given all three patients "pretty significant deficits."[82]

c. That same week, the Interim Chairman of Oral Maxillofacial Surgery at LSU warned Angola about the "number of inmates who present to us with 3 week old fractures that are already infected and thus use a lot of resources to fix something that could have been treated easily if diagnosed sooner."[83] Angola suggests "Train[ing] nurses to perform better exams and to refresh on some basic anatomy."[84]

[79] JX 4, D. Woodberry Depo. at 14:22-17:13.
[80] PX 265 at 0014; *see infra* ¶ 6.
[81] PX 29 (Dr. Singh forward "salient points" to Secretary LeBlanc); PX 24 (Dr. Singh forwarding Wexford report to Warden Cain); PX 30 (Ms. Falgout discussing Wexford report); PX 87.
[82] PX 12 at 0001-2.
[83] PX 13 at 0001-2.
[84] PX 274 at 0002.

d. Numerous documents showing that Defendants were not providing crucial diagnostic services and medical procedures such as colonoscopies, CT scans, MRIs, hernia surgery, cataract surgery, and cancer treatment.[85]

e. Testimony and Contemporaneous Admissions by Current and Former DOC Employees

55. Defendants and their current and former employees have repeatedly acknowledged that Class members receive delayed care and suffer harm. These include:

a. Former Assistant Warden for Healthcare Services Kenneth Norris, who testified that patients "did not get the timely treatment" because Defendants refused to authorize hernia surgery "until, you know, it becomes a life-threatening deal."[86]

b. Multiple Defendants acknowledged the substantial backlog of physician encounters.[87] This is verified by Defendants' expert Dr. Thomas, who acknowledged that more than one out of every three specialty consultations over the previous year had not been completed.[88]

c. Dr. Singh and Secretary LeBlanc, who informed the Louisiana Secretary of Health and Governor's Office that they were concerned about the "delay of critical care."[89]

f. Mortality Statistics

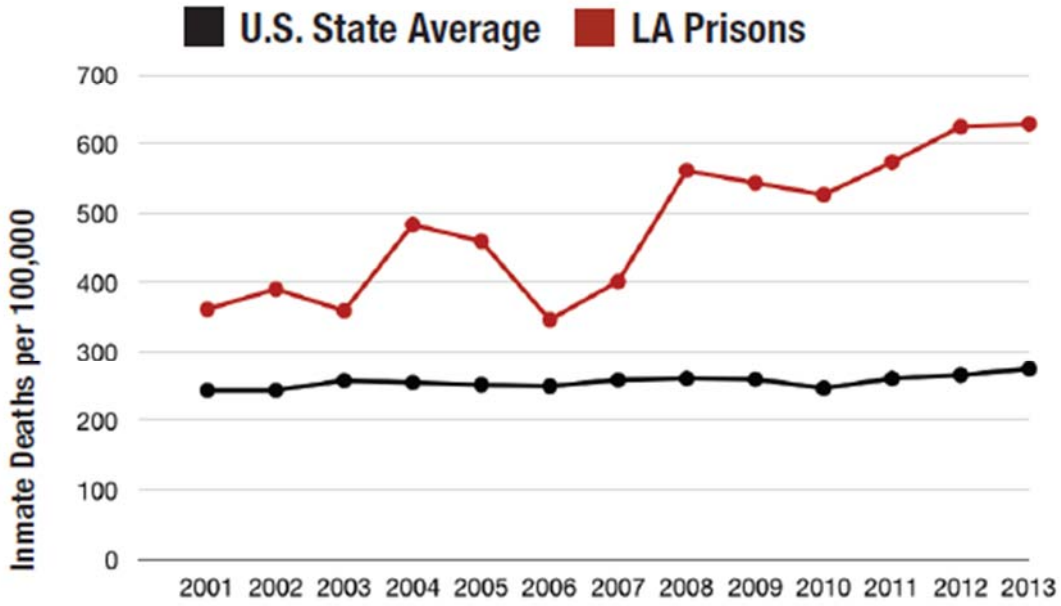
56. Finally, the substantial risk of serious harm to which Defendants expose Class members has manifested in a shockingly high mortality rate, as documented by the U.S. Department of Justice's Bureau of Justice Statistics in its Mortality in Local Jails and State Prisons report ("BJS Report").[90] This data, drawn from statistics self-reported by the DOC, shows that Louisiana has the worst mortality rate in the country by far.

---

[85] PX 36 ("mid-2012, Defendant Stacye Falgout was informed that cancer patients at Angola awaiting follow-up treatment were put on hold because the treatment center did not have a contract with the prison.); PX37 ("in January 2015, Defendant Poret sent a list of 65 hernia patients to DOC headquarters, which responded that only the top 10 could be scheduled for treatment. "); PX 2 (Dr. Singh on 12/13/13: "Some of the offenders at LSP were waiting for CT scan and MRI or cancer care since late 2011. … As far as I know no [colonoscopies] were done at LSP for 2 years or longer. Once access has been restored, even then we can not get all 600 colonoscopies done immediately."); PX 26 (Ms. Lamartiniere: "[W]e will temporarily suspend the entering of screening referrals [for colonoscopies] until notified by [headquarters] to resume."); PX 32 (cataract backlog).
[86] JX 4, K. Norris Depo. at 37:13-38:5.
[87] *See, e.g.*, JX 4, S. Lamartiniere Depo. at 69:2-16 (acknowledging that "at the end of March 2016, there were 820 offenders who were waiting to have an eye appointment").
[88] DX 14 at 19.
[89] PX 152 ("documenting cancellations").
[90] PX 345.

a. As shown in the following chart summarizing the BJS Report, the DOC's prison mortality rate has been at least 40% above the national average in every year since at least 2001, and has been more than twice the national average in every year since 2007.[91]

U.S. State vs. LA Inmate Mortality (2001-2013)
SOURCE: PX 345 AT 0026



b. As the chart shows, the DOC's mortality rate has shown an unmistakable upward trend. In the early 2000s, the DOC's mortality rate rose from the mid-300s (per 100,000) to the mid-400s. After a brief respite, it continued to rise—first into the 500s, territory that few states have reached in even a single year, and ultimately into the 600s. From 2008 to 2013, DOC's mortality rate ranged from 526 to 628 in every year. By contrast, only three other states recorded 500 or more deaths per 100,000 inmates for even a single year, with none surpassing 528 deaths.[92]

[91] PX 345 at 0026 (Table 26).
[92] *Id.* Notably, BJS says that the data point reporting 528 deaths per 100,000 inmates, Wyoming in 2008, should be "[i]nterpret[ed] with caution," because Wyoming had "too few cases to provide a reliable rate." *Id.* Only two states with sufficient data points for a reliable rate ever reached 500 deaths per 100,000 inmates, and the highest of those reached just 507—below the *best* year for Louisiana since 2008. *Id.*

c. This interpretation is consistent with Plaintiffs' medical experts' conclusion "that there are many preventable deaths at LSP that contribute to this extraordinary prisoner mortality rate [and] that these preventable excess deaths are a consequence of the systemic inadequacies in the health program."[93]

57. In conclusion, the credible evidence points to the irrefutable conclusion that Defendants' practices expose Class members to a substantial risk of serious harm, including delayed diagnosis, non-treatment or mistreatment of serious medical needs, needless pain and suffering, and preventable death.

B. Specific Practices Contributing to Substantial Risk of Serious Harm

58. In addition to establishing beyond any doubt that Angola's medical system exposes Class members to a substantial risk of serious harm, Plaintiffs have identified several policies, practices, and procedures that contribute directly to this risk.

59. To ensure adequate medical care, a correctional health care system maintains administrative infrastructure (a table of organization, a budget, staffing, training, supervision, credentialing, etc.); integrated health care processes through which care is accessed and provided (sick call, chronic disease management, emergency care, medication administration, specialty services, etc.); and various forms of quality improvement activities designed to identify and correct problems (peer review, mortality review, and continuous quality improvement ("CQI")).[94]

60. The medical system at Angola is fundamentally deficient at each of these levels.

61. At the administrative level, Angola is underfunded and understaffed. These deficits lead Defendants to assign critical aspects of medical care to staff who are unqualified to perform them.[95] This manifests in EMTs providing independent medical care and determining which patients will receive a professional medical opinion; complex care being performed by physicians who could not be credentialed for that care outside of a correctional facility, both because of expertise and because of disciplinary history; correctional officers administering medication; and inmate orderlies caring for the prison's sickest patients in the infirmary. It also manifests in unqualified and overburdened leadership, both at the clinical and administrative levels. And it leads to policies, practices, and procedures that have the effect, and often the purpose, of interposing barriers between Class members and needed medical care, both within Angola (e.g., high copays, impractical sick call times, and disciplinary policies) and outside it (e.g., centralized headquarters review and approval of all external specialist appointments).

62. These failings at the administrative level lead to a catastrophic breakdown of care at the clinical level. The use of EMTs in place of nurses and unqualified, overburdened physicians

[93] PX 6 at 0085.
[94] *Id.* at 0007.
[95] See, for example, JX 2a, in almost all the reports from the Medical Warden understaffing and the necessity for overtime work is documented.

for care beyond their training results in utterly inadequate chronic disease management and emergency care. The resistance to using outside providers leads to delayed consultation of specialists, failure to implement their recommendations or follow through on their care, and a failure to provide access to a hospital in the event of emergency. The burdens of seeking medical care, combined with the reality that care will likely be inadequate anyway, dissuades patients from seeking necessary care to which they are constitutionally entitled. And the medical use of correctional staff renders medication administration thoroughly unreliable. These flaws produce neglect of patients with all types of serious medical needs, but most particularly patients who have chronic illnesses, need full-time nursing care, or experience medical emergencies.

63. These problems go unremedied in part because of DOC's wholly inadequate—and at times consciously inadequate—quality improvement processes. Their peer review process does not monitor the quality of providers' care; their mortality review does not investigate the contributing causes of the frequent deaths discussed above; and their CQI program, which lacks participation from anybody outside the nursing staff, does not seek to identify or reduce problems on an ongoing basis. As a result, Angola's ailing medical system is incapable of diagnosing its own life-threatening conditions.

(1) Administrative Policies and Practices Contributing to the Substantial Risk of Serious Harm

a. Inadequate Funding and Inappropriate Budget Management

64. Plaintiffs' experts demonstrated that Angola's budget is "drastically less than an amount that would be expected for a facility of this size." Based on budget documents provided by Defendants, they determined that "the total medical budget at LSP is $16,888,447," which, based on the contemporaneous population of 6,303 Class members, is approximately $2,679 per inmate per year. This is "an extremely low expenditure per inmate per year"—indeed, nearly $2,000 lower per inmate than the statewide average for correctional healthcare just two years earlier, not accounting for medical inflation. Given that the acuity and thus complexity of medical needs is higher than at other facilities, it is troubling that its funding is significantly *lower* than average.[96]

65. Moreover, the budget's allocation compounds these shortfalls. 74% of the budget is spent on salaried and contracted professionals—meaning that just 26% of the budget goes to pharmaceuticals, specialty services, off-site medical care, and other essential expenses of adequate medical care. Plaintiffs' medical experts explained that "[l]abor costs are typically 50% of a correctional medical program budget." The fact that these concrete and critical

[96] PX 6 at 0027.

elements of medical care constitute an unusually small share of an unusually small budget is consistent with the many findings of inadequate outside care and medication.[97]

66. Along with underfunding the budget, Angola's medical leadership is insufficiently involved with it to ensure that it is adequate to provide necessary medical care. None of the medical leadership at Angola—and in particular, neither the Assistant Warden for Healthcare Services nor the Medical Director—have any input into or knowledge of the content of the budget or the budgetary needs of the medical program.[98]

67. This inattention to the budget is concerning given how many decisions appear to be driven by budgetary concerns. For example, the evidence includes meeting minutes (each just a sentence or two long) from three years of meetings between then-Warden Cain and the last two Medical Directors, Dr. Lavespere and Dr. Collins. Even these sparse notes show that budgeting concerns played a role in decisions at six of the ten meetings in the record. Indeed, the most prominent topic in the minutes across the ten-year period was a desire to reduce trips to outside providers, often identified as a means of reducing costs. For example, minutes from March and May 2012 both say "Topics discussed: We are trying to cut down on costs and make fewer trips," and then discuss telemedicine clinics as a means of doing so. The May 2013 minutes report that the Medical Director and Warden discussed how a planned Surgical Center would "be an asset to our facility by that [sic] will cut down on trip costs and overtime worked." The final set of minutes, from April 2015, reads "Topics discussed: Specific Offender surgeries such as joint replacement, cataract, and hernia repair and budgeting costs for these types of surgeries."[99]

68. Other contemporaneous correspondence among Defendants, as well as sworn testimony, confirms that operational decisions for the medical program were frequently made with an

[97] *Id.*; *see also* JX 4, J. Lanoue Depo.. at 29:6-21 (testifying that it is impossible to know how much was spent on a given type of medical good without reviewing "thousands of records").
[98] PX 6 at 0012, 27.
[99] JX 3-b.

eye to budget constraints.[100] As Secretary LeBlanc testified, DOC has "maxed out" medical and mental healthcare on the existing budget.[101]

69. Given the obvious and well-documented role that budget constraints play in Defendants' decision-making, medical leadership's disengagement from the process of allocating and managing the budget is an abdication of Defendants' responsibility to ensure adequate medical care. This appears to contribute directly to the improper allocation identified by Plaintiffs' medical experts and the under-provision of critical medical care demonstrated throughout these Proposed Findings.

b. Inadequate and Inappropriate Staffing

70. To maintain an adequate medical system, a facility must have "[a] sufficient number of health staff of varying types provid[ing] inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care." All health care personnel must "have credentials and provide services in accordance with the licensure, certification and registration requirements of the jurisdiction."[102]

71. Angola's medical staffing falls grossly short of this standard. Its staffing numbers at each level of the medical chain are insufficient to provide the medical care needed for a facility of Angola's size and acuity. To make up for these deficits, it uses the staff that it does have—and even the Class members themselves—to provide care that should be performed at a higher level of the chain.

72. As detailed *infra* ¶¶ 73-105, Angola's medical staff includes providers (both physicians and nurse practitioners), nurses, EMTs, and correctional officers. At each level, Defendants' staffing is inadequate and/or inappropriate and impedes Class members' ability to obtain timely, professional medical opinions and treatment.

i. Providers

[100] JX 46 at 00357837; PX 55 at 0001; PX 84 at 0001-02 ("We are trying to make sure we keep costs down for services provided on site."); PX 87 at 0001-03 ("We believe the Department would realize both improved operational service and additional cost containment through the implementation of a hybrid system consisting of external pharmacy services along with two facility-specific stand-alone pharmacies.") JX 4, K. Norris Depo. at 36:10-38:5, 46:18-47:19, 48:16-19, 39:9-22 (refusals to provide hernia surgery was budgetary decision); JX 4, J. Collins Lewis Depo. at 136:5-14; JX 4, J. Lanoue Depo. at 14:24-15:5 (when costs are too high in one area, it cuts into other areas); JX 4-d, C. Butler Depo. at 9:21-11:3 (Dr. Lavespere informed Class member that he would not receive medication for hepatitis C because interferon treatment had been ineffective and alternative treatment, Harvoni, was too expensive); JX 4-q, B. Prine Depo. at 65:15-66:12 (Class member informed by orthopedist that rotator cuff surgery would not be performed "because of money").
[101] JX 4, J. LeBlanc Depo. at 52:4-9.
[102] PX 6 at 0016.

73. In addition to Dr. Lavespere, Angola has five provider-level medical professionals: four physicians and one nurse practitioner.[103] With a population of approximately 6400,[104] that averages out to 1280 patients per provider. As Plaintiffs' medical experts have credibly testified, "[t]ypically, a physician can reasonably provide care to approximately 600 to 800 inmates depending on medical acuity." The Angola providers' caseloads are "drastically high," which "contributes to poor quality" because "[w]hen physician patient load is too high, physicians have inadequate time to properly evaluate patients."[105]

74. Providers' caseloads appear even more concerning when looked at on the level of individual providers:[106]

a. A single nurse practitioner covers an outcamp housing 1,067 Class members, which is already well above a reasonable caseload even for low acuity patients. But in addition, the nurse practitioner is responsible for Nursing Unit 2 and all HIV, cancer, and hospice patients. These groups are all complex patients, with Nursing Unit 2 in particular comprising patients with "complicated and serious medical conditions." Proper coverage of Nursing Unit 2 alone could require "as much as a half-time or full-time provider"—yet a single nurse practitioner covers it herself along with three other complex types of patients *and 1,067 more patients*.

b. The other three outcamps, which house 1713 inmates, are covered by a single physician. This on its own is more than double a reasonable caseload—and yet the physician is also assigned to the ATU and death row. The ATU, of course, features much of the prison's most urgent medical care, yet it comes on top of an already overwhelming caseload.

c. The second physician is responsible 16 dormitories in the main prison, including one of the three medical dormitories. All told, his caseload comprises 1348 patients, nearly twice the average reasonable caseload. In addition to these clinical responsibilities, he serves as Assistant Medical Director, further detracting from the time he can spend on this excessive caseload. Moreover, as discussed further momentarily, this physician is a rehabilitation doctor, not a doctor trained in primary care—the principal need of the patients in his care.

d. The third physician covers the other 16 dormitories, including the other two medical dormitories, for a total of 1241 inmates, approximately 50% to 100% higher than a typical caseload. He, too, lacks primary care training; his specialty is pain medicine.

e. The fourth physician is the only one whose caseload even approaches reasonable limits. He covers 841 patients in the main prison cellblocks in addition to the

[103] *Id.* at 0017; UF ¶ 10.
[104] UF ¶ 1.
[105] PX 6 at 17.
[106] *Id.* 6 at 17-18. All numbers are as of Plaintiffs' medical experts' site visit.

anticoagulation clinic and general medicine clinic—i.e, "all patients who have uncommon medical conditions."

f. Each provider is also responsible for patients from his or her housing units when they are admitted to Nursing Unit 1, the acute care infirmary, further burdening their caseload. Like Nursing Unit 2, Nursing Unit 1 on its own "is large enough to require a single physician to cover."

75. Plaintiffs' medical experts' opinion that these caseloads are excessive and leave providers with "inadequate time to properly evaluate patients" is consistent with Plaintiffs' showing that providers are insufficiently involved in their patients' care, and that they do not perform adequate examinations, take adequate histories, timely review diagnostic results, or implement specialists' recommendations. The massive provider understaffing thereby contributes directly to the substantial risk of serious harm documented throughout the evidence.

76. Even Defendants acknowledge the need for more providers; as recently as a few days before Dr. Singh's deposition, Angola personnel told him that they needed more doctors.[107] Defendants' expert Dr. Moore similarly acknowledged "physician manpower shortages" and "backlogs … due to a shortage in physician staff.[108]

77. The risk created by Defendants' insufficient provider staffing is compounded by Defendants' nearly non-existent credentialing process and exclusive reliance on physicians who have been disciplined by the Louisiana State Board of Medical Examiners ("LSBME").

78. Credentialing is "a process whereby a physician's qualifications are evaluated by reviewing their education, training, experience, licensure, malpractice history, and professional competence with respect to the work they will be expected to perform." The credentialing process looks at "whether the practitioner is trained properly and capable of providing safe and effective care to patients and whether the type of training of the candidate is sufficient given the expected assignment of the candidate." This process "protects safety by preventing incompetent, poorly trained, or impaired physicians from engaging in patient care."[109]

79. Credentialing files typically include a National Practitioner Data Bank report, verification of license and board certification, verification of training, and an attestation regarding prior malpractice, adverse actions, criminal offenses, or other adverse events affecting the physician's ability to practice.[110]

---

[107] JX 4, R. Singh Depo. at 263:5-9; *see also* JX 4, J. Collins *Lewis* Depo. at 91:21-92:14 (former Medical Director Jason Collins acknowledging that Angola could use "a few more hands" on any given day).
[108] DX 13 at 0017, 25.
[109] PX 6 at 0021-22.
[110] *Id.* at 0022-23.

80. "In correctional facilities, the health care needs of patients are typically primary care," the provision of day-to-day medical care, treatment of common chronic conditions and coordination and implementation of specialists' recommendations. This "requires physicians who have residency training in internal medicine or family practice," or, in certain situations, "[e]mergency medicine physicians."[111]

81. For all intents and purposes, however, Angola does not have a credentialing process. Plaintiffs' medical experts found that credentialing was "inadequate and places patients at risk of harm." Neither Angola nor DOC headquarters maintain any of the standard information identified above. Instead, they contain only the state personnel application, in which "the only requirement … is a current medical license."[112]

82. Even that information is lacking for most of Angola's physicians. As of the experts' site visit, only three providers were included in the credential files—including two providers who had since left Angola. Of Angola's six providers, only Dr. Lavespere had a credential file at all. This "lack of complete and current credential files demonstrates lack of organization and an indifference to the quality of physicians providing care to inmates at LSP."[113]

83. Even with this absence of documentation, however, it is clear that LSP's physicians are, as a group, dangerously unqualified to care for Class members. As Plaintiffs' medical experts explain, "[t]he credentials and training of a physician determine what privileges that physician should have. For example, … [a] physician trained and credentialed in obstetrics can obtain privileges to deliver babies [and] [p]hysicians trained and credentialed in internal medicine or family practice can obtain privileges to practice primary care," but "[p]hysicians trained and credentialed in internal medicine cannot typically obtain privileges to perform surgery (except for minor procedures)."[114]

84. At Angola, by contrast, "physicians are hired without apparent consideration of their training." Two of the five physicians are not trained in any form of primary care and would be unable to obtain privileges to practice primary care at any other facility. DOC, quite simply, "hires any physician who is willing to work at the prison." As Dr. Singh, the former Statewide Medical Director, put it, "When I was new, I was told that 'we just need a body in that job.' Sometimes it's so desperate a situation, you just need a body in the job." As Plaintiffs' medical experts explain, however, this attitude "results in hiring physicians not qualified to provide primary care." "This is a patient safety issue."[115]

85. In addition to their indifference to physicians' qualifications, Defendants show a tolerance—as discussed momentarily, perhaps even a preference—for physicians who have been sanctioned by the LSBME. *Every single physician* at Angola has had their license suspended or

[111] *Id.* at 0021.
[112] *Id.* at 0021-23.
[113] *Id.* at 0023.
[114] PX 6 at 0023.
[115] *Id.* at 0023-24; JX 4, R. Singh Depo. at 238:9-238:23.

restricted by the LSBME—yet as of the site visit, there was no mention of this information in the physicians' credential files. Many of these sanctions arose from criminal conduct or ethical misconduct relating to the physicians' medical practice, and often involved repeated episodes of substance or alcohol abuse that required their removal from practice "to ensure the health, safety and welfare of the citizens of this state against the unprofessional, unqualified and unsafe practice of medicine."[116]

86. Despite the LSBME having determined that these physicians were a danger to the community, it allowed them to practice in a correctional facility, refusing to extend the same protection against "unprofessional, unqualified and unsafe" medical care to Class members. Moreover, DOC's decision to hire these physicians "places inmates at risk of serious harm." As Plaintiffs' medical experts note, "[t[his is particularly disturbing because inmates have no choice about their provider." Outside of prison, patients choosing providers in the healthcare market would avoid physicians known to provide unprofessional, unqualified, or unsafe care, protecting themselves and creating a market incentive for providers to improve their practice; at Angola, where patients have no choice but to see a sanctioned physician, there is no such protection. For this reason, the NCCHC standards "specifically state that hiring physicians with licenses restricted to practice in correctional institutions is not in compliance."[117]

87. It bears emphasizing that this is not an isolated occurrence; *every* physician at Angola has been sanctioned by the LSBME. This appears to be another cost-saving mechanism for Defendants: as Warden Vannoy testified, physician salaries at Angola are "considerably lower" than salaries outside the correctional setting. As he acknowledged, "primary care doctors with clear licenses are not going to work for the salary that is being offered." Defendants have defended their practices by arguing that it is difficult to find qualified physicians interested in working at Angola, but it could more accurately be said that it is difficult to find qualified physicians while paying 75 cents on the dollar. Dr. Singh maintained that hiring doctors with restricted licenses should be "a last resort," but this is belied by Defendants' willingness to fill their entire physician staff with disciplined physicians rather than pay market salaries.[118]

88. Finally, any pretense of concern for the quality of care that Angola's physicians provide is belied by the almost complete failure to monitor and supervise the sanctioned physicians. In most if not all cases, LSBME required regular monitoring and supervision. There is no evidence that this occurs with any consistency, and Defendants' documentation suggests that it is treated as a rarely observed formality. As Plaintiffs' medical experts found "[t]he fact

---

[116] *Id.* at 0024-25; *see* Rec. Doc. 349 (granting Plaintiffs' Motion Request of Judicial Notice of the licensure of Angola physicians); see also Rec. Doc. 247-2 (Angola physicians' licensure documents, including disciplinary judgments by Louisiana State Board of Medical Examiners); UF ¶ 10.
[117] PX 6 at 0024-25.
[118] JX 4, D. Vannoy Depo. at 38:19-23; JX 4, R. Singh Ind. Depo at 238:9-16; *see also* JX 4, J. LeBlanc Depo. at 26:9-10 (acknowledging that "pay has a lot to do with" DOC's hiring of physicians with disciplinary histories).

that every doctor at LSP has a significant disciplinary history makes the lack of adequate credential files and performance monitoring particularly troubling. Given these histories, it is particularly important that their compliance with medical standards, the terms of their restrictions, and their basic competencies be documented and monitored. There is no evidence that this occurs in any meaningful way."[119]

89. In summary, Defendants employ too few physicians; hire them without regard to training, expertise, and disciplinary history; and do not monitor their performance in any meaningful way. This practice naturally and foreseeably contributes to the pervasive harm that countless Class members have suffered and that all Class members risk any time they develop a serious medical need.

ii. Nurses

90. Angola is staffed by 57 nurses, including 20 RNs, 34 LPNs, two certified nurse assistants, and one respiratory therapist. This is significantly below the number needed to deliver numerous aspects of an adequate medical system, resulting in unqualified staff performing infirmary care, medication administration, and telemedicine.[120]

91. First, Plaintiffs' medical experts have shown that the number of nurses assigned to the infirmary "is inadequate to provide adequate nursing care to this high acuity population that includes patients with quadriplegia, amyotrophic lateral sclerosis (ALS), stroke, etc." As discussed *infra* ¶¶ 168-70, Defendants instead deliver care through inmate orderlies supervised by custody staff. This places patients needing infirmary care—some of the most vulnerable among all Class members—at serious risk of substantial harm.[121]

92. Second, nurses administer medication in the two Nursing Units and at Camp J. In most of the rest of the prison, including the three medical dormitories, correctional officers administer medications. As discussed

93. *Infra* ¶¶ 189-92, correctional officers are not qualified to administer medication safely, leading to severe and documented errors in medication administration and depriving Class members of reliable, timely, and consistent access to necessary medication. These problems are the direct result of Defendants' decision to employ an insufficient number of nurses.[122]

94. Third, a single LPN serves as the presenter for nearly all telemedicine appointments. In a telemedicine appointment, a distant provider conducts a videoconference with a patient and a presenter, with the presenter performing tests and otherwise assisting the provider with tasks that cannot be conducted remotely. While it is appropriate for a nurse to serve as

[119] PX 6 at 0025; PX 6 at 25.
[120] *Id.* at 0019-20.
[121] PX 6 at 0019.
[122] *Id.* at 0020.

presenter, it should be an RN, because "[g]enerally, LPNs lack the requisite training to perform medical assessments required to adequately facilitate telemedicine."[123]

95. In sum, the understaffing of nurses harms patient care in multiple ways that contributes to the substantial risk of serious harm to which patients are exposed.

iii. EMTs

96. With a severe shortage of providers and nurses, Defendants rely on EMTs for duties related to access to care and emergency care that require a higher level of medical professional. As a result, they are "assigned duties not commensurate with their training and licensure, exceed their scope of practice and are not adequately supervised."[124] This is a major contributor to the catastrophically inadequate care Class members frequently receive.

97. EMTs are trained and licensed "to respond to medical emergencies and perform an initial triage of the patient." They are also trained and licensed to "assist providers in clinics" in many ways. But while they are qualified to perform these important tasks, their training is limited: they cannot independently manage patients; they cannot perform differential diagnosis; and they cannot provide a professional medical opinion.[125]

98. The evidence shows that EMTs do all of these things, however. As discussed *infra* ¶¶ 120-25, EMTs act without meaningful physician supervision and without meaningful reference to written protocols throughout the sick call process and when providing emergency care in the ATU. This is a wholesale denial of timely access to a professional medical opinion, diagnosis, and treatment: undertrained EMTs acting far beyond the scope of their qualifications perform front-line treatment that should be occurring at the nurse or provider level, while patients' access to a provider actually qualified to diagnose their conditions is delayed for days, weeks, or months.

99. EMTs lack clinical supervision not only at the level of individual patient encounters but globally. While the Medical Director is nominally responsible for clinical supervision of EMTs, "for all practical purposes, the EMTs receive no training or supervision."[126] Dr. Lavespere, who is nominally responsible for EMTs' clinical performance, testified that he provides no formal training for EMTs and does not meet with them in any regular, formalized way.[127] Indeed, EMTs are not technically considered medical staff at all; they are designated as security staff and report through a custodial major to the Assistant Warden, and the custodial chain of command performs their evaluations.[128] Even Defendants' expert

[123] *Id.*
[124] *Id.* (footnote omitted).
[125] *Id.* at 0020-21; DX 15.
[126] PX 6 at 0015.
[127] JX 4, R. Lavesepere ind. Depo. at 92:13-93:15.
[128] JX 4, A. Cowan Depo. at 9:20-10:20 (EMTs are part of security, and neither role is primary; "[i]t's basically whichever hat needs to be worn primarily at that time"); JX 4, D. Cashio 30(b)(6) Depo. at 73:18-74:18 PX 6 at 0015

Dr. Thomas conceded that EMTs should be removed from the custodial chain of command and placed wholly under medical supervision.[129]

100. This lack of supervision also manifests in the lack of adequate, updated protocols to guide EMT care and the lack of documentation regarding how EMTs employ those protocols. Under the Louisiana Bureau of Medical Services Approved Scope of Practice Matrix ("Scope of Practice Matrix"), EMTs may implement "treat and release" protocols, under which EMTs provide specific treatment in response to specific symptoms in lieu of transporting to a physician. Such protocols are "optional modules" that may be performed only if the EMS service (here, DOC) maintains documentation demonstrating all individuals authorized by the service's medical director to perform the module have attended a specific training module, which must be validated every 24 months.[130] There is no record of such training or documentation occurring at Angola, and when asked about it Dr. Lavespere declined to articulate any training he provided.[131]

101. Moreover, Angola's EMS Sick Call Protocols are wholly deficient. They are undated, unsigned documents that lack any indication that they have been authored or reviewed by any Angola medical authority, or any guidance as to who may use them, when they may use them. Plaintiffs' medical experts documented numerous defects in the protocols that prevent them from being responsibly used to determine whether a patient may be safely released or requires immediate transfer to a medical professional. As examples of these defects:[132]

a. The Burning with Urination protocol does not require a urinalysis, needed to diagnose patients with urinary tract infections;

b. The Shortness of Breath protocol does not include obtaining a medical history for previous heart disease (e.g., myocardial infarction, heart failure), cardiovascular review of systems (e.g., chest pain, palpitations, dizziness) or cardiovascular risk factors (e.g., hypertension, diabetes);

c. The Chest Pain protocol states that "If the patient has severe chest pain with unstable vital signs, he should be sent to the ATU immediately." Since many patients experiencing an acute cardiovascular event may not initially have severe chest pain or unstable vital signs, this criteria is likely to delay diagnosis of life-threatening conditions (e.g., myocardial infarction, aortic aneurysm, etc.);

d. The Vomiting protocol does not include criteria to immediately refer patients with abdominal pain and abnormal abdominal findings (e.g., distended, tender, rigid, and rebound tenderness) to a physician;

[129] DX 14 at 72.
[130] DX 15 at 02960.
[131] PX 6 at 0040-41; JX 4, R. Lavespere Ind. Depo. at 92:13-93:15.
[132] PX 6 at 0040.

e. The Constipation protocol does not include a review of systems (e.g., weight loss, loss of appetite, blood in stools) to rule out more serious illnesses (e.g., colon cancer);

f. Some protocols are diagnosis rather than symptom-based and require the EMT to determine the diagnosis before assessing the patient (e.g., athletes foot and jock itch).

102. The protocols provided reveal a confusing, disorganized document often altered by hand which fails to provide clear directions for EMTs to use, bearing in mind the limited training and education required by Angola for this role.[133]

103. Even if EMT protocols were medically adequate and accurate, EMTs rarely document what protocol they purported to follow, making it impossible for medical leadership at Angola to review their care even if they wanted to. As countless sick call and ATU records demonstrate, EMTs typically write "according to protocol" without identifying the protocol they chose, let alone how they chose it. Indeed, in many cases, they write "according to protocol" without even documenting which protocol they are providing.[134] Given the complete impossibility of reviewing EMTs' medical performance, it is unsurprising that no EMT has ever been disciplined for incorrect treatment, according to Major Cashio, the supervisor of all EMTs[135]—even though Plaintiffs' medical experts found that "in the majority of cases … EMT medical examinations are completely inadequate"[136] and Defendants' own providers have acknowledged that EMTs sometimes do not perform a thorough exam.[137]

104. Medical treatment performed by EMTs in the ATU is even more deficient. Due to the severe understaffing at the provider level, most patients are treated principally by EMTs, with physicians providing at most telephone orders in response to EMTs' reports and questions. Even when physicians are present in the ATU, they rarely perform and document physical examinations and take medical histories. These catastrophic failures are discussed *infra* ¶¶ 132-37, but for the purposes of this section it suffices to say that Defendants' attempt to use semi-trained EMTs to make up for the dire shortage of physicians denies Class members access to professional medical opinions and treatment, and is a major source of the ever-present risk of serious harm faced by Class members when they develop emergency medical needs.[138]

---

[133] JX 8a.
[134] PX 6 at 0041;
[135] JX 4, Cashio 30(b)(6) Depo. at 72:21-73:16; *see also* JX 4, A. Cowan Depo. at 98:22-99:4 (EMT testifying that she had never heard a doctor or nurse tell an EMT that he or she had made a mistake in 14-year career).
[136] PX 6 at 0032; *see also id.* at 0061 ("EMTs [are] typically managing medical emergencies that are beyond the scope of their training, resulting in harm including many deaths.").
[137] JX 4, C. Park Depo. at 73:14-17 ("Q: Have you ever gotten a sick call from an EMT and thought they didn't do a very thorough exam? A: Yes.").
[138] PX 6 at 0041, 60-71.

iv. Correctional officers

105. Due to Defendants' understaffing of nurses or other medical professionals licensed to administer medication, "LSP has inadequate health care staff to correctly administer medications," leading Defendants to use "unqualified correctional officers" to administer medication. This would fall below appropriate operational standards even with proper training and supervision, but Plaintiffs' medical experts found that correctional officers administering medications "are not meaningfully trained or supervised by medical staff." As discussed *infra* ¶¶ 189-92, this results in an unreliable, dangerous system of medication administration that places patients at risk.[139]

c. Inadequate Leadership

106. Angola's administrative and clinical leadership have tolerated or even promoted all of the deficient policies and practices documented throughout the evidence—both the administrative problems identified above and the clinical problems identified below.

107. A medical program in a large prison is typically managed by "a responsible health authority, which is the person or entity responsible for all levels of health care and for ensuring quality, accessible and timely health care." Under NCCHC Standards, this role must be filled by "a person who by virtue of education, experience, or certification (e.g. MSN, MPH, MHA, FACHE, CCHP) is capable of assuming [that] responsibility."[140]

108. While Dr. Lavespere is nominally the health authority, in practice the Assistant Warden "has operational control over all aspects of the medical program and directly supervises a significant portion of health care staff."[141] At all times during the discovery period, this position was filled by Ms. Lamartiniere, Warden Cain's former secretary, who has no training in health care and no degree above high school.[142] Both in an interview with Plaintiffs' medical experts and in her deposition, Ms. Lamartiniere exhibited "no knowledge about specific medical program operational issues" and disclaimed any knowledge of the budget or budgetary needs, let alone input into the budget or staffing levels. She had attended just two CQI meetings in the prior five years. In all, "her leadership involve[d] no real authority to manage the health program."[143]

109. Dr. Lavespere, Angola's Medical Director, "does not perform many of [the] typical functions" of a medical director. "The role a Medical Director is typically to organize and

[139] *Id.* at 0015, 49-54.
[140] PX 6 at 0011.
[141] *Id.* at 0012.
[142] JX 4, S. Lamartiniere Depo. at 5:24-2.
[143] PX 6 at 0012, 16, 27, 88. After the close of discovery, Defendants moved Ms. Lamartiniere to another position within DOC and named Defendant Tracy Falgout as the Assistant Warden for Health Services. Because this occurred after the close of discovery, it is irrelevant to the liability portion of this case. *See* Rec. Doc. 419 at 3 ("[T]he evidence shall be limited to the healthcare conditions and the facility as they existed as of September 30, 2016.")

implement the medical program; to provide clinical supervision to provider staff; and to be the final medical authority on all clinical decisions." But Dr. Lavespere does not perform any formal review of his clinical subordinates; does not formally supervise the EMT staff; does not participate in quality improvement efforts; does not perform or oversee mortality review; and has no input into the budget. In an expert interview, Dr. Lavespere could not even estimate the types or frequency of chronic clinical conditions among the patients for which he is responsible. In all, "[h]e was unable to provide any specifics of how he spends his time in organizing or supervising the medical program."[144]

110. Dr. Lavespere's disengagement from operational aspects of the medical system is mirrored in his clinical care. Neither Dr. Lavespere nor the medical providers he supervises "document adequate examinations (e.g. history of the chief complaint, review of systems, past medical history and pertinent physical examination and labs) that support the patient's diagnosis and treatment plan." In case after case, Dr. Lavespere and his supervisees fail to perform or document the basic steps necessary to timely diagnose and treat Class members. This does not "adhere to standards of medical practice" and results directly in the serious harm documented above.[145]

111. Equally disturbing, Dr. Lavespere, by his own admission, believes that his biggest challenge is determining which of his patients are lying to him. He believes that fully half of his patients do not tell the truth to their treating physician because they "don't want to go to work—that his patients "don't want to be better" because "if they get well, then they have to do things" or because they want to "pin[] [a medical problem] on DOC."[146]

112. This attitude, as Plaintiffs' medical experts explain is "not consistent with accepted standards of professionalism and medical practice. … For any physician, much less the Medical Director, to begin each encounter with a presumption that patients are not telling the truth is the epitome of unprofessionalism." This presumption of dishonesty puts the pervasive failure to perform proper examinations of patients' complaints in a dark light: in many cases, Class members do not receive necessary care for serious, even life-threatening medical needs because Dr. Lavespere and his clinicians do not believe them and do not take the medically necessary steps to determine the source of their symptoms. Even more pointedly, as discussed *infra* ¶¶ 132-144, it leads Dr. Lavespere and other physicians to direct EMTs not to transport patients to the ATU for treatment or to forcibly test and treat patients experiencing ongoing medical emergencies for drugs without indication, both of which have directly contributed to numerous preventable deaths[147]

---

[144] PX 6 at 0012-13; *see also, e.g.*, JX 4, Lavespere Ind. Depo. at 97:12-14.
[145] *Id.* at 0014.
[146] JX 4, R. Lavespere Ind. Depo at 17:25-19:2, 52:8-10; JX 4, R. Lavespere 8/5/16 30(b)(6) Depo. at 7:16-20.
[147] PX 6 at 0014; *see also, e.g.*, JX 4, R. Singh Depo. at 100:21-25 (former Statewide Medical Director Dr. Singh: "Q: If you[] were to treat patients with a presumption that the majority of patients were malingering, can you see ways that would cause problems for treatment and diagnosis? A:

113. Dr. Lavespere's attitudes toward treatment make it "likely that in his role of Medical Director he will tolerate substandard care from other medical providers." This fear is borne out by the pervasive appearance of Dr. Lavespere's inadequate clinical tendencies throughout all providers' records, as shown above.[148]

114. These failings put Defendants' failure to perform appropriate credentialing, exclusive reliance on disciplined physicians, and absent monitoring into perspective. Dr. Lavespere's license was suspended due to a conviction for possession with the intent to distribute methamphetamine, after which, he acknowledged in an LSBME consent order, he was "diagnosed with amphetamine and cocaine dependence, history of cannabis dependence," and, among other things, "personality disorder NOS [not otherwise specified] with antisocial, narcissistic and avoidant features."[149] The LSBME placed his suspension on probation upon a finding that he could potentially be fit to practice medicine *if* he were subject to strict monitoring. While the LSBME lifted these restrictions in 2014 (at Dr. Singh's request, so that Dr. Lavespere could serve as Medical Director), there is no evidence of proper monitoring either before or after that time.[150] Indeed, Dr. Lavespere is not reviewed annually by another clinician; rather, he is reviewed by the Assistant Warden for Healthcare Services, who, as already noted, had no medical background during the discovery period.[151]

115. Dr. Thomas accuses Plaintiffs' medical experts of "disparaging the background of the physicians without concomitantly unequivocally demonstrating individual inadequacies of provider care." Of course, they *have* unequivocally demonstrated individual inadequacies of provider care, as demonstrated throughout the evidence. But more generally, Dr. Thomas's objection misses the point: Defendants' practice of relying on disciplined physicians who expose patients to a risk of "unprofessional, unqualified and unsafe" care contributes to a risk of serious harm—and Defendants knowingly subject Class members to that risk, without providing monitoring that could catch the risk when it manifests itself. To do so with one or two physicians would raise concerns; to have a disciplined physician who has historically exhibited clinically antisocial behavior lead an entire staff of disciplined physicians elevates those concerns to a level unknown across the country. Given that Plaintiffs have conclusively shown that that harm has pervasively manifested itself

---

Absolutely."); *id.* at 102:5-102:12 (if doctor thought 90 percent of patients were malingering, "I would lose my sleep and I will find a way to get him out. I can't work with people like that.").

[148] *See also, e.g.*, JX 4-f, K. Clomburg Depo. at 62:12-31:2 (describing EMTs accusing patients of "faking," or laughing at broken bones).

[149] *See* Rec. Doc. 349 (granting Plaintiffs' Motion Request of Judicial Notice of the licensure of Angola physicians, including disciplinary consent orders); *see also* Rec. Doc. 247-2 at 5.

[150] See Rec. Doc. 349 (granting Plaintiffs' Motion Request of Judicial Notice of the licensure of Angola physicians, including disciplinary consent orders); see also Rec. Doc. 247-2 at 10; PX 6 at 0013, 24.

[151] JX 4, R. Lavespere Ind. Depo. at 82:19-22.

throughout the Angola medical system merely proves the inappropriateness and inadequacy of Defendants' practice.[152]

(2) Clinical Practices Contributing to the Substantial Risk of Serious Harm

116. The administrative failings outlined above lead directly to a pervasive, systemic failure to provide clinically adequate, medically appropriate care. This manifests at every step of the health care process: at sick call, where patients attempt to access care; in the chronic disease program, where patients with long-term medical needs are treated; in specialty care, where patients seek diagnosis and treatment recommendations for complex conditions; in the ATU, where emergency treatment is provided; and in the infirmary, where long-term nursing care is provided. It is also reflected in incomplete and unheeded diagnostic services, unreliable and inconsistent medication administration, and unsanitary and inadequate medical facilities. Throughout the system of care, virtually every program that could break is broken.

d. *Sick Call and Access to Care*

117. To have a medically adequate health care system, inmates must have timely access to a medical professional, a professional medical judgment, and the care that medical professionals order. This can be inhibited by underfunding, understaffing, and poor organization; it can also be impeded by unreasonable barriers, such as punishment, excessive fees, or impractical times for accessing the system. All of these factors exist at Angola, and each contributes to the substantial risk of serious harm.

118. Sick call is the main process by which patients access the medical system at Angola. The standard practice at Angola is for EMTs to make rounds of each housing unit, typically around 4:30 a.m.. Class members write their medical complaint on an undated Health Service Request ("HSR" or "sick call form") and provide it to the EMT, who reviews the HSR and assesses the patient on the spot, typically in the patient's dormitory or cell. The EMT may prescribe treatment, transport the patient to the ATU, contact a provider for instructions, or do nothing. The EMT then writes their observations on the sick call form along with a recommendation of how soon the patient should see a doctor. After performing sick call, the EMT places the day's HSRs in a box for the physician responsible for the housing unit.[153]

119. As practiced at Angola, this system has numerous substantive and procedural flaws that deprive Class members of timely access to a professional medical judgment and

[152] DX 14 at 20-21.

[153] PX 6 at 0031-32; JX 5-a at 0019-21 (HC-01, DOC Access to Care and Clinical Services Policy); *see also, e.g.*, JX 4, D. Cashio Depo. at 29:15-30:22, 44:20-45:8, 54:8-55:8, 60:4-6 (describing sick call process); JX 4, R. Lavespere Ind. Depo. at 26:22-30:14 (describing EMT decisions about whether to bring to ATU); *id.* at 38:1-12 ("if the EMS didn't think the person needed to be transported or didn't need to have anything urgently done, then those charts are put in a physician's room"; physicians only change recommendation "if you think, you know, that they missed something").

corresponding treatment. It is a major contributor to the risk and reality of serious harm that Class members experience.

v. Inappropriate role of EMTs and inadequacy of sick call assessments

120. Plaintiffs' medical experts observed sick call and reviewed hundreds of HSRs as part of their sample. Their report concisely summarizes the fundamental deficits in Defendants' sick call practice:

> The EMT does not have the health record available to review the patient's past medical history or determine if the patient's complaint is a new or recurring complaint, and what if any previous treatment was provided to the patient. EMTs do not conduct assessments in examination rooms that are adequately equipped and supplied, afford privacy and confidentiality, or have access to handwashing. Moreover, the medical equipment and supplies that EMTs bring with them is not standardized. One EMT in Camp J had only a stethoscope, whereas another in the Transitional Unit brought a small bag with more equipment. Given the circumstances in which assessments take place, it is not surprising that in the majority of cases we reviewed, EMT medical examinations are completely inadequate. In addition, documentation reflected that EMTs usually do not directly communicate or consult with a physician regarding assessment findings at the time the patient assessment is performed. Therefore, the EMTs make independent assessments on a daily basis, which is beyond their scope of practice.
>
> After EMTs perform sick call, they place the patient's HSR in a physician's box. For the majority of HSRs we reviewed, physicians did not document any information regarding the assessment performed by the EMT or perform any independent evaluation. In most cases, the provider documented that the patient would be seen for sick call PRN (*as needed*) or scheduled the patient for a physician appointment in accordance with a priority system (e.g. category I, II or III). In the majority of forms reviewed, physicians did not legibly date, time or sign the form. Thus, the timeliness of provider review of care provided by EMTs in most cases was unknown. There is no evidence of any physician supervision of the EMTs' practice.[154]

121. Thus, the principal—and often only—medical attention Class members receive in response to sick call is a cursory and inadequate EMT assessment. This does not qualify as a

[154] PX 6 at 0032; *see also, e.g.*, JX 4, K. Hawkins Depo. at 23:24-24:4 (acknowledging that EMTs do not have access to medical records during sick call); JX 4, A. Cowan Depo. at 32:8-18 (EMTs perform "a visual exam, you know, just looking at somebody" to determine whether they need to examine the inmate); *id.* at 30:23-32:3 (EMTs only pull charts if they think the chart needs to be reviewed by a doctor); *id.* at 80:17-23 (EMTs write their actions in the "physician assessment and treatment" section); JX 4-n, M. Murray Depo. at 21:11-13 ("Sick call responses vary from two days to never. There are times I do not ever see—you never see the doctor."); JX 4-q, Prine Depo. at 38:11-39:3 (describing sick call requests for shortness of breath where patient was never seen by a medic).

professional medical judgment, and denies or delays access to diagnosis and treatment. As explained *supra* ¶¶ 96-104, EMTs have limited licenses and training, which render them qualified to perform specific types of care but not to independently manage patients or make diagnoses. The hundreds of HSRs in the medical records reviewed by Plaintiffs' medical experts show a consistent pattern of inadequate medical examinations and independent EMT decision-making that is not based on professional medical examination or judgment.

122. This frequently results in Class members receiving superficial, inadequate treatment for a symptom without any effort to diagnose its potential causes. As the experts concluded:

> Our review showed that patients submitted repeated HSRs for the same complaint. Because EMTs never have the health record with them when they conduct sick call, in many cases the patient is treated repeatedly with the same medication regimen even if it's failed in the past. This practice resulted in cases where patients complained repeatedly of chest pain, abdominal pain, and other symptoms of potentially serious medical conditions, and were not diagnosed and treated in a timely manner. These patients were later diagnosed with serious medical conditions resulting in adverse outcomes, including death … .[155]

123. The experts' case studies—not to mention the Named Plaintiffs' medical histories—detail numerous such cases. For example:

a. Patient # 17 repeatedly complained of chest pain at sick call for over 16 months before he was ultimately tested and diagnosed with adenocarcinoma of the lung. He died a little over one week later. Even prior to complaining of chest pain in 2012, doctors had discovered a pulmonary nodule and even referred the patient to a thoracic surgeon for biopsy. Yet no biopsy took place until 2014—days before the patient died. For over sixteen months, the patient was seen at sick call but was only cursorily evaluated by EMTs and doctors, who failed to adequately document the progression of the patient's symptoms.[156]

b. Patient # 20 complained of significant abdominal pain for over four months. Evaluations by both EMTs and physicians were frequently cursory and failed to note that the patient was HIV positive. More than once, EMTs failed to refer the patient to a physician despite his severe symptoms. After months of complaining of "burning" pain, weight loss, and vomiting blood, the patient was admitted to a nursing unit. He died the following day.[157]

c. In a single month, Patient # 29 made ten sick calls for symptoms consistent with exacerbation of congestive heart failure. On these visits, EMTs were the primary

[155] PX 6 at 0032-33.
[156] *See* PX 6 at 0193-0199.
[157] *See Id.* at 0216-0227.

providers of care and failed to conduct meaningful evaluations. It took over one month for the patient to be hospitalized despite acute worsening of symptoms. [158]

d. Patient # 18 requested an HIV test but was not tested and discovered positive for over two months—when he was acutely ill. On multiple occasions, the patient complained to EMTs of chest pain, shortness of breath, and a 55-pound weight loss, but there is no documentation that EMTs notified physicians of the patient's abnormal vital signs during a period when his symptoms worsened. Further, physicians failed to timely provide patient with any meaningful clinical evaluation for his symptoms. The patient died a little over one month after his HIV diagnosis. Faster diagnosis of his HIV status and corresponding anti-retroviral intervention could have prevented his death. [159]

Former Plaintiff Shannon Hurd (now deceased) repeatedly complained of substantial weight loss, testicular swelling and numerous other symptoms consistent with renal cell carcinoma, but Angola medical staff waited over two years before conducting the diagnostic testing that would uncover this fatal illness. During this period, Mr. Hurd saw doctors and EMTs on numerous occasions, but they routinely failed to conduct meaningful testing or scrutinize his symptoms and medical history. Even when tests did occur, doctors failed to provide necessary follow up. From the time that he began showing symptoms until his ultimate diagnosis two years later, Mr. Hurd had lost 61 pounds.[160]

124. Former Plaintiff Joseph Lewis (now deceased) repeatedly complained for 33 months—nearly three years—of symptoms consistent with laryngeal cancer until testing was finally conducted to uncover the fatal illness. Despite the clear warning signs of worsening symptoms and frequent complaints, medical staff failed to conduct routine diagnostic testing that could have revealed his underlying condition[161] and potentially prolonged his life. Instead, Mr. Lewis was mostly evaluated by unqualified EMTs at sick call who referred him to a physician on only a few occasions. In some cases, EMTs do contact physicians to report assessments and request instruction. But there is significant evidence that physicians' participation actively impedes care. When EMTs request instructions, physicians often give "no-transport" orders, which are "verbal orders given to the medics over the radio … advising that the patient not be transported from his cell." These orders "result in delay in care, lack of evaluation by a physician and in some cases death."[162] Plaintiffs' medical experts identified several examples of such delays and inadequate care. For example:

[158] *See Id.* at 0256-0257.
[159] *See Id.* at 0200-0208.
[160] *See* PX 28 0018-0022.
[161] *See Id.* 0017-0018.
[162] PX 6 at 0063.

a. Patient # 39 was a 65-year-old man with "a history of diabetes, [and] severe coronary artery disease and heart failure."[163] In July of 2011, patient was seen by EMTs seven times variously for "temperature of 103.6," "an altered mental status," "chest tightness," "breathing but unresponsive," and lying on the floor of his cell "'vomiting and won't move [sic].'"[164] No-transport orders were given three times. After the third order at the end of July, the patient died in his cell. The medical records do not explain or describe the reason for or circumstances of the death.[165]

b. Patient # 34 made an emergency sick call on June 20, 2010, complaining of pain in his right flank.[166] On June 24, an ambulance was sent to Patient # 34 at Camp D because he was unable to get out of bed. The EMT "[c]alled Dr. Lavespere [who] ordered 'NO TRANSPORT' and advised patient to get meds at pill call . . . ." Three days later EMTs again were called to visit the patient who was "unresponsive / disoriented, lethargy cool and clammy" and "found with altered mental status."[167] The following day the patient died at Earl K Long Hospital. The cause of death was determined to be "hypothermia due to hypoglycemia due to complications of cirrhosis due to Hepatitis C with contribution of sepsis."[168]

125. These examples have a troubling resonance with Dr. Lavespere's testimony that he doesn't believe patients, and with the general understaffing and lack of qualifications at the provider level. Doctors do not believe patients, so they do not bother to see patients; doctors are not qualified to perform primary care, so they do not understand when an assessment is incomplete or abnormal; and Defendants do not employ enough doctors, so they jump to the conclusion that patients do not need a doctor. Whatever the reason in a particular case, the harm to Class members—and the risk of additional harm at any time—is irrefutable.

vi. Policies and practices that impede access to care

126. In addition to the fundamental inadequacy of Defendants' system of EMT-led sick call, Defendants maintain numerous policies and practices that impede Class members' access to care.

127. First, Defendants do not follow their own practice for how frequently sick call should occur. Under DOC's Access to Care and Clinical Services Policy, patients are supposed to have daily access to routine and urgent services, with sick call requests triaged every day.[169] This

[163] *Id.*
[164] *Id.*
[165] *Id.* at 0063-0064.
[166] *Id.* at 0267.
[167] *Id.*
[168] *Id.* at 0267. *See also id.* at 0063.
[169] JX 5-a at 0020 (HC-01).

does not occur in the outcamps and on death row, where sick call is only conducted Sunday to Thursday.[170]

128. Second, sick call occurs at unscheduled times, beginning as early as 4:30 in the morning in some housing units. Many Class members are sleeping at this time, and may not wake up for sick call. Patients who miss sick call must wait until the next sick call, or declare an emergency; they are not permitted to have another Class member submit an HSR for them. This is an unreasonable barrier to care that lacks a clinical or operational justification.[171]

129. Third, Class members must pay $3.00 for sick call, and $6.00 for a self-declared emergency. Given the fact that most Class members make 12 cents an hour, and that they frequently will not receive medical attention from a provider even if they make sick call, this is an unreasonable barrier to care that "likely discourages inmates from accessing emergency care when they need it."[172] Indeed, this is Defendants' acknowledged intent in maintaining the co-pay system at these rates: Major Cashio testified that the purpose of the co-pays is so patients "don't clog up the system." If inmates are denied care, they may still be charged for repeat requests; Defendants will charge for every sick call request if an inmate "decide[s] … that I'm going to catch sick call every day until somebody sees me."[173] Defendants also charge also pay $2.00 for a new prescription or even over-the-counter medication—even if they are receiving only a single dose. This further discourages medical care and provides Class members care well below the community standard.[174]

130. Fourth, Class members who seek medical care must face the possibility that they will be disciplined for malingering if medical personnel do not believe them. Every sick call form states "I am aware that if I declare myself a medical emergency and health care staff determine that an emergency does not exist, I may be subject to disciplinary action for malingering."[175] While Defendants claim that malingering charges are rare, they concede that medical personnel can "[a]bsolutely" threaten to write up Class members, and that they have no statistics on the frequency of that threat.[176] As Plaintiffs' medical experts explain, "[t]his is

---

[170] PX 6 at 0031; *see also, e.g.*, JX 4, Poret 9/19 Depo. at 32:7-17 (no sick call Friday or Saturday).
[171] Anticipated Testimony; PX 6 at 0033; JX 4, D. Cashio Depo. at 31:9-32:15 (patients cannot use other Class members as proxies; if they miss sick call, must catch it the next day); *id.* at 33:6-13 (sick call runs from "4:30 in the morning to 4:30 in the evening usually" and has no schedule); JX 4, A. Cowan Depo. at 23:8-25:4.
[172] PX 6 at 0033.
[173] JX 4, D. Cashio Depo. at 86:15-22; *see also* JX 4-t, H. Varnado Depo. at 38:11-19 (EMTs told Class member "they refused to take [sick call request] because they said [he] was filing too many"); Anticipated Testimony
[174] PX 6 at 0033; PX 53 *see also, e.g.*, JX 4-m, R. McCaa Depo. at 21:7-22 (Class member testifying that he has frequently not sought treatment due to co-pay); JX 4-l, J. Marsh Depo. at 54:3-55:11 (same); JX 4-d, C. Butler Depo. at 51:10-18 (same); JX 4-n, M. Murray Depo. at 66:8-12 (same); JX 4-t, H. Varnado Depo. at 38:6-17 (same).
[175] PX 53.
[176] JX 4, D. Cashio Depo. at 83:17-84:10; *see also, e.g.*, JX 4, S. Poret 9/19 Depo. at 42:15-43:7 (Mr. Poret acknowledging that when he provided direct care, he used malingering charges "often"); JX 4,

unreasonable because patients in distress often cannot distinguish between a true medical emergency versus a non-emergency," and because it involves medical personnel "in initiating disciplinary action against inmates which is a role conflict." Even Defendants' expert Dr. Thomas agrees that the malingering rules should be removed.[177]

131. Fifth, the HSR does not provide a place for Class members to document the date on which they completed the form, so there is no way to determine the timeliness of an inmate's access to care. Given that neither patients nor providers record the relevant date, there is no way for DOC or outside reviewers to monitor the timeliness of care, and no check on providers who delay review.[178]

e. *Inadequate Treatment of Medical Emergencies*

vii. Inappropriate use of EMTs, lack of physician involvement, and failure to transfer to a hospital

132. As with sick call, "EMTs perform all emergency response."[179] EMTs transport patients to the ATU either when they determine it is appropriate in response to a routine sick call, or in response to self-declared emergencies. As many as 76 patients may be seen in a day in the ATU, according to Dr. Lavespere.[180] Wait times are often hours long, leading some patients to give up on seeking care and returning to their housing units.[181]

133. But "[a]lthough a physician is assigned to provide on-call coverage to the ATU, physicians are not in the ATU at all times and do not consistently evaluate patients while they are in the ATU. Therefore, EMTs solely conduct most evaluations of patients presenting urgently. Physician participation is typically only to give orders, often by phone." In the ATU, as on sick call, "EMTs do not consistently reference … protocols," and "in many cases, the EMTs in fact are acting independently."[182]

134. This practice entails the same denial of access to care and risk of harm as the sick call process described above—but with the higher consequences that come from neglect and mistreatment in life-or-death situations.

A. Cowan Depo. at 42:21-25 (EMTs can write people up for making an SDE declaration without an emergency or if they "continuously see sick call for not life-threatening problems"); JX 4-t, H. Varnado Depo. at 29:11-21, 31:1-2 (describing accusation of malingering).

[177] PX 6 at 0033; DX 14 at 72; PX 53 at 001; *see also, e.g.*, JX 4-u, D. Woodberry Depo. at 43:6-9 ("[S]ometimes if you catch the wrong EMT, you're threatened with a write-up … for trying to make a sick call.").

[178] PX 6 at 0032; PX 53 at 001.

[179] PX 6 at 0061 (footnote omitted).

[180] JX 4, R. Lavespere 8/5 ind. Depo. at 44:4-7.

[181] JX 4-c, A. Brent Depo. at 67:22-70:8.

[182] PX 6 at 0061.

135. At the same time that Defendants provide substandard care in the ATU, they frequently decline to send patients to outside hospitals when indicated by urgent, life-threatening vital signs and symptoms. The ATU is not an emergency room; it lacks numerous forms of diagnostic testing (or lacks qualified operators much of the time), including ultrasound, stress testing, and echocardiograms, which are necessary to diagnose emergency conditions and determine a proper course of treatment. Similarly, laboratory testing is not available after hours or on the weekend, making it impossible to perform critical diagnostic tests. It is therefore "not equipped to diagnose and treat many serious medical problems." Without this capacity, the ATU is insufficient to treat most emergent conditions and transport to a true emergency room at an outside hospital is necessary—but in numerous cases, it is delayed until the patient is beyond treatment, or foregone altogether.[183]

136. Plaintiffs' emergency medicine expert, Dr. Vassallo, was on hand in the ATU to witness a trauma emergency response, which exhibited many of these failings. Patient #44 attempted to hang themselves in their cell, and was brought to the ATU with abnormal posturing indicating brain injury and bruising at the C spine, findings that warrant immediate hospitalization. Despite these significant findings, EMTs continued managing his care—even though Dr. Toce, an Angola physician, was present. Dr. Toce, did not assess the airway or listen to the lungs, or perform a primary or secondary survey or neurological examination, which are critical in trauma resuscitation. Nor, critically, did Dr. Toce recognize that the EMTs had failed to ensure proper ventilation by providing positive pressure assistance. About 15 minutes later, Dr. Lavespere entered and advised applying positive pressure assistance, but due to the long delay, "[t]his level of inadequate ventilation most likely harmed the patient and promoted extension of his brain injury." This represented a "fail[ure] to understand major aspects of advanced life support" and one of multiple "significant departure[s] from standard of care" observed in this encounter.[184]

137. Other examples of severely deficient ATU care, placing patients at immediate risk of serious harm and in some cases contributing to preventable deaths, include:

a. Patient # 40 presented to the ATU thin and wasted with a 30-pound weight loss over the previous two years. An X-ray showing pneumonia and a potential chest mass necessitated immediate laboratory testing. Yet, the ATU was unable to conduct such testing because the patient arrived over the weekend. Making matters worse, medical staff refused to transfer him to an appropriate facility where such testing could be immediately conducted.[185]

b. After already presenting with abdominal pain and jaundice Patient #31—who was Hepatitis C-positive—came to ATU complaining of vomiting, but was discharged without meaningful evaluation. Two days later, he returned to the ATU complaining of worsening pain. An X-ray showed signs of infection that the ATU could not

[183] *Id.* at 0065-72.
[184] PX 6 at 0061-62.
[185] *Id.* at 0066.

properly treat. Instead of being transferred to a hospital, the patient was asked to sign a do-not-resuscitate order. He died the following day.[186]

viii. Inappropriate procedures in emergency care

138. In addition to these critical failures to provide competent care in the ATU, Defendants employ several wholly inappropriate practices in the ATU.

139. First, Defendants presume that any patient with altered mental status is using drugs, and thus routinely perform a urine toxicology test—often by forced catheterization, a painful and invasive process that may introduce infection—whether or not a patient has symptoms of a serious condition that might explain his mental status. Notably, this routine application of urine toxicology does not appear in any written protocol, although staff apparently consider it a routine part of critical tasks such as stroke work-up.[187]

140. Similarly, Defendants routinely pump patients' stomachs (known medically as "lavage") and apply naloxone, an anti-overdose drug, without any evidence of overdose or drug use. For example:

a. Patient #37 presented to the ATU for new onset of seizures. Defendants subjected him to gastrointestinal lavage and naloxone, during which he developed decerebrate posturing and other symptoms indicating significant brain damage. He was eventually transported to a hospital, where a CT scan showed intracerebral bleeding before he expired in the hospital. As Plaintiffs' medical experts explain, "[l]avage for drugs and administration of naloxone for new onset of seizures shows a gross lack of knowledge of emergency care. Lavage of a patient with new onset seizures represents medical care with no basis in modern practice and delays transport to the hospital. Both the lavage of a patient and the administration of naloxone may have serious complications when misapplied and may delay proper medical care."[188]

b. Patient #30 presented to the ATU with focal motor seizures of the arm and face. He was given naloxone with a plan for gastrointestinal lavage, despite having no symptoms of opioid or any other overdose. As Plaintiffs' medical experts concluded, "this plan does not meet standard care" and was simply "incoherent."[189]

141. As a whole, "in all of the instances of gastric lavage … [Plaintiffs' medical experts] could see no indication for gastric lavage."[190]

142. Second, Defendants inappropriately use restraints as a substitute for mental health treatment in the ATU. One patient with a history of mental illness who presented to the ATU after

[186] *Id.* at 0067, 0261-0264.
[187] *Id.* at 0064.
[188] PX 6 at 0064-65.
[189] *Id.* at 0065.
[190] *Id.* at 0065.

cutting his forearms received no mental health treatment and instead was placed in 4-point metal restraints with flex-cuff reinforcements as the sole form of care.[191]

143. Third, Defendants improperly use Do Not Resuscitate ("DNR") orders instead of providing actual medical treatment or transferring patients to hospitals where they can receive appropriate care.

144. For example, Patient #31 was examined in a clinic on June 6, 2014, and found to be significantly hypotensive—but was discharged without his hypotension being addressed. Two months later he reported abdominal pain and was distended and jaundiced, but was again discharged. The next day, he was additionally vomiting, and was again discharged without treatment. Two days later he returned to the ATU complaining of worsening abdominal pain and tenderness in his abdomen. Instead of receiving an evaluation of his acute decompensation, he was asked to sign a DNR order. Two days later he began vomiting blood and died in the prison—all without a diagnosis or treatment of his worsening abdominal pain.[192]

> These deficits in care and improper policies combine for a dire, often deadly situation. As the Plaintiffs' medical experts summarized: In summary, our review showed that urgent and emergent care is inadequate and has resulted in multiple deaths, many of which were likely preventable. In several cases, patients with serious medical conditions failed to be transported to the ATU for medical evaluation by a physician. Physicians do not evaluate patients in the ATU; medics manage patients and appear to be acting out of the scope of their licenses. Patients with life-threatening conditions are not timely transferred to a hospital. Serious medical conditions are mismanaged. Use of improper medic protocols (use of urinary catheters for obtaining specimens in persons capable of normal urination; use of gastric lavage; etc.) demonstrates lack of medical leadership. Repeated presentations to the ATU, or repeated calls for an ambulance, or repeated sick call requests for the same problem, are not perceived as a "red flag" warning for undiagnosed, undifferentiated or undertreated illness. Instead it is cynically perceived as a sign of inconsequential disease or malingering. A cynical attitude toward inmates is unprofessional. In the meantime, serious infection, stroke and other conditions are unrecognized. Mental illness manifesting as suicide attempts are seen as a cause for punishment by the medieval practice of 4-point restraints. Rather than offer the community standard of medical care, patients are made DNR, do not resuscitate and acute problems are left untreated. All of these deficiencies place inmates at risk of harm or actually cause harm.[193]

f. Inadequate Chronic Disease Management Program

[191] *Id.* at 0065.
[192] *Id.* at 0067.
[193] *Id.* at 0071 (footnote omitted).

145. Chronic disease management is the long-term monitoring and treatment of patients with chronic diseases such as diabetes, HIV, hypertension, hypothyroidism, clotting disorders, or others. The goal of a chronic disease program is to decrease the frequency and severity of symptoms, prevent disease progression and complication, and foster improved function.[194] An adequate chronic disease management program has several basic minimum components:

a. Disease review, which includes identifying and evaluating each of the patient's chronic diseases at each visit and performing a pertinent history, including review of symptoms for each disease.

b. Examination, which includes referencing current laboratory results and performing a focused physical exam pertaining to each of the patient's medical conditions.

c. Medication review, which includes reviewing medication adherence and assessing obstacles to compliance, such as side effects.

d. Treatment, which includes assessing disease control for each of the patient's chronic diseases; developing and modifying, as needed, treatment plans related to each of the patient's chronic diseases; and scheduling clinical follow-up in accordance with the patient's disease control.[195]

146. Angola's chronic disease program is woefully inadequate, both on paper and in practice. HC-11, Angola's Chronic Care/Special Needs policy, "is generic and lacks sufficient operational detail to provide guidance to staff regarding the requirements of the program, including procedures for enrollment, tracking, frequency of monitoring visits, etc." Defendants also lack "a true chronic disease tracking system that includes all patients with chronic diseases, their last appointment, next scheduled appointment and scheduled labs."[196] Even Defendants' expert Dr. Moore noted a "lack of chronic care," which she attributed to "physician manpower shortages."[197]

147. Angola's Chronic Disease Manual contains guidelines for only eight diseases, omitting major chronic diseases such as chronic kidney disease, thyroid disease, sickle cell disease, and lupus. Even the guidelines that do exist "are skeletal in nature" and "do not include the community standard of care." They "provide no clinical criteria for inclusion in the chronic disease program, procedures for enrollment; components an adequate history and physical examination, definitions of disease control and medical treatments for each disease." They are, simply put, "completely inadequate."[198]

---

[194] *Id.* at 0042.
[195] *Id.* at 0043.
[196] PX 6 at 0042-43.
[197] DX 13 at 0025.
[198] PX 6 at 0042- 43; JX 8-l (Chronic Care Manual); *compare, e.g.*, JX 8-l at 0018 (LSP hypertension guidelines) *with* Rec. Doc. 466-6 (Eighth Joint National Committee, 2014 Evidence-Based Guideline

148. Hepatitis C ("HCV") presents an example of the failings of the chronic disease guidelines:

a. HCV is a liver infection caused by the hepatitis C virus and spread when blood from a person infected with the virus enters the body of someone who is not infected.[199] Symptoms include fever, fatigue, dark urine, clay-colored bowel movements, abdominal pain, loss of appetite, nausea, vomiting, joint pain, and jaundice.[200]

b. Acute HCV occurs within the first 6 months after someone is exposed to the virus: 75% to 85% of people with acute HCV develop a chronic HCV infection. Chronic HCV can lead to serious health problems including liver damage, cirrhosis, liver cancer, and death if left untreated.[201]

c. The American Association for the Study of Liver Disease ("AASLD"), the Infectious Diseases Society of America, and the International Antiviral Society—USA have authored and published evidence-based, expert-developed recommendations for HCV management.[202] According to these sources, all persons who have a risk should be tested for HCV.[203] Being incarcerated is its own risk factor.[204] Consequently, anybody who is incarcerated should be tested for HCV.

d. Angola does not have mandatory HCV testing (also known as "opt-out" testing) for patients.[205] Instead, patients are tested if a healthcare practitioner at Angola has a "clinical suspicion" that a patient is infected with HCV.[206] This inappropriately delays diagnosis for HCV.[207]

e. Angola's chronic disease guidelines are not based on nationally recognized clinical practice guidelines.[208] Angola's physicians do not perform history and physical

---

for the Management of High Blood Pressure in Adults). *See* Sept. 25, 2018 Minute Order (taking judicial notice).

[199] Rec. Doc. 438-5 (*Hepatitis C Questions and Answers for the Public,* CENTERS FOR DISEASE CONTROL AND PREVENTION: VIRAL HEPATITIS, https://www.cdc.gov/hepatitis/hcv/cfaq.htm (last visited Aug. 1, 2018)). *See* Sept. 25, 2018 Minute Order (taking judicial notice); *see* JX 6-iii at 003 ("Hepatitis C virus (HCV) infection is a bloodborne pathogen and is transmitted primarily through large or repeated direct percutaneous exposures to blood.")

[200] Rec. Doc. 438-5.

[201] *Id.*

[202] *See* Rec. Doc. 438-8 (The American Association for the Study of Liver Diseases and Infectious Diseases Society of America's Recommendations for Testing, Managing, and Treating Hepatitis C). *See* Sept. 25, 2018 Minute Order (taking judicial notice).

[203] *Id.* at 11.

[204] *Id.* at 12.

[205] JX 4, S. Poret. 9/19 Depo. at 20:1-20:14.

[206] *Id.*; JX 6-iii at 003-004.

[207] Angola's chronic care manual does not require testing but starts from a clinical suspicion or diagnosis. JX 8-1 at 17.

[208] *See* PX 6 at 0008.

examinations pertinent to the patient's disease, timely address abnormal laboratory tests, assess medication adherence, and monitor the patient in accordance with the patient's disease control.[209]

f. Angola's chronic care treatment guidelines provide no clinical criteria for inclusion in the chronic disease program, procedures for enrollment, components of an adequate history and physical examination, definitions of disease control, and medical treatments for each disease.[210]

g. Even with limited testing, in 2016, almost 14% (873 patients) at Angola had a diagnosis of Hepatitis C.[211]

This inadequate program predictably produces catastrophically poor care. Without adequate guidance—and in some cases without relevant training, *see supra* ¶¶ 73-89—Defendants' physicians appear not to recognize or know how to treat chronic illnesses in ordinary or critical states. In the Plaintiffs' medical experts' sample, "virtually every chronic disease record [the experts] reviewed showed a similar pattern of inadequate medical evaluations and lack of timely monitoring and treatment. In nearly all records [they] reviewed, patients' chronic diseases were poorly controlled or inadequately treated, increasing the risk of serious harm to these patients."[212]

149. Plaintiffs' experts reviewed at least 33 patients with chronic diseases, and found major, prolonged delays and errors in care in every one.[213]

150. In case after case, all of the elements of a chronic disease management program were missing. Providers did not review each of the patient's diseases, perform a relevant examination or review and incorporate laboratory results, assess obstacles to medication compliance, or assess and develop a treatment plan appropriate for the patient's disease states. Specialty care was delayed or denied, and when it did occur it went without follow up. These systemic failures are directly responsible for the pervasive risk of delayed or withheld diagnosis and treatment, serious harm and suffering, and preventable death.

g. *Failure to Provide Timely Access to Specialty Care*

151. To provide adequate medical care, a correctional system must make hospitalization and specialty care available to patients in need of these services. Off-site facilities or medical professionals must provide a summary of the treatment given and any follow-up

[209] *Id.*
[210] *Id.* at 43; *see also* JX 6-iii at 003-006.
[211] DX 16 at 02960.
[212] PX 6 at 0047.
[213] PX 6.

instructions, which must be incorporated into the patient's medical records and reviewed by the patient's primary care provider.[214]

152. As the chronic disease management section makes clear, Defendants inappropriately limit Class members' access to specialty care. While these failings are, like the problems in chronic disease management, pervasive throughout the specialty care process, they fall into two basic categories: delayed or withheld access to specialists, and delayed or withheld implementation of care recommended by specialists.

ix. Delays in obtaining specialty care

153. Numerous practices and procedures interfere with Class members' ability to access necessary specialty care.

154. First, Defendants' understaffing and reliance on underqualified personnel, detailed at length above, prevents providers from recognizing the need for specialty care and making appropriate referrals. Because of the limited participation and diagnostic examinations of physicians, and "[b]ecause of the lack of training of physician staff, physicians do not always appreciate when patients need referrals for care."[215] This is seen most prominently in the management of chronic diseases, as just discussed.

155. Second, Defendants' process for reviewing and scheduling referrals creates significant delays and often prevents indicated consultations and procedures altogether. All referrals for off-site specialty care (and some on-site specialty care) are entered into a computer database called Eceptionist. Through Eceptionist, the Statewide Medical Director and other non-treating RNs review each referral to determine whether it is "medically necessary." Unless the Statewide Medical Director determines that the referral is medically necessary, the consultation or procedure will not be scheduled.[216]

156. This frequently results in care being delayed or denied, as shown by Eceptionist records and the Plaintiffs' experts. Headquarters review often involves requests for substantiation of medical necessity that may take weeks to be completed, if it is completed at all. Moreover, Defendants do not actually maintain a definition of the critical "medically necessary" threshold, leaving review within the Statewide Medical Director's amorphous discretion—even though he is not a treating provider for the patients whose care is at issue.[217] As former

[214] PX 6 at 0071.
[215] PX 6 at 0075.
[216] PX 6 at 0072-73; *see also, e.g.*, JX 4, S. Lamartiniere Depo. at 28:11-28:23 (Ms. Lamartiniere testifying that Dr. Singh reviews and makes the approves offsite surgeries); JX 4, R. Lavespere 9/19 Depo. at 63:22-64:15 (Dr. Lavespere testifying that scheduling requests go through headquarters and are sometimes denied).
[217] PX 6 at 0073; JX 4, R. Singh Depo. at 151:20-21 (Dr. Singh: "[W]e don't have a definition of medically necessity. [sic]"); *see also* JX 9.1 at 0156; *see, also, e.g.*, JX 4, Carroll Depo. at 17:2-19:24, 23:17, 23:25-24:2, 24:8-25:8 (discussing cases where Dr. Singh denied or altered referral requests); *id.*

Assistant Warden for Healthcare Services testified: "the treating physician has no control over the final scheduling of the surgery. He doesn't. We recommend this guy needs surgery, and it goes to Dr. Singh's office. You know, he decides, based on the doctors talking, who gets treated and who don't."[218]

157. Additionally, Eceptionist does not track whether appointments are completed or rescheduled. This information often appears not to be transmitted back to facility providers, leading interruptions in care instead of the referrals that providers originally intended. Eceptionist records are often left out of patients' paper medical record, so the reasons for the denial of a referral may not be incorporated into a patient's ongoing care.[219]

158. Third, there are "frequent communication errors with respect to what needed to be done or what tests needed to accompany the patient on the consultation visit." This results in patients going for specialty care visits without recommended tests, requiring the tests to be re-ordered and thereby delaying care of the patient.[220]

159. Fourth, appointments are often canceled for patients who have disabilities requiring transport in a handicap-accessible vehicle, due to the unavailability or unusability of Angola's handicapped van. When the van is unavailable, inmates must either travel in a regular, ill-equipped van or reschedule their appointment. Given that UMC, the primary location for specialty care, is approximately 150 miles away—a 4- to 5-hour drive each way—this places patients with disabilities in a Hobson's choice: undergo a dangerous, likely painful journey in an inappropriate vehicle, or delay the appointment indefinitely.[221]

x. Failure to follow up on specialty care and timely implement specialists' recommendations

160. When specialty consultations, procedures at outside facilities, or hospitalizations occur, patients frequently return with recommendations for medication or particular treatment plans. But Defendants' providers rarely maintain any continuity of care between these recommendations and patients' ongoing care. Instead, "[t]he LPNs in the Trip Office appear

---

at 21:15-24, 27:22-28:1, 28:15-29:1 (acknowledging that headquarters does not see patients but reviews and closes requests).

[218] JX 4, K. Norris Depo. at 40:15-21; *see also, e.g.*, JX 4, J. Collins Lewis Depo at 23:2-9 (Former Medical Director Jason Collins: "[W]e sent these referrals to whatever the mechanism was at headquarters. They took it from there. … So every time we saw the problem my medical team would send the referral, and that's what our job was, and that's as far as we could take it.").

[219] PX 6 at 0073.

[220] PX 6 at 0073; *see also, e.g.*, JX 4-q, B. Prine Depo. at 23:22-24:2 (describing outside physician's refusal to perform procedure because Angola wouldn't "do all of the follow-ups that I need to see you" and "wasn't going to bring me to [outside facilities] to take the—take kind of therapy he would want me to take").

[221] PX 6 at 0073; *see also, e.g.*, JX 4-l, J. Marsh Depo. at 52:7-20 (describing use of shackling during medical trips); JX 4-e, T. Clarke Depo. at 79:24-80:10 (describing returning from UMC in the back of a police car).

to manage the follow up for the patient; the doctors do not appear to be involved in managing specialty care at all." It is often unclear whether a provider reviewed the results of the consultation at all, and "there is seldom a physician visit after an off-site visit (either hospitalization or specialty consultation) to address any change in plan based on the hospitalization or off-site consultation." Patients' records at Angola seldom include the "[c]ompleted consultation requests," making it "difficult to determine what occurred at the consultation." In all, the record suggests "that LSP providers [do not] review consultation or hospital discharge summary reports in order to synchronize their primary care efforts with efforts of the specialists."[222]

161. As a result, the care that patients receive from specialists often goes without any follow-up. This undermines the purpose of sending patients to outside providers by leaving patients without follow-up, sometimes even after surgical procedures that require post-operative care. Follow-up appointments made by providers often do not occur, or, if they do, diagnostic studies that were requested by the consultant prior to follow up do not occur. This leads to ineffective appointments, as discussed in the previous section.[223]

162. This tracks closely with the experience of UMC doctors, who reported that their recommendations are frequently ignored by Angola providers; that follow-up appointments are frequently delayed or canceled; and that when they do see patients for follow-up appointments, they often have not been receiving medications or other treatment prescribed at the previous appointment.[224]

163. Both of these categories of problems are illustrated in many of the case studies already described, as are their consequent harms. Additional examples include:

a. An aortogram was requested for Patient No. 13 on Nov. 20, 2013, but it was not performed until almost 10 months later, on Sept. 11, 2014. The patient was hospitalized for a heart attack, and Defendants did not review the hospital record or note the recommendations of the hospital physicians. Defendants failed to follow up after this hospitalization and failed to manage the patient appropriately, as Plaintiffs' experts noted, "resulting in heart failure requiring another hospitalization."[225] After the patient returned from the hospital, Defendants failed to review the hospital discharge records. A cardiologist requested an echocardiogram on about Jan. 29, 2015, which was done, but it was not reviewed by Defendants; the recommendation wasn't documented as needed by the cardiologist, and it was not sent with the patient at a follow-up cardiology visit on May 7, 2015. The cardiologist again recommended an echocardiogram, and again it was performed but not reviewed by Defendants. Again the patient went to the cardiologist without the echocardiogram result, causing another request for an echocardiogram on Sept. 23, 2015. Consequently, the

[222] PX 6 at 0074.
[223] PX 6 at 0074-75.
[224] Anticipated Testimony of Dr. Monica Dhand, Dr. Catherine Jones, and Dr. Jane Andrews.
[225] PX 6 at 0075.

cardiologist was unable to assist in the management of the patient; between January and September of 2015, the patient was hospitalized twice for heart failure. As Plaintiffs' experts explained, "The failure to coordinate specialty care contributed to the harm to the patient."[226]

b. Patient # 6 had hypertension and significant cardiac arrhythmia. The patient was evaluated by outside cardiologists, but "communication with consultants was poor and ineffective in describing the condition of the patient," Plaintiffs' experts found.[227] In 2013, a cardiology consultant recommended an echocardiogram and an event recorder test. The echocardiogram was done, but the event recorder was not. Because of this, the patient's atrial fibrillation was not treated with anticoagulation, as it should have been. Two years later, in April 2015, the patient developed another episode of atrial fibrillation and was hospitalized. During this hospitalization, the patient was anticoagulated at the hospital. When the patient returned to Angola, defendants did not evaluate the patient, and the patient failed to receive recommended anticoagulation for approximately 10 days. Within four days of returning to Angola, the patient developed critical symptoms. Instead of sending the patient to a hospital, Defendants ordered a next day follow-up. The patient then developed signs of serious heart failure. Instead of hospitalizing the patient, Defendants treated the patient on the infirmary without the benefit of diagnostic testing. For four more days the patient remained on the infirmary with poor and inadequate history and physical examinations. The anticoagulation was finally started, but the patient failed to improve, and he died. Plaintiffs' experts found the death was preventable, and it "was caused by lack of recognition of the need for anticoagulation over a two-year period and, finally, a lack of providing ordered anticoagulation medication for 10 days due to lack of review and acting on consultant recommendations."[228]

c. Patient #7 developed an abnormal chest x-ray showing a mass suspicious for cancer. The patient was referred to a pulmonologist, who requested repeatedly that Defendants order a pulmonary function test and biopsy. The patient returned to the pulmonologist three times without the tests being done. The patient had lung cancer, but his diagnosis "was delayed for over a year and a half because of lack of coordination of specialty care," Plaintiffs' experts found.[229] Defendants who saw the patient failed to take adequate histories, failed to perform adequate physical examinations, and failed to review or acknowledge specialists' requests. After being diagnosed with lung cancer at a hospital, the patient returned to Angola, where his lung cancer was not recognized or acknowledged for weeks. Defendants who evaluated the patient failed to take adequate histories, failed to perform adequate physical examinations, and failed to coordinate follow up oncology care. Within

[226] *Id.* at 0075.
[227] *Id.* at 0076.
[228] PX 6 at 0076.
[229] *Id.* at 0077.

approximately seven weeks after returning to the prison, the patient was sent to the hospital, where he died. As Plaintiffs' experts explained, "The lack of adequate provider care contributed to this patient's death."[230]

d. Lab results for Patient # 10 indicated potentially life-threatening obstructive jaundice. A CT scan showed a mass in the pancreas. Instead of sending the patient to a hospital for a biopsy and to address the jaundice with a stent, Defendants kept him on the infirmary. The patient developed fever. Defendants told the patient the he had a poor prognosis and recommended palliative care before a diagnosis was made. The patient was discharged from the infirmary and was not sent to a hospital for over a month. As Plaintiffs' experts explained, the delay in definitive biopsy and treatment "was a significant departure from standard of care."[231] At the hospital, the patient's pancreatic cancer was diagnosed; Defendants placed him on the infirmary when he returned to Angola. Defendants seldom took a history or performed a physical examination, did not coordinate a follow up with an oncologist, failed to monitor the patient's condition, and did not review the hospital care. Defendants failed to take histories, perform physical examinations, monitor the patient's progress, or otherwise coordinate oncology care. After the patient developed hypotension, he was evaluated in the ATU, transferred to a hospital and died in the emergency room. As Plaintiffs' experts explained, Defendants "showed a lack of concern for this patient and appeared to promote a terminal prognosis and delay care before the patient had an adequate chance at treatment."[232]

h. Inadequate Inpatient Care

xi. Inadequate provider care in infirmary.

164. Angola provides care to patients with acute or long-term nursing needs in its two infirmary units, Nursing Unit 1 and Nursing Unit 2. The two units house the highest-acuity patients among all Class members, including both patients with high-level disabilities and severe ongoing medical needs.[233]

165. Given the acuity of patients in the Nursing Units, regular provider and nursing rounds is crucial, as is the presence of a qualified health care professional who can see or hear patients at all times. But as with the rest of Angola's medical system, the Nursing Units are understaffed: Nursing Unit 2 is managed by a nurse practitioner who also oversees more than 1000 other patients, while Nursing Unit 1 is visited irregularly by providers responsible for patients from their housing units.[234] As a result, "providers on the infirmary seldom take adequate history and seldom perform physical examinations appropriate for the patient's

[230] *Id.* at 0077.
[231] *Id.* 6 at 0077.
[232] *Id.* at 0077.
[233] *Id.* at 0080.
[234] *Id.* at 0017

condition. Laboratory and other diagnostic testing are seldom integrated into the care of the patient. Providers fail to properly manage patients [in ways] that cause harm, including managing patients in the infirmary that should be sent to the hospital." And here again, providers obtain DNR orders as a substitute for providing actual therapeutic care.[235]

166. Plaintiffs' experts documented numerous examples of the substandard, often fatal care this produces. Among others:

a. Patient #3 had diabetes, peripheral vascular disease, coronary artery disease, hypertension and Hepatitis C. His diabetes was uncontrolled for 2 years. "He was not timely monitored receiving only two hemoglobin A1C tests over a 2 year period,"[236] whereas uncontrolled patients usually have such tests every 3 months. The patient frequently had high blood pressure readings and was rarely given medication to control these episodes. The patient's records did not confirm that he was consistently receiving medication. He "developed confusion, extremely high blood pressure and critical ischemia with symptoms of a leg infection"[237] but was not sent to the hospital in a timely way and died.[238]

b. Patient #5 suffered from hypertension and "asthma" which was probably misdiagnosed as chest x-rays demonstrated interstitial lung disease that providers did not recognize.[239] He lost 60 pounds over the next two years, but this went unrecognized by providers, who also failed to adequately examine him when he complained of abdominal pain, diarrhea, and vomiting. He was admitted to a hospital because of fever and diagnosed with advanced cancer. He died from complications of the resultant surgery.[240]

c. Patient #17 had a history of chronic lymphocytic leukemia and had received six cycles of chemotherapy in 2011.[241] In May of 2012 he presented with a lung nodule "suspicious for malignancy," and was recommended for "pulmonary cytology studies and follow-up wth thoracic oncology clinic in 1-2 week after studied are obtained."[242] This never occurred. Patient complained of chest pain from October 2012 until November 2013, but was never evaluated by a physician. During this time, hematology/oncology requested labs that were not performed. In November he had chest x-rays that showed "a large mass in the left parahilar region" of his lung and

[235] *Id.* at 0080-82. Patient #23, referred to on these pages, is plaintiff Farrell Sampier. He is not considered part of the experts' judgment sample.
[236] *Id.* at 0044.
[237] *Id.* at 0044.
[238] *Id.* at 0044.
[239] *Id.* at 0075.
[240] *Id.* at 0075.
[241] *Id.* at 0078.
[242] *Id.* at 0078.

"numerous pulmonary nodules through the lung fields on both sides."[243] A further examination showed "bilateral lymphadenopathy in the neck, axilla and groin" that had never been found by LSP doctors.[244] A January 2014 x-ray revealed indicators that the cancer had metastasized. Patient #17 died in February.[245]

xii. Inappropriate nursing, orderly, and custody practices in nursing unit

167. In addition to lacking sufficient provider care, the infirmary units lack sufficient nurses to properly attend to the patients. This produces numerous problems that deprive Class members of adequate medical care and increase their risk of serious harm.

168. First, due to the scarcity of nurses in the nursing units, major components of nursing care are provided by inmates themselves. Inmate orderlies clean, bathe, dress, feed, and position patients.[246] This violates ACA and NCCHC operational standards that prohibit inmates from assisting patients with activities of daily living in infirmaries. Giving inmate workers control over how and when patients with serious medical needs are cleaned, bathed, and positioned puts those patients at substantial risk of neglect and inadvertent or intentional mistreatment. Improper cleaning can lead to infections; improper positioning can lead to dangerous decubitus bed sores. It also poses a high risk of abuse, as Nurse Falgout acknowledged.[247]

169. Moreover, inmate orderlies are not actively supervised by registered nurses, but rather security staff. Security staff alone select healthcare orderlies, even though DOC's policy requires a board of security and medical staff to select orderlies.[248] The custody department is responsible for determining showering and hygiene even for patients who cannot move and require total care. But given the medical needs and heightened vulnerability of these patients, "clinical staff must determine the frequency of showers and hygiene needs" to ensure that patients are properly cared for.[249]

---

[243] *Id.*
[244] *Id.*
[245] *Id.*
[246] JX 4, K. Hart Depo. at 50:1-53:19 (acknowledging that nurses rely on orderlies to change diapers, turn patients, assist with hygiene); JX 4, C. Park Depo. at 90:15-22 (same); JX 4, Poret 9/19/16 Depo. at 61:9-63:13 (same).
[247] PX 6 at 0080-81; JX 4, *see also, e.g.*, JX 4, T. Falgout Aug. Depo. at 33:22-9 ("That's why I'm continually training [new orderlies], because we do have that percentage of guys who don't play by the rules. They have an infraction. They get taken out of the program, so I'm training new ones to follow up.").
[248] *Compare* JX 8-k (Nursing Service Policy 20) *with* JX 4, T. Falgout 8/18 Depo. at 17:23-25 (Mr. Falgout testifying that security deals with staffing and assigning orderlies).
[249] PX 6 at 0082; *see also, e.g.*, JX 4, T. Falgout Aug. Depo. at 17:23-24, 78:23-79:2 (security manages orderly staffing and whether it's safe to assign an inmate as a healthcare orderly); *id.* at 36:14-16 (Tracy Falgout, who runs the orderly program, is sometimes not on the nursing unit for two weeks

170. Even if their use were appropriate, medical orderlies are inappropriately trained. Their training is a shorter version of a certified nursing assistant ("CNA") training PowerPoint, which is not adapted to account for orderlies who have difficulty reading or other limitations understanding the presentation. Along with the training, they have "hands-on" training that is principally provided by other orderlies, rather than nurses or other medical professionals. Some orderlies start their duties even before they are trained, and they neither take a test after training nor undergo annual reviews.[250] This training does not comply even with Angola's own policies, which require orderlies to be trained annually and requires 24 hours of classroom training and 24 hours of clinical training.[251]

171. Second, the nursing units contain several single-patient rooms, which have solid, locking doors, lack any call system to reach nurses, and cannot be seen or heard from the nursing station.[252] Some of these rooms are used for hospice patients or dialysis—but others are used to discipline patients in the nursing units. Placing patients with severe disabilities or medical needs in locked cells with solid doors and no system for calling for help exposes them to severe risk. For this reason, "a person with an infirmary-level illness should not be housed in a room that is not within sight or sound of a nurse." For example, Kentrell Parker, who is quadriplegic and uses a tracheostomy tube to help with breathing, has been locked in an isolation room facing away from the door, with no way to summon help and no way to get attention if his tracheostomy tube becomes clogged.[253]

172. Third, Defendants do not maintain sanitary conditions in the infirmaries. As already noted, custody, rather than medical staff, determines how and when the infirmaries will be cleaned. Nurses and nurse practitioners have described it as "a dire situation" in which "some of the beds are grossly dirty."[254] Given the heightened vulnerability of patients in the infirmaries, unsanitary conditions in the infirmaries place patients at a substantial risk of serious harm.

---

at a time); JX 4-c, A. Brent Depo. at 83:12-85:24 (orderlies don't know who their supervisor is or who they should contact with concerns about patients).

[250] JX 4, T. Falgout Aug. Depo. at 19:15-17, 30:13-17, 31:2-6, 33:6-9, 80:16-21.

[251] JX6-eee (annual training); JX 8-k (24 hours of classroom training and 24 hours of clinical training); *compare* JX 4, T. Falgout Depo. at 29:22-30:9 (classroom training lasts from eight to three for 2.5 days, with breaks for lunch, pill call, etc.; practical component has "really no time frame on it").

[252] JX 4, Hart Depo. at 33:14-35:7 (acknowledging that isolation rooms lack monitoring); *id.* at 38:12-24 (claiming that nurses have no control over locked rooms in Nursing Unit 1); *id.* at 74:25-75:13 (acknowledging that on-duty nurse can't see all patients).

[253] PX 6 at 0081-82. Plaintiff Kentrell Parker is referred to as Patient #24 in the expert report, but is not considered part of the experts' judgment sample.

[254] PX 21 at 0001-2 (RN Manager Karen Hart to Sherwood Poret, July 18, 2014: "I'm sorry to bring this up again, but it is an ongoing concern of mine and the nurses. The units, especially Unit 2 is not kept as clean as a nursing unit should be. Why is that? … Maybe the orderlies are not trained to clean every surface, because whoever is training them does not know. Or maybe the orderlies just don't want to and security doesn't make them because they don't know to make them … . On Nursing Unit 2 some of the beds are grossly dirty. … [T]o me it is bad. I would like for it to be as

xiii. Absence of care in the medical dormitories

173. Finally, outside the infirmaries, many patients with serious medical needs or disabilities, but who do not need nursing care—or for whom there is simply no room in the infirmaries—are clustered in so-called "medical dormitories." These dormitories, however, are "no[] more suited to disabled men than in any other general population units," and are crowded and disorganized. Indeed, Defendants themselves have acknowledged that the "medical dormitories" are actually "designed for general population" rather than being outfitted to provide services or treatment to individuals with disabilities or medical needs.[255]

174. Medical staff do not make rounds of the medical dormitories; neither providers nor nurses visit the medical dormitories, and even medication administration is carried out by correctional officers.[256] These "are not proper hygiene practices … to house very sick individuals."[257] The medical dormitories are also often dirty and moldy, particularly in the bathroom.[258] In addition to the ADA violations discussed below, the medical dormitories present risks of developing infections or exacerbating injuries that subject Class members housed therein to the possibility of serious harm.[259]

i. Inadequate Pharmacy Services and Medication Administration

175. Angola's provision of medication is inadequate in both policy and practice. Defendants refuse to provide adequate pain medication or treatment for hepatitis C; maintain a disorderly and unclean that increases the risk of error and contamination; and use unqualified correctional officers to administer medication, leading to medication error, improper recordkeeping, and other serious consequences. All of these choices increase the risk of serious harm to Class members.

xiv. Refusal to provide adequate pain medication

176. At the procurement level, Defendants maintain a policy that directly interferes with patients' ability to receive adequate pain medication. Patients can only receive narcotics at the

---

clean as a hospital and I think it should be."); PX 11 at 0002-3 (Hart to Poret, Nov. 12, 2014: "This is a dire situation. … The units could and should be a lot cleaner.").

[255] PX 6 at 0084; PX 15 at 0002 ("Louisiana State Penitentiary … [is] operating Medical Dorms in dormitories designed for general population.").

[256] JX 4, T. Falgout Aug. Depo. at 12:22-13:15 (healthcare orderlies in medical dorms are not supervised by medical staff); JX 4-e, T. Clarke Depo. at 8:16-9:3 (there are no healthcare professionals of any kind in medical dormitory Ash 2 on a regular basis); JX 4-c, A. Brent Depo. at 40:24-41:18 (medical personnel deliver patients from infirmary to medical dormitory without telling orderlies what they need, what diet they should have, etc.); *id.* at 73:25-75:2 (doctors and nurses don't do rounds in medical dormitories, and patients aren't taken out regularly to see medical staff).

[257] PX 6 at 0084.

[258] JX 4-q, B. Prine Depo. at 76:14-78:15, 80:8-81:10; JX 4-n, M. Murray Depo. at 59:22-60:14.

[259] PX 6 at 0084.

REBTC—but many patients who need narcotic pain medication are not housed at the main prison, and have difficulty getting to the infirmary to receive it.

177. This denies Class members access to adequate medical care for severe pain and exposes them to needless suffering. For example, plaintiff Ian Cazenave has sickle cell disease, which produces chronic pain that, if not properly managed, can lead to leg ulcers, osteomyelitis, and other severe, debilitating symptoms. When Mr. Cazenave has been housed outside the REBTC, he must travel, as much as several miles, every day to get what should often be daily pain management. Given his leg ulcers and the frequent indication of bedrest for managing osteomyelitis, this is impractical and often impossible, and aggravates his pain rather than relieves it.[260]

178. Instead of providing properly indicated pain management, Defendants "treat chronic pain with a combination of non-steroidal anti-inflammatory medications (NSAIDS), aspirin and acetaminophen. They also use Keppra, primarily an antiseizure medication, and Neurontin, for treatment of neuropathic and nonneuropathic pain. These medications are not the standard for treating non-neuropathic pain and can cause physical and mental side effects." Fully one of every ten Class members is prescribed Keppra, despite its *only* FDA indication being seizure treatment. As Plaintiffs' medical experts observe "LSP's use of these medications appears to be excessive." The principal reliance on off-label use of a drug that does not treat non-neuropathic pain as the front-line form of pain management does not meet standard of care and leaves patients' serious pain untreated.[261]

xv. Refusal to provide adequate HCV medication

179. Highly effective treatment is available for chronic HCV. There are several Food and Drug Administration (FDA) approved medications available to treat chronic HCV. They are direct-acting antiviral agents and are referred to as DAAs. These medications usually involve 8 to 12 weeks of oral therapy, cure over 90% of people who take them, and have few side effects.[262]

180. All persons infected with chronic HCV should receive treatment unless they have a limited life expectancy (less than 12 months) due to a non-liver-related comorbid condition.[263] Patients with advanced fibrosis or compensated cirrhosis should receive urgent initiation of treatment.[264] Patients with chronic HCV should be treated with antiviral therapy early in the course of their chronic HCV infection before the development of severe liver disease and other complications.[265]

---

[260] PX 28 at 0008-10.
[261] PX 6 at 0049; *see also, e.g.*, JX 4, R. Singh depo Ex B/1-000000826; JX 4-q, B. Prine Depo. at 26:6-23 (Class member testifying that Keppra provided no relief from orthopedic pain); PX75.
[262] Rec. Doc. 438-5; *see also* Sept. 25, 2018 Minute Order (taking judicial notice).
[263] Rec. Doc. 438-8 at 30-31.
[264] *Id.* at 30.
[265] *Id.* at 31.

181. Earlier forms of treatment (Interferon, Ribavirin) are classified as *not* recommended for treating HCV.[266] A regimen classified as "not recommended" is "clearly inferior" to other regimens or "deemed harmful" to the patient and should not be administered to patients with HCV.[267] Regardless of whether the patient has previously been treated for chronic HCV, DAAs remain the standard of care for treatment over Interferon or Ribavirin.[268]

182. In 2016, Department of Corrections Secretary LeBlanc specifically requested that DOC Medical Director Dr. Singh input a line item budget funding request for HCV medicine in light of the high cost of contemporary HCV treatment medicines, DAAs.[269] Secretary LeBlanc acknowledged that drug companies stopped making the earlier HCV medicines Interferon and Ribavirin. He also acknowledged that DAAs are now the only treatment option for HCV and that they are expensive.[270] Secretary LeBlanc thinks that it is "crazy" that drug companies are no longer selling outdated HCV treatment medications in lieu of the more expensive and contemporary HCV medications.[271]

183. As discussed *supra* ¶ 148, Angola's guidelines for treating HCV "are skeletal in nature" and do not include the community standard of care upon which they are based.[272]

184. Incarcerated patients with chronic HCV whose sentence is sufficiently long to complete a recommended course of DAAs should receive treatment for the chronic HCV according the aforementioned standards.[273] Yet at Angola, patients are not receiving timely treatment.

185. For example, Charles Butler is incarcerated at Angola and diagnosed with HCV. Angola treated Mr. Butler with Interferon around 2005. His treatment was discontinued before it finished because, as he was told, it was ineffective.[274] After his treatment was discontinued, he spoke with doctors at Angola about pursuing alternative treatments.[275] He recalls being told by Dr. Lavespere approximately two or three years ago that Harvoni is the standard

---

[266] *Id.* at 53-62 (noting that for each genotype, the earlier forms of treatment, namely Interferon and Ribavirin, are not recommended).
[267] *Id.* at 48 ("When a treatment is clearly inferior or is deemed harmful, it is classified as 'Not Recommended.' Unless otherwise indicated, such regimens should not be administered to patients with HCV infection.").
[268] *Id.* at 72-89 (noting that for each genotype's previous HCV treatment regimen, DAAs are the recommended form of treatment).
[269] JX 4, J. LeBlanc Depo. at 65:9-17.
[270] *Id.* at 65:9-25 ("I told him that this week for hep C, to make sure we need to show it as a line item, the request of funding for the hep C medicine. But, again, that's an area where I think drug companies are taking advantage of us when they shut down the other – I forget the name of them, but they shut down the one that was being used and was working, in some cases – in a lot of cases, actually, and they don't sell it anymore, so you have to buy the expensive stuff. That's crazy, but anyway.")
[271] *Id.*
[272] *Id.*; *see also* JX 6-iii, at 003-006.
[273] *See* JX 6, at 0211.
[274] *See* JX 4-d, C. Butler Depo. 9:21-11:3.
[275] *Id.*

accepted treatment nowadays but that it costs too much. Charles Butler has never again been treated for his HCV since the initial failed round of Inerferon over ten years ago.[276]

186. Lawrence Jenkins was diagnosed with HCV while at Angola and received a year-long course of treatment with the older medications prior to FDA approval of DAAs. He had to take shots for five days a week, every week, for a year.[277] Three months after completing the treatment, the HCV was determined to still be present. When Mr. Jenkins asked a nurse practitioner about the possibility of taking the new DAA treatments that he had seen on TV, he was told that he could not get the new treatment because a large group of people needed it and he had already been treated—even though the treatment was unsuccessful.[278] He was further told he had to wait in line so that other prisoners who had not been treated yet could get treated first.[279] Lawrence Jenkins has not received any treatment for his HCV since the failed round of earlier treatment methods approximately ten years ago.[280]

xvi. Internal pharmacy problems

187. Angola's pharmacy is cramped, cluttered, and dirty. Because Class members provide all janitorial duties at the prison but are not allowed in the pharmacy, the floors are not routinely cleaned and there is no schedule for sanitation and disinfection. Pharmacy technicians do not always wear gloves to pack medication, and inspection reports demonstrate numerous problems, from failing to record no-shows and refusals properly to corrections officers "ordering too much medication."[281]

xvii. Improper medication administration and medication administration records

188. In a proper system of medication administration, medication is administered by persons properly trained and under the supervision of the health authority and facility or program administrator or designee. Proper medication administration procedure ensures that patients receive the "5 rights of medication administration": "the right medication[,] given to the right patient, at the right dose, by the right route at the right time." Consistent, accurate, and understandable records are kept, so that medical personnel can understand what medication a given patient has taken, in what dose, and with what consistency.[282]

189. Defendants' medication administration system violates all of these requirements. Correctional officers and even inmate orderlies administer medication, leading to improper

[276] *Id.*
[277] Anticipated Testimony of Lawrence Jenkins.
[278] *Id.*
[279] *Id.*
[280] *Id.*
[281] PX 6 at 0049.
[282] *Id.* at 0049, 51-52.

administration; pill call times are inconsistent and at improper times such as 3 a.m.; and medication administration records ("MARs") are demonstrably inaccurate and inadequate.

190. First, due to the shortage of nurses or other medical professional, Defendants use correctional officers with limited training to deliver medication to the majority of patients, including in the so-called medical dormitories. LPNs administer medication only on the infirmary and in the ATU, and in some centralized pill call rooms.[283] While Defendants provide some training to correctional officers, the "level of training is simply inadequate for officers to safely administer medication to inmates" and "fails to meet NCCHC and ACA Standards," creating "a systemic risk of harm to all inmates at LSP."[284]

191. This concern "is validated by actual practice, showing that officers do not follow correct procedure and have no supervision by qualified health care professionals. This practice is dangerous and creates a systemic risk of harm to inmates at LSP." Officers do not use MARs to compare medications against what the patient was supposed to receive; do not sanitarily dispense medication; cannot answer questions about what medication was provided; and do not contemporaneously document administration to record what was given to each patient and when.[285]

192. In the so-called medical dormitories, the situation is even worse. Correctional officers conduct pill call from one spot near the door to the dormitories. Because many patients in these dormitories have mobility or vision impairments, they may not be able to access the officers. Instead, Dr. Lavespere acknowledged, inmate orderlies deliver medication to these patients.[286] This prevents correctional officers, even if properly trained, from ensuring that the five rights of medication administration are observed.[287]

193. Based on Plaintiffs' medical experts' observations, LPNs perform little better. LPNs do not always use MARs to determine what medication each patient is supposed to receive, and therefore do not ensure that the medication, dosage, and frequency match. Like correctional officers, LPNs do not contemporaneously document medication administration, instead waiting until after administration to recreate MARs from memory. "As LPNs may administer medications to more than 100 inmates, this renders MARs unreliable with respect to

[283] *Id.* at 0049-50.
[284] *Id.* at 0051; *see also, e.g.*, JX 4, T. Willis Depo. at 11:20-12:2 (correctional officers' performance of pill call is overseen by other correctional officers); *id.* at 89:11-12 (medical training not required of correctional officers), Orderly Training Manual
[285] PX 6 at 0050-51; *see also, e.g.*, JX 4-n, M. Murray Depo. at 56:19-24 (describing errors in medication administration); JX 4, C. Butler Depo. at 34:11-35:13, 36:16-37:2, 40:8-25 (describing Angola running out of medication and providing wrong medication).
[286] JX 4, R. Lavespere first 30(b)(6) Depo. at 40:23-41:12.
[287] PX 6 at 0051.

accuracy of medication administration."[288] Defendants acknowledge that it is impossible to reliably record medication after distributing medication to dozens of patients.[289]

194. Predictably, this system of administration results in inconsistent receipt of medication and wholly inadequate and unreliable documentation. MARs document patients receiving medication in their housing units at times they were in a hospital or in the infirmary. They record IV antibiotics and nebulized treatments—treatments that can only be given in person by a medical professional—as "keep-on-person" medications that are distributed to patients to take on their own. In at least one case in the experts' sample, the MAR even documented receipt of medication after a patient died. "This is essentially falsification of the health record" and shows that "LSP staff do not adhere to procedures to safely administer and document medication administration."[290]

195. As a result, health care providers cannot rely on the accuracy of MARs to make appropriate treatment decisions. Clinically appropriate provider decisions are based on knowing both the patient's current condition and the type, dosage, and consistency of medication the patient is currently taking. Without this information, providers cannot responsibly determine whether to increase or decrease dosage, add or subtract a medication, and the like.[291]

196. Similarly, when a patient appears to be noncompliant with their medication, clinically appropriate practice is for the provider to discuss obstacles to compliance with the patient, such as medication side effects, lack of understanding of the importance of the medication or the proper means to take it, or scheduling conflicts. This rarely happens, directly contributing to, among other things, the long-term uncontrolled states of many patients' chronic illnesses discussed above.[292]

j. Inadequate Diagnostic Services

197. As noted above, Angola has the ability to perform a limited number of laboratory tests and radiology examinations. However, as discussed *supra* ¶¶ 34-38, the availability of these tests is inconsistent—and when they are performed, they are often not timely reviewed by providers. This results in patients not receiving vital diagnostic tests, and in "egregious

[288] *Id.* at 0050; *see also, e.g.*, JX 4, S. Poret 9/19 Depo. at 51:16-53:4 (acknowledging that correctional officers do not complete MAR contemporaneously in cell blocks).
[289] JX 4, T. Willis Depo. at 25:7-9 ("Q: Do they ever do it [at] the end of the whole— A. There is no way you can remember that. …); *id.* at 26:2-5 ("Q: You said that's because they could not remember all of that? A. There is no way that they can. They know they have to write it down … ."); JX 4, S. Poret Depo. at 52:16-25 (Mr. Poret testifying that it would be concerning if correctional officers weren't keeping notes and were just remembering who they had given pills to, because they might make mistakes; *see also* JX 4, T. Willis Depo. at 81:6-15 (officers may see hundreds of patients for pill call).
[290] PX 6 at 0052-53; *see also* JX 4, T. Willis Depo. at 20:1-21:20, 22:7-23, 23:4-11, 24:2-25:1, 35:11-36:1 (acknowledging medication administration errors).
[291] PX 6 at 0053.
[292] *Id.* at 0053-54; JX 4, JX R. Lavespere 8/5/16 Depo. 42: 17-25.

examples of physicians not addressing abnormal labs or treating patients timely for their serious acute and chronic medical conditions." As discussed earlier, Defendants' failure to transport patients to outside providers who can perform indicated diagnostic services in critical conditions exposes patients to a serious risk of severe harm.[293]

198. In addition to these pervasive, life-threatening problems, there is evidence that Defendants are providing insufficient testing in non-critical, chronic contexts. For example, the number of capillary blood glucose tests performed annually is troublingly low in light of the prison population, and is "insufficient to assess diabetics' disease control on a daily or weekly basis."[294] Similarly, Defendants stopped performing screening colonoscopies altogether for a period of time, and still refuse to provide them for patients whose age puts them at risk of colon cancer and other serious conditions.[295]

199. Practices in the laboratory and radiology clinic themselves are also below the standard of care. The laboratory "is small for the scope of the work performed," so Defendants put "[l]ab equipment, supplies and tracking logs are placed on every counter, and it is not possible to adequately clean and disinfect countertops on a daily basis." This presents a serious risk of an infectious outbreak: "Because thousands of potentially infectious body fluids are tested on a monthly basis, it is important that the lab has adequate space to permit sanitation and disinfection of equipment and countertops on a daily basis."[296]

200. Similarly, testing logs are left open on the counters next to the machine performing the test. These logs contain confidential medical information, identifying which patients have been tested for HIV, syphilis, and other sensitive conditions that may expose patients to social or physical abuse or stigma from others in the prison. Yet inmates work in the lab and have access to this information at a glance.[297]

201. Finally, refusals are improperly recorded in the radiology clinic. Radiology staff do not obtain refusal of treatment forms, and staff do not follow up with patients who do not show up for more than two appointments. This falls below standard of care and places patients at risk;

---

[293] PX 6 at 0055-57, 65-71; *see also, e.g.*, JX 4-c, A. Brent Depo. at 71:3-73:10 (discussing that providers will not tell patient about abnormal results).
[294] PX 6 at 0055.
[295] *See* PX 58; 92 & 93 ; JX 42 (Dr. Singh on 12/13/13: "Some of the offenders at LSP were waiting for CT scan and MRI or cancer care since late 2011. … As far as I know no [colonoscopies] were done at LSP for 2 years or longer. Once access has been restored, even then we can not get all 600 colonoscopies done immediately."); PX 26 (Ms. Lamartiniere: "[W]e will temporarily suspend the entering of screening referrals [for colonoscopies] until notified by [headquarters] to resume."); *compare* JX 4, J. Collins Depo. at 78:6-9 (Dr. Collins: "You had a screening colonoscopy when you hit 50. … That's basically the requirement."); JX 4-c, A. Brent Depo. at 56:23-57:21 (61-year-old Class member requested colonoscopy and was denied by multiple doctors); JX 4-f, K. Clomburg Dep. at 69:18-71:4 (similar).
[296] PX 6 at 0054-55.
[297] *Id.* at 0056.

"staff need to follow-up to determine whether the patient refused the appointment, or an event outside the inmate['s] control was responsible for not keeping the appointment."[298]

k. Failure to Create, Maintain, and Use Adequate and Reliable Medical Records

xviii. Inadequacies of Defendants' medical records system

202. Angola has a hybrid health record system, in which most records are kept on paper but MARs and Eceptionist scheduling are kept electronically. This chaotic system has numerous flaws that increase patients' risk of mistreatment and harm:

a. First, this hybrid system is not properly integrated, leaving providers unable to readily search the record to review current medications or medication adherence, or to verify appointment scheduling and completion.[299]

b. Second, as documented above, records from specialty consultations and hospitalizations are often missing, leaving follow-up recommendations unimplemented and leaving providers in the dark as to what treatment a patient received off-site.[300]

c. Third, because many Class members are in Angola's care for years or decades, their paper records grow unwieldy, requiring records clerks to transfer "the current and most pertinent documentation" to a new medical record. Defendants' medical records policy, HC-33, provides no guidance on this, leading to a high risk—and high reality—of missing or misfiled documents.[301]

d. HC-33 is also outdated and unsigned, and appears not to have been reviewed since 2011, suggesting inattention to and failure to review the adequacy of the records department's performance.[302]

e. The proliferation of paper records is cumbersome, leading examination rooms to be full of records "in a manner that makes physical examination difficult to impossible." (This is documented in more detail *infra* ¶¶ 208-11.) Moreover, transportation to the outlying clinics is often impractical, and results in sick call, urgent, and walk-in evaluations to be performed without benefit of access to the medical record. This "lack of timely and complete health information when providers and health care staff

[298] *Id.* at 0057.
[299] *Id.* at 0058-59; *see also, e.g.*, JX 4, K. Hawkins Depo. at 14:9-15:16 (acknowledging possibility of records getting out of order and EMARs not being included in paper record).
[300] *See supra* ¶¶ 151-163; *see also, e.g.*, JX 4, R. Lavespere Ind. Depo. at 65:11-66:7 (noting that most records from outside hospitals do not become part of the paper record); *see also, e.g.*, JX 4, K. Clomburg Depo. at 39:12-40:6, 45:6-18 (describing providers not putting information about treatment or condition in medical records); JX 4, B. Prine Depo. at 41:25-42:25, 45:9-46:7 (same).
[301] PX 6 at 0058-59; JK 5-a at 0169-80 (HC-33, Offender Medical Records Policy).
[302] PX 6 at 0058; JK 5-a at 0169-80.

> evaluate patients is a serious systemic issue that places the patients at risk of outgoing harm."[303]

203. Plaintiffs' medical experts' record review identified instances of all of the problems that would be expected from this poorly managed system:

> Based on record review, there were multiple duplicate documents in the records, many misfiled paper documents, and failure to include off-site specialty and hospital discharge summaries in the medical record. Medication Administration Records (MAR) were seldom completely and consistently filed in the paper records. The MARs also frequently had no entries. These deficiencies made it impossible to determine whether the patient received medication. In many cases there were no meaningful notes; only signatures, verbal orders, telephone orders and orders for follow up appointments. Some notes written by physicians were not dated or timed and were illegible. These records were inadequate for use and place patients at risk of harm by reducing the ability of clinicians to understand the medical care being given to their patients.[304]

xix. Inadequate confidentiality and access policies

204. Additionally, Defendants do not properly ensure confidentiality of records, nor do they allow patients to see their own records.

205. As to confidentiality, HC-33 allows the Health Authority to share any "information regarding an offender's medical management with the Warden," with no restriction to situations that are necessary for medical or security purposes.[305] In addition, the use of correctional officers to administer medications gives correctional officers access to the patients' personal medical information, a serious breach of confidentiality.[306]

206. By contrast, patients themselves cannot see their own medical record. Patients can only access their medical records if specifically authorized by the Warden. Placing patients' ability to review their own medical information at the discretion of a non-medical, custodial official inhibits Class members' ability to understand their own conditions and treatment, impairing their ability to comply with treatment plans and alleviate their symptoms.[307]

l. Inadequate and Unsanitary Facilities

[303] PX 6 at 0060; *see also, e.g.*, JX 4, K. Hawkins Depo. at 23:9-24:4 (EMTs don't bring medical records to sick call; records must be transported in vans).
[304] PX 6 at 0059.
[305] JX 5-a at 0171.
[306] PX 6 at 0049-52, 60.
[307] *Id.* at 0060.

207. Finally, the facilities in which Defendants provide clinical care are inadequate and unsanitary, denying Class members adequate and confidential medical treatment.

208. Provider evaluations "mostly occur in poorly sized rooms with inadequate equipment and supplies; without adequate privacy; and without a means to sanitize hands between patients." As Plaintiffs' experts documented, examination tables are covered in medical records, blocked by doors, or lack sanitary paper. Patients are examined in chairs in some rooms, to the extent they are examined at all.[308]

209. These rooms are poorly equipped. Many of them lack critical functioning devices such as sphygmomanometers (blood pressure measures), otoscopes, ophthalmoscopes, and glucometers.[309]

210. They are also unsanitary. Sinks are often obstructed, and lack soap or hand sanitizer; in one room, there was no sink at all. And examination rooms have food and cooking devices like blenders and microwaves. "Eating and cooking in clinical examination areas is typically prohibited in health care facilities for sanitation reasons."[310]

211. Medical encounters are also rarely confidential. Doors typically remain open, depriving patients of confidential examinations. Sick call and other EMT assessments occur at patients' cells or dormitories, rather than clinical rooms where patients can disclose their medical complaints in private and confidential assessments can be performed.[311] Defendants openly dismiss the idea that Class members should be entitled to a confidential examination; in Dr. Lavespere's words, "I mean if you're in a cell with a guy, you're sitting on a toilet next to him, you know, every time you use the bathroom. … So I mean privacy, you know, I mean I don't know that that's a really big issue."[312]

(3) Inadequate Monitoring and Quality Assurance

212. These pervasive, systemic problems persist because Defendants do not engage in appropriate monitoring or quality assurance.

213. Defendants use three principal forms of monitoring and quality assurance: peer review; mortality review; and a continuous quality improvement ("CQI") program. None of the three is remotely adequate, allowing the problems demonstrated above to fester and significantly contributing to the risk of harm that Class members face.

---

[308] *Id.* at 028-29, 274-78.
[309] *Id.* at 0028, 30, 276-77.
[310] PX 6 at 0030.
[311] *Id.* at 0029, 32.
[312] JX 4, R. Lavespere Ind. Depo. at 33:13-19; *see also, e.g.*, JX 4, A. Cowan Depo. at 34:4-25 (EMT not aware of any policy requiring private examination when medical issue involves patient's genitalia).

m. Inadequate Peer Review

214. Peer review is a means to monitor the quality of provider care and thereby protect patient safety. Correctional medical systems use two main types of peer review. The first is routine monitoring of each physician, known as a performance evaluation program ("PEP"), which typically occurs every year in correctional medical programs. The second is a quasi-legal investigation "when a member of the medical staff may have committed a serious error or exhibits a serious character or behavior problem and needs to be evaluated with respect to possible reduction of privileges."[313]

215. *Neither* of these types of peer review is performed at Angola—even though the entire physician staff has been under some license restriction and some are not trained in the primary care they are performing, and even though serious medical errors resulting in patient harm and death occurs on a regular basis.[314]

216. Instead of reviewing individual providers' performance, Angola's "peer review" is an audit of the facility as a whole, which occurs roughly every other year. To perform this review, the Statewide Medical Director or a doctor elsewhere in the DOC system reviews 15 randomly selected charts from the prison. Because only 15 charts are reviewed, each provider will have on average just 2.5 records reviewed; in any given year, some physicians' work may not be reviewed at all. Moreover, although Dr. Singh testified that charts should be chosen from among the population with chronic conditions or other serious medical needs, this does not happen in practice: sentinel events and high acuity patients are not specifically sampled, so "potentially preventable outcomes are not assessed."[315]

217. As Plaintiffs' medical experts explain, this form of peer review does not identify individual physician problems; does not review a sufficient number of records; fails to address potentially preventable events or care of higher acuity patients; and fails to address patients who need specialty care but are not referred.[316]

218. There is also evidence that DOC personnel consciously refrain from identifying problems during peer review. When a peer reviewer recommended "additional medical personnel" at another DOC facility, the facility's warden urged to Dr. Singh and other DOC officials "that

[313] PX 6 at 0026.
[314] *Id.*; *see also* JX 4, R. Singh. Depo. at 233:9-234:5 (Dr. Singh acknowledging that DOC has no formal way of evaluating individual doctors' performance).
[315] PX 6 at 0026; PX 62 at 0003 (describing peer review process); JX2b; JX 4, R. Singh Depo. at 215:23-25 ("If this is being done for a physician, then the reviewer is expected to go and pull the chronic diseases … ."); *id.* at 229:4-231:16 (explaining why chronic diseases should be reviewed in particular).
[316] PX 6 at 0027.

such remarks not be included in future peer reviews" because "[i]n a subsequent suit against the institution, an offender may use that opinion as a part of his argument."[317]

219. This failure to review providers' performance and reluctance to honestly review institutional performance contributes directly to the pervasive neglect and mistreatment shown above. As Plaintiffs' medical experts summarize:

> Given the number of physicians with license problems and given that several LSP physicians are practicing primary care without primary care training, peer review needs to be thorough and rigorous. Instead, it is ineffective. We identified preventable deaths and inadequate care in almost every medical chart we reviewed. Yet, the current process does not appear to address existing problems with clinical care.

n. Inadequate Mortality Review

220. As a matter of standard clinical practice, and under NCCHC and ACA standards, all deaths must be "reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted and to identify issues that require further study."[318]

221. Mortality review at Angola, however, invariably reports no problems with patients' care—despite the serious errors and delays found in virtually every recorded death that Plaintiffs' medical experts reviewed.[319] "LSP physicians conduct a Medical Summary Report for a Deceased Offender that is typically an incomplete summary of the patient's care and does not identify whether care for the patient was timely and appropriate, does not identify problems related to systems or quality, and does not determine whether the patient's death was preventable."[320]

222. This appears to be by design: knowing that they may be liable for fatal neglect and mistakes in care, Defendants consciously refrain from "dig[ging] too deep" into concerning deaths.[321]

223. Even Defendants' expert Dr. Thomas concedes that the mortality review program is inadequate, recommending that a "non-institutional physician" be involved in the process.[322]

o. Inadequate Continuous Quality Improvement Program

---

[317] PX 285; *see also* JX 4, Park Depo. at 65:20-67:3 (unaware of peer review ever resulting in improvement).
[318] PX 6 at 0084.
[319] *See supra* ¶¶ 33-47.
[320] PX 6 at 0085; *see also* See PX 233 at 0339-0340
[321] PX 66.
[322] DX 14 at 72.

224. Finally, to monitor and improve health care, correctional medical facilities should maintain continuous quality improvement ("CQI"; also known as quality assessment/quality improvement, "QA/QI") programs. A CQI program "identifies health care aspects to be monitored, implements and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan." This requires participation by "representatives from major program areas," including the responsible physician (i.e., the Medical Director). When the committee identifies a health care problem, it should conduct "a process and/or outcome quality improvement study." It also "completes an annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative and/or staff meetings, or other pertinent CQI written materials." Without an operational CQI program, "there is a greater likelihood that quality concerns are not identified or corrected, with adverse patient outcomes."[323]

225. Plaintiffs' medical experts evaluated all Quality Improvement minutes and determined that Defendants maintain a "minimal," "ineffective" quality program that falls far below these standards. Angola's CQI program "does not appear to have support of clinical leadership, is not adequately staffed, does not identify ongoing quality concerns, and includes only a small number of nursing staff as participants."[324]

226. With rare exceptions, *only* nurses participate in CQI. In the five years of minutes produced in discovery, the Medical Director never participated in a CQI meeting or activity, nor did anyone from the medical department, EMS department, pharmacy, laboratory, radiology, or medical records departments. Even the Assistant Warden for Healthcare Services, Ms. Lamartiniere, attended just two meetings in the five-year period.[325] Angola's nurse practitioner, one of only six providers, had never heard of QI/QA taking place at LSP, even though she had participated in it at previous DOC facilities.[326]

227. The content of the meetings was also wholly deficient. Rather than identifying problems, developing improvement plans, and monitoring their implementation, the CQI committee mainly performs an identical set of studies every year. The only improvement activities that occurred were confined to nursing issues, due to the lack of participation by other departments.[327] Even after urgent warnings, like the 2014 warning that patients with strokes

---

[323] PX 6 at 0087-88; *see also* PX 265 at 0014 ("Most national standards require a comprehensive [Quality Management Program] … . The intent of a comprehensive QMP is to proactively identify issues.").
[324] PX 6 at 0088.
[325] *Id.*; PX 6 at 0007; JX 4, R. Lavespere 8/5 Ind. Depo. 80:12-81:2 (Dr. Lavespere: "Q. And do you perform any quality improvement or quality—QA/QI is what Dr. Singh called it. Do you do any of that? A. I don't.").
[326] JX 4, Park Depo. at 67:4-68:8.
[327] PX 6 at 0088-89; JX 3a; *see also, e.g.*, JX 4, S. Poret 9/19 Depo. at 101:13-22 (QA study on post-operative infections did not change behavior).

were not being sent to the hospital in time, no CQI studies and improvement plans were added.[328]

228. Even Defendants' expert Dr. Moore agrees that "[t]he CQI program is largely ineffective because it is felt that the staff doesn't understand the principles of CQI and those that are on the committee are powerless to make changes in the care provided."[329]

229. Defendants thus lack an appropriate program to identify and remediate problems. This directly contributes to the pervasive risk of severe harm—and the frequent manifestation of actual harm—that Class members consistently experience.

II. DEFENDANTS HAVE SUBJECTIVE KNOWLEDGE OF THEIR POLICIES AND PRACTICES, THEIR INADEQUACIES, AND THE RISK OF SERIOUS HARM

230. The risks of Defendants' woefully inadequate practices and policies are so long-standing, pervasive, and obvious that Defendants' knowledge cannot be in serious dispute. There is no question that Defendants know their own policies, practices, and procedures; and there is no dispute that they know about the many patients who pass away or suffer adverse events. In light of the obvious and pervasive nature of the deficiencies and the risks they create, Defendants' knowledge is well-established.

231. But even beyond the obvious and pervasive nature of the deficiencies proven by Plaintiffs, Defendants have repeatedly been warned of and acknowledged the various structural and clinical deficiencies that place Class members at risk, without taking reasonable steps to eliminate that risk.

232. Defendants have been aware for more than 25 years that their policies and practices expose inmates to a risk that they will receive inadequate health care. External investigations in 1991 and 1994 reported unconstitutional failures in the system, including most if not all of the problems that Plaintiffs' have proven today: failure to properly assess, diagnose, or treat medical problems; unacceptable delays in treatment; inadequate staffing, both in number and training; and failure to follow-up or properly refer patients for further treatment.[330]

233. These findings were supplemented by later external reviews of Angola in 2009, by medical peer reviewers in 2012 and 2014, and by numerous warnings from individual medical personnel. Indeed, Dr. Singh, then the Statewide Medical Director, observed in 2009 that the Department of Corrections was "[a]lready operating with bare minimum staff" and not adding employees could "lead to compromised health care delivery" and affect DOC's

[328] *Compare* PX 12 *with* JX 4, R. Singh. Depo. at 61:20-62:2 (acknowledging that there had been no CQI study on stroke diagnosis).
[329] DX 13 at 29.
[330] *See infra* ¶¶ 237-54.

"Constitutional obligation to provide optimal health care to inmate population."[331] As Dr. Singh put it:

> By not hiring staff now, we will end up spending more down the line in costly lawsuits such as the class action lawsuits California has faced as well as an increase in overall health care costs for the management of complications for diseases that early treatment or detection would prevent. When we are stretched thin, chances for errors are high and it is very possible for cancers and other diseases to be missed early on.[332]

234. Nonetheless, LSP has *fewer* medical employees today, despite housing roughly 1000 more inmates.[333]

235. Defendants' knowledge of the deficiencies in their practices and their disregard of the ongoing risks associated with them is established not only by these clear warnings, but by their own words and the observations of medical providers with whom they worked. On each of the issues at the heart of Plaintiffs' claim, the evidence irrefutably shows Defendants' awareness over the past several years.

236. In the face of these several sources of knowledge of the dire state of the Angola medical system, Defendants did not act to cure its deficiencies or protect Class members from its risks. Their failure to take reasonable steps to eliminate these long-standing, pervasive failures establishes deliberate indifference under the Eighth Amendment.

A. Defendants Received Repeated Warnings About Deficiencies

237. Over the past 25 years, Defendants have repeatedly been warned about the inadequate, harmful care they provided to patients within their care. These warnings came from the Department of Justice; from consultants that Defendants retained; from outside providers; and from DOC personnel themselves.

(1) Warnings from the DOJ

238. On August 8, 1989, the Civil Rights Division of the United States Department of Justice ("DOJ") began an investigation into conditions of confinement at Angola, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.[334]

---

[331] PX 67 at 0004 (also listing "high number of elderly inmates with cancer, heart disease, diabetes, HIV and other chronic diseases" and "[i]nfectious disease monitoring" as among things affected by understaffing).
[332] *Id.*; *see also id.* (acknowledging that nursing turnover rate is double the rate in California before being put under court supervision); *id.* at 0001 (acknowledging "bare minimum staff"; "Current staff is stretched thin to the point that many times they are not willing to work even with overtime … .").
[333] *See, e.g.*, PX 22 at 0002 (since 2011, "Nursing Unit Staff has not increased"); PX 6 at 17.
[334] PX 239.

239. The investigation included tours of the prison with experts; observation of conditions in the cellblocks, dormitories, and infirmary; interviews with administrators, staff and inmates; and review of records.[335]

240. On May 13, 1991, the DOJ issued a findings letter that concluded conditions at Angola deprived inmates of their constitutional rights, including the failure to provide adequate medical and psychiatric care.[336]

241. The DOJ identified "serious flaws in the provision of medical care," beginning at the intake point in the prison's healthcare system and permeating the entire process. As a result, the DOJ concluded that "inmates who need medical care and attention are not receiving it." Among the deficiencies identified by the DOJ were delays in treatment; inadequate follow-up when diagnostic tests are ordered; "grossly inadequate" treatment of chronic illness; a lack of adequately trained and sufficient numbers of staff (physicians, nurses, and security); inadequate sick call procedures; a lack of safeguards to ensure inmates receive correct medication; and insufficient health-care policies.[337]

242. The DOJ specifically found that an inmate "may wait three to five days to see a physician" because of staff shortages, and delays in treatment also occurred through scheduling errors and a failure to follow-up or refer patients to hospitals or off-site health care providers.[338]

243. On January 2, 1992, inmates at Angola filed a class action lawsuit under 42 U.S.C. § 1983 against the prison warden and the DOC secretary, alleging medical care at the prison was unconstitutionally deficient. The DOJ intervened as a plaintiff under CRIPA, and the case was tried in September 1994.[339]

244. In April 1994, Dr. Michael Puisis, acting as an expert on behalf of the DOJ, made the second of two investigatory visits to Angola. He found "serious problems in health care delivery," including "failure to follow up diagnostic testing; failure to properly examine patients; failure to perform indicated diagnostic testing; inappropriate treatment; lack of timely diagnostic testing or treatment; failure to treat in accordance with current standards … lack of review by an appropriately qualified health care person; ignorance of appropriate treatment for a given disease; and finally, callous treatment by health care personnel."[340]

245. Dr. Puisis found the aging population at Angola had a significant chronic-disease burden, and his review of medical records "demonstrated a lack of follow up and lack of timely treatment of chronic diseases." Dr. Puisis specifically noted the number of physicians was "insufficient to provide appropriate care." During his visit, every prison staff member he

[335] *Id.*
[336] *Id.* at 0002.
[337] *Id.* at 0002-04.
[338] *Id.* at 0002-03.
[339] PX 17.
[340] PX 20 at 0012.

spoke with acknowledged the number of health care personnel was "inadequate to serve the inmates."[341]

246. Dr. Puisis also noted that security officers were required to perform medical tasks; that emergency medical technicians worked "out of the scope of their training" and made medical decisions they were not trained or experienced in making; that unlicensed nursing assistants worked independently in examining patients and diagnosing illnesses; and that officers "illegally repackage[d] and dispense[d] medication."[342]

247. Also in 1994, the DOJ prepared a report of its finding based on its experts' investigations. The DOJ found significant delays in treatment because security decided the manner and time of patients' transportation, and inmates were forced to wait for excessive and unacceptable periods for elective and radiological services. Angola officials' practice of placing patients in the infirmary who should have been sent to the hospital also caused delay.[343]

248. The DOJ found that "no medical protocols exist at LSP to guide medical staff in how to recognize and treat chronic illnesses, and that there was "no screening system to detect chronic illnesses, particularly for older inmates," and concluded Defendants were "dangerously deficient in the treatment of chronic illnesses."[344]

249. The DOJ found the physician clinic was understaffed and consistently overcrowded, and that there were "critical" staffing shortages in (1) physicians, (2) licensed physician assistants (3) registered nurses, (4) licensed practical nurses, (5) a medical records professional, (6) a registered dietician, and (7) physical therapists."[345]

250. Staff physicians had "limited experience and training in recognizing and treating chronic conditions" and emergency medical technicians in charge of sick call had "no training in recognizing symptoms of chronic illnesses." The EMTs were "not adequately trained nor sufficiently experienced to recognize serious medical illness or triage sick call," and they could not differentiate "between acute, chronic, and minor illnesses."[346]

251. Angola had "no policies or procedures specifically designed to guide health care practitioners in managing care on the infirmary unit."[347]

---

[341] *Id.* at 0008-09.
[342] *Id.* at 0003-10.
[343] PX 17.
[344] *Id.* at 0008.
[345] *Id.* at 0005, 17.
[346] *Id.* at 0002, 8.
[347] *Id.* at 0007.

252. There was "no ongoing quality assurance" at the prison; officials had no program "to review, identify, and correct medication errors or to control access to the medications." No quality assurance committee or peer review system existed to monitor the quality of medical care.[348]

253. On September 24, 1998, District Court Judge Frank J. Polozola approved a settlement agreement to the 1992 lawsuit. The agreement required specific improvements to the system of medical care at Angola, including "sick call" reviews by physicians within 72 hours; the use of contemporary standards of care to diagnose, treat, monitor, and classify inmates with chronic illnesses; establishment of a quality assurance committee; provision of physical therapy; reduction of orthopedic and neurology backlogs; automatic referrals to external physicians; and the provision of "adequate medical leadership" at Angola.[349]

254. Most of the issues identified by the DOJ and Dr. Puisis still plague the medical care at Angola. In other words, Defendants have been on notice for more than two decades of the risks caused by the deficiencies that Plaintiffs have proven exist today.

(2) Warnings from Consultants

255. In 2009, Defendants retained Wexford Consulting Group ("Wexford") to assess the medical care provided at Angola and two other DOC prisons. On December 23, 2009, Wexford issued a report titled "Summary of Observations and Recommendations" that provided its conclusions from two site visits earlier that fall.[350]

256. The Wexford report noted that inmates suffered delays in health care provider appointments because of "a large number of backlogged encounters." The report suggested inmates were "not being seen in a timely fashion" and that "the sick call process would need to be examined closely"—and that "obviously this process would need intense intervention to bring it within [national] standards."[351]

257. The Wexford report also noted that security officers were engaged in distributing medications. It warned Defendants that "National standards prefer that in facilities where health care staff is on duty 24/7, medications should be administered by health care staff. … Should the facility seek accreditation, the medication administration practices would need to be looked at very closely to ensure compliance with industry standards."[352]

258. Wexford similarly noted that Defendants' Quality Management Program (a forerunner to the current CQI program) "has little structure, thus rendering it less functional than desired."[353]

---

[348] *Id.* at 0012, 16.
[349] PX 17
[350] PX 265.
[351] *Id.* at 0014.
[352] *Id.*
[353] *Id.*

259. Secretary LeBlanc and Ms. Falgout, along with then-Warden Cain and then–Statewide Medical Director Singh, all received and reviewed the Wexford report. Their follow-up discussions with other DOC personnel included various acknowledgments of the "salient points" in the report and of problems with their practices—such as the fact that even certified Medical Assistants, who have state certification that DOC correctional officers lack, "are not certified to pass medication to a large volume of people."[354]

(3) Warnings from Outside Providers

260. Outside providers have repeatedly warned Defendants of issues that were causing patient harm and delay.

261. In January 2014, for example, Defendants were notified that outside providers had to cancel many procedures and surgery dates "due to inadequate preparation and/or following of instructions," in a wide variety of settings, including cardiac catheterization labs, endoscopy, and surgical procedures. Defendant Stacye Falgout was specifically advised of the need for staff to "be aware of instructions and follow through with the specific time frames for preps, stopping [anticoagulants], adding Medications, etc…"[355]

262. In August 2014, Defendant Singh received notice from a treating physician at LSU that Angola patients were arriving at ILH with "obvious stroke symptoms" "out of the window because it either took them a while to get [there] or the medical staff at Angola did not think the inmate was having a stroke."[356] Defendants were specifically informed that stroke patients "need to get emergent care within [4.5 hours] to attempt [to] prevent severe disability," and that the patients arriving at ILH all suffered "pretty significant deficits" due to the lack of recognition and transport.[357] Despite this warning, Defendants did not warn EMTs that they were failing to recognize signs of stroke.[358]

263. Around the same time, Defendants Singh and Stacye Falgout received notice from LSU's Chairman of Oral Surgery that Angola had sent them a number of inmates "with 3 week old fractures that are already infected and thus use a lot of resources to fix something that could have been treated easily if diagnosed sooner."[359] Despite this warning, Defendants did not warn EMTs that they were failing to recognize signs of infection.[360]

B. Defendants' Own Documents and Testimony Demonstrate Defendants' Knowledge

[354] JX 403; PX 29 (Dr. Singh forward "salient points" to Secretary LeBlanc; *see also, e.g.*, PX 24 (Dr. Singh forwarding Wexford report to Warden Coin); PX 30 (Ms. Falgout discussing Wexford report).
[355] PX 142.
[356] PX 12 at 0001-2.
[357] *Id.* at 002.
[358] JX 4, Cashio Depo. at 77:9-19.
[359] PX 13 at 0001-2.
[360] JX 4, Cashio Depo. at 77:9-19.

264. In addition to the warnings they received from outside entities, Defendants themselves repeatedly acknowledged and discussed various deficiencies and harms to Class members.

265. Indeed, far from denying knowledge, Defendants have held themselves out as being aware of the faced at Angola. Dr. Lavespere testified that Dr. Singh—then the Statewide Medical Director—"knows every challenge in DOC."[361] Secretary LeBlanc testified that he is "responsible for whatever goes on in this department."[362]

266. For example, in 2009, Dr. Singh noted that the entire DOC was operating with "bare minimum staff," which he acknowledged was "taking its toll." He knew that the inadequate staffing at Angola could lead to "compromised health care delivery and possible law suits which will cost millions of dollars," and that "[w]hen we are stretched thin, chances for errors are high and it is very possible for cancers and other diseases to be missed early on."[363] Likewise, Angola's nursing director in 2010 informed a deputy warden that her department was "extremely short staffed," despite an increase in workload, which she said could cause patient care to suffer to the point of unsafe practice, including a greater risk of medication errors that could lead to patient deaths.[364]

267. However, the staffing situation is *worse* today than it was in 2010: Angola now houses over 1000 more patients than it did in 2009 and 2010, but has approximately the same number of staff.[365]

268. In 2012, Secretary LeBlanc and Dr. Singh again recognized that funding and staffing shortages would result in "delay of critical care."[366]

269. Defendants also recognized the risks of having correctional officers administering medication at least as early as August 2010. An Assistant Warden for Treatment who had trained as a nurse wrote to Dr. Singh that a nurse had caught a medication error. "Thank God a nurse found this," he wrote. "I am not as confident that a pill call officer would have even known to question this … Very serious adverse effects is an understatement. This could have been life threatening. … It is a matter of time before one of these slip through and we have a bad outcome."[367]

---

[361] JX 4, R. Lavespere Ind. Depo. at 24:5.
[362] JX 4, LeBlanc Depo. at 24:4-5.
[363] PX 67 at 0001, 4.
[364] PX 127; PX 147.
[365] PX 6 at 0017; *see also, e.g.*, PX 22 (2015 email documenting an increase in inmate population and chronic conditions while "[t]he Nursing Unit staff has not increased").
[366] PX 152
[367] PX 266.

270. Similarly, DOC personnel conducting peer review have repeatedly noted deficiencies in chronic care services, as did the 2016 ACA audit.[368] There is no sign of any changes made in response to these warnings.

271. Angola personnel have repeatedly documented such deficiencies as well. Numerous emails report backlogs, delays, and even full cessation of various types of treatment, including colonoscopies, hernia surgery, cataract surgery, CT scans, MRIs, and cancer treatment.[369]

272. Former DOC personnel have also acknowledged delays in treatment. Former Assistant Warden for Healthcare Services Kenneth Norris, who testified that patients "did not get the timely treatment" because Defendants refused to authorize hernia surgery "until, you know, it becomes a life-threatening deal."[370] Mr. Norris testified that both Dr. Singh and Warden Cain knew about the delay.[371]

273. Defendants are also well aware of the high rate of chronic medical conditions within the prison, and the increasing number of chronic diseases their patients present with—and aware that their staffing and resources have not kept pace.[372]

274. Similarly, Defendants are aware of the stunningly high mortality rate discussed *supra* ¶¶ 56-57. Defendants have repeatedly cited the BJS statistics as an authoritative source of information on the mortality rate in Louisiana's prisons.[373]

275. At the same time that they were aware of the high mortality rate and high rate of chronic disease, Defendants were aware that their health care spending was declining. Even beyond their obvious knowledge of their own budget, Defendants openly acknowledged that their health care spending declined between 2014 and 2015.[374]

C. Defendants Received Thousands of Complaints and Grievances from Class Members

[368] PX 35, 33; JX135; *see also* JX 4, Lavespere Ind. Depo. at 85:2-21 (acknowledging that peer review said they needed to update chronic care guidelines).
[369] PX 36; 37. JX 42 (Dr. Singh on 12/13/13: "Some of the offenders at LSP were waiting for CT scan and MRI or cancer care since late 2011. … As far as I know no [colonoscopies] were done at LSP for 2 years or longer. Once access has been restored, even then we can not get all 600 colonoscopies done immediately."); PX 26 (Ms. Lamartiniere: "[W]e will temporarily suspend the entering of screening referrals [for colonoscopies] until notified by [headquarters] to resume."); PX 32 (cataract backlog).
[370] JX 4, Norris Depo. at 37:13-38:5.
[371] JX 4, Norris Depo. at 70:8-13, 71:23-25.
[372] *See, e.g.*, PX 22; DX 16 at 02960.
[373] *See, e.g.*, PX 286 at 0005; *see also* JX 4, R. Singh. Depo. at 286:8-11 ("Louisiana has the highest inmate death rate in the country. This has been my concern from day one when I got on this job.").
[374] PX 286 at 0023-26.

276. Defendants were also put on notice of the dire state of their medical system by the sheer number of complaints and grievances they receive. The single largest category of administrative remedy procedure ("ARP") grievances filed at Angola is access to health care.[375] Angola receives on average 500 to 525 medical ARPs a year.[376] Between administrative remedy procedure ("ARP") filings and letters to the Assistant Warden of Health Services, Defendants receive as many as 2000 complaints a year about health care—nearly one complaint for every three Class members housed at Angola.[377]

277. Class members also alerted Defendants to problems informally, in innumerable encounters, often without result, as discussed above.[378]

278. Similarly, Plaintiffs' counsel in this case raised the issues in this lawsuit before filing in an effort to seek voluntary improvement.[379] These communications were circulated among Defendants, who reviewed them and determined not to do anything to fix the problems.[380] Indeed, Ms. Lamartiniere acknowledged receiving "numerous letters" regarding patient concerns from the Advocacy Center, Louisiana's federally mandated and state-designated Protection and Advocacy agency, and acknowledged that none of those letters had ever caused Defendants to change their practices.[381]

D. Defendants Have Been Willfully Blind to the Deficiencies of Their Policies and the Risk of Serious Harm to Class Members

279. Finally, Defendants have repeatedly sought *not* to document or learn about the harms caused by their practices.

280. As noted above, both peer review and mortality review seem calculated to avoid explicitly identifying serious problems. Mortality reviews in particular exhibit glaring omissions that suggest conscious avoidance: not one Medical Summary Report reviewed by Plaintiffs' experts reported a problem with patients' care, despite the serious errors and delays found in virtually every death that Plaintiffs' medical experts reviewed.[382] This is consistent with Dr. Singh's advice to Secretary LeBlanc not to "dig too deep" when it looks like DOC might be liable for a death.[383]

281. There is also evidence that DOC personnel consciously refrain from identifying problems during peer review. When a peer reviewer recommended "additional medical personnel" at

---

[375] DX 13 at 30.
[376] JX 4, T. Foster Depo. at 15:14-18.
[377] Rec. Doc. 194-8, 194-9.
[378] *See, e.g.*, JX 4-l, J. Marsh Depo. at 15:6-21, 18:3-15, 32:18-22 (discussing problems raised with Angola providers).
[379] PX 275.
[380] *Id.*
[381] JX 4, S. Lamartiniere Depo. at 39:11-40:3.
[382] PX 6 at 0085; *see supra* ¶¶ 33-47.
[383] PX 66.

another DOC facility, the facility's warden urged to Dr. Singh and other DOC officials "that such remarks not be included in future peer reviews" because "[i]n a subsequent suit against the institution, an offender may use that opinion as a part of his argument."[384] Sure enough, no peer reviews produced by Defendants in this suit contained any such criticism; the only negative feedback was the chronic care notes discussed *supra* ¶¶ 214-19, 270.

282. Additionally, some Defendants and DOC employees admitted that they are conscious of the need to avoid leaving a paper trail that could be used against them in litigation. This furtiveness suggests a desire to avoid liability and consciousness of guilt.

283. In summary, there is no serious dispute that Defendants were aware of their policies and practices, nor that they were aware of the harm that they caused. Nonetheless, the continued, long-standing, and dire situation persists. As former Medical Director testified when explaining why he left Angola:

> A. Well, my place wasn't here to fix DOC. … My place here was to take care of the patients.
>
> Q. Huh-huh. So it's kind of like a patient with, say, a mental health problem, they've got to maybe want to change before you can help them and –
>
> A. Exactly.
>
> Q. Would you say that the DOC similarly didn't really want to change?
>
> A. Well, if you have a cancer patient that's refusing chemo –
>
> Q. Huh-huh.
>
> A. – what are you going to do?[385]

III. Americans with Disabilities Act and Rehabilitation Act Claim

A. The subclass consists of qualified individuals with disabilities.

284. On February 26, 2018, the Court certified a subclass of "all qualified individuals with a disability, as defined by the ADA/RA, who are now, or will be in the future, incarcerated at LSP."[386] Warden Donald Barr, who served as ADA Coordinator in the summer of 2016, testified that at Angola, "there is all sorts of disabilities. . . . You have prisoners who have hearing problems, prisoners who have limb problems, walking, hearing, and visual and things of those natures."[387] Tracy Falgout, who assumed the role of ADA Coordinator after

[384] PX 285; *see also* JX 4, Park Depo. at 65:20-67:3 (unaware of peer review ever resulting in improvement).
[385] JX 4, J. Collins Depo. at 124:20-125:9.
[386] Rec. Doc. 394.
[387] JX 4, D. Barr at 12:13-17.

Warden Barr's retirement, similarly confirmed that Angola's population includes wheelchair-bound patients, including individuals who are paraplegic.[388] Aaron Brent, a former inmate health care orderly in one of Angola's so-called "medical dorms," testified that his responsibilities involved caring for 29 or 30 patients in wheelchairs, as well as other patients who used walkers or had cognitive impairments.[389] Angola's own tracking database reflects some 1445 auxiliary aids or other devices provided to patients with disabilities.[390] Additionally, several named plaintiffs and Class members testified regarding their disabilities.

B. Angola Denies Programmatic Access to and Discriminates Against Individuals with Disabilities

285. In a prison setting such as Angola, individuals with disabilities depend on the facility to provide essential services such as housing, toilets and showers, meals, transportation, and medical services, as well as various other programs and activities, including education classes, religious services, recreational facilities and programs, and hobby craft. The Department's own orientation materials confirm that "[t]he ADA thus affects Corrections decisions regarding offender housing, indoor and outdoor recreations, shower and toilet facilities, access to the courts, medical services, disciplinary hearings, telephone and canteen privileges, visitation programs, education, vocation and counseling programs, as well as therapy, substance abuse treatment, and work release." Warden Richard Peabody, who served as ADA Coordinator until mid-2016, described several of these services, including vocational training, religious services, medical services, access to inmate counsel, and recreational activities.

286. The Department denies programmatic access to and discriminates against individuals in five key respects.

(1) Architectural Barriers to Angola's Programs, Services, and Activities

287. Plaintiffs' ADA expert, Mark Mazz, has over 30 years of experience as an architect and architectural accessibility consultant, including three years in the Department of Justice's Disability Rights Section.[391] In his practice, he regularly assesses facilities' compliance with the requirement under ADA Title II and Section 504 of the Rehabilitation Act to ensure that their programs, services, and activities are accessible to individuals with disabilities (the "programmatic access" requirement).[392] His work includes reviews of correctional facilities in approximately ten states, as well as other Section 504 and ADA Title II barriers assessment

[388] JX 4, T. Falgout Oct. Depo. at 17:10-11, 13-14.
[389] JX 4-c, A. Brent Depo. at 76:5-23.
[390] JX12-b at 2 (ADA Tracking Database). (Of the 2339 "auxiliary aids" in the database, 894 are listed as "none.")
[391] PX 7, ("Mazz Report") at 0002.
[392] *Id.*

and transition plans.[393] Mazz has served as a consultant or expert on behalf of the Department of Justice as well as private litigants.[394]

288. Mazz was not told which parts of Angola's facilities were constructed or altered after the Uniform Federal Accessibility Standards went into effect on March 7, 1988, or after the 1991 ADA Standards for Accessible Design went into effect on January 26, 1992.[395] However, he limited his survey to areas that are used by individuals with disabilities to access Angola's programs, services, and activities, and therefore would be subject to Title II and Section 504's programmatic access requirement, regardless of the dates of construction or alteration.[396] Specifically, he surveyed Dormitories Ash 2 and Cypress 2, as well as the accessible routes from those dormitories to the public check-in desk, associated recreation yards, van transit parking, law library, and visiting area.[397] He also surveyed portions of the visiting area and law library used by residents of those dormitories. Ash 2 and Cypress 2 are known as "medical dormitories" or "offender assistance dormitories," which are used to house individuals with mobility impairments and other disabilities.[398] Mazz also surveyed Dormitory 1 at Camp F, which is a trustee dorm that also has been used to house blind individuals.[399] Additionally, Mazz reviewed various cells and showers in Angola's Transition Unit ("TU"),[400] including in the Protection Tier and Mental Health Tier. Defendants describe the TU as a transitional housing area for individuals with severe mental illness or developmental disabilities.[401] The TU houses individuals in wheelchairs, including Named Plaintiff Reginald George.[402] Finally, Mazz surveyed Wards I and II on the Nursing Unit at the R.E. Barrow Treatment Center.[403] Ward I operates as Angola's infirmary, while Ward II houses patients requiring long-term nursing care and assistance with basic life functions, including Angola's hospice patients.[404]

---

[393] *Id.*
[394] *Id.* at 16.
[395] *Id.* at 8. Mr. Mazz noted, however, that most of the toilet rooms and showers and the flooring in the cafeteria and visiting area that he surveyed appeared to have been altered since 1992, *id.*, and Defendants' architectural expert, Brian Nolan, did not dispute this finding. *See* Expert Report of Brian Nolan ("Nolan Report"). PX 18.
[396] PX 7 at 0009, 0005.
[397] *Id.* at
[398] JX 4-c, A. Brent Depo. at 7517-:76-23 (identifying Ash 2 and Cypress 2 as the dormitories housing disabled individuals receiving care from inmate health care orderlies); JX6-eee (LSP Directive 13.088) at 1 (establishing offender assistance dormitories to provide housing "for offenders who require assistance with activities of daily living").
[399] Anticipated Trial testimony of John Tonubbee.
[400] In his report, Mazz identified the TU as the "Treatment Unit," consistent with the floor plans that were provided to him. JX 7 at 9.
[401] DX 567 at 3.
[402] PX 231.
[403] PX 18 at 0009.
[404] JX 6-v (LSP Directive 13.033 – REBTC Nursing Units), at 1-3; JX7-b at 1 (stating that "severely handicapped inmates" will be housed at the Treatment Center).

289. Mazz identified programmatic access barriers by noting instances in which the areas used by individuals with disabilities fall short of the 1991 ADA Standards for Accessible Design.[405] In his report, he identifies 190 architectural barriers impeding independent access to a range of programs, services, and activities, including housing, toilets, showers, phones, JPay stations,[406] common areas, drinking fountains, recreation areas, transportation, the law library, visiting areas, medication administration, meals, medical services, and mail services. Specifically, Mazz found that:

a. The accessible route between dormitories and other facilities have many wide gaps that are not covered that can cause the caster wheels on wheelchairs to snag and spill an inmate onto the floor.

b. The accessible route between dormitories and other facilities have several abrupt changes in level which can trip inmates who have trouble lifting their feet and can snag a caster wheel on a wheelchair.

c. Drinking fountains are not paired. Consequently, either the drinking fountain is too high for an inmate in a wheelchair or too low for an inmate who is unable to bend over.

d. The undersides of objects, such as counters, are too high and project too far from the wall for inmates with vision impairments to detect with their canes.

e. Sign-in desks and counters are out of reach for a person in a wheelchair.

f. The paved accessible routes to the recreation yards stop well before the recreation areas, preventing inmates in wheelchairs from independently using the facilities.

g. Many visitors in wheelchairs lack the use of a toilet room in that the toilets, lavatories, mirrors, and dispensers are inaccessible.

---

[405] Mazz testified that he has applied this methodology in every barriers assessment he has performed in which the construction or alteration dates of the facilities were not known, including during his time at the Department of Justice. Anticipated Trial Testimony of Mazz .Mazz also reviewed a letter from the DOJ detailing the results of its own assessment of Angola's compliance with the programmatic access requirement. PX007.0008. He noted that the DOJ's analysis "follows the same methodology for determining whether spaces provide program access." *Id.* at PX007.0009. *See also* PX 399 at 0001 (DOJ Letter) (stating that "the Department surveyed LSP – Angola to determine whether the facilities are operated so that each program, service, or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities"); PX399.0011–0028 (Attachment A) (identifying barriers to programmatic access by reference to the ADA Standards for Accessible Design).

[406] JPay stations are used by inmates at Angola to send and receive email, receive money from friends and family, and download music.

h. In the visiting area, many inmates in wheelchairs lack an accessible toilet room in that the door is too narrow, the space around the door is too constricted to open the door, and the lavatory and toilet have no accessible features.

i. Many ramps lack edge protection such that inmates in wheelchairs or using crutches may stumble at the sides of ramps.

j. Many ramps lack accessible handrails making it more difficult for an inmate with balance or stamina issues to use the ramps without falling.

k. Some ramps are too steep for many inmates in wheelchairs to use independently.

l. In some locations, mail slots are out of reach for many inmates in wheelchairs.

m. TTY's were not available in the dormitories of inmates with hearing impairments to use. Additionally, shelves were not provided for the TTY's.

n. In several locations, stools at the J-Pay stations blocked access for an inmate using a wheelchair.

o. In several medical dormitory bathrooms and nursing unit bathrooms:

Ramps at the entrance were too steep for many inmates in wheelchairs to use.

Urinals were too high to use from a wheelchair.

Mirrors are too high for inmates in wheelchairs.

Lavatories are unusable for many inmates in wheelchairs because they lack any accessible features; lack adequate knee and toe underneath; or lack pipe insulation to protect against abrasive edges.

Toilets are unusable for many inmates in wheelchairs and many inmates who have difficulties with balance or standing from a seated position because grab bars are missing, too short, or otherwise noncompliant; the toilets were too low or too close to the wall; or the space around the toilet is too constricted.

Showers are unusable for many inmates in wheelchairs and many inmates who have difficulties with balance or standing from a seated position because seats are in the wrong place; grab bars are missing, too short, or otherwise noncompliant; controls are inaccessible; or the space adjacent to the shower is too small.

Bathtubs are unusable for many inmates in wheelchairs because they lack any accessible features including seats, noncompliant grab bars, or controls not within reach.

p. The Protection Tier shower is unusable for many inmates in wheelchairs because the controls are out of reach, grab bars are too short and missing on one wall, and there is no handheld shower spray or showerhead low enough to use in a seated position.

q. The Extended Lockdown shower is unusable for inmates in wheelchairs because it lacks any accessible features.

r. The Extended Lockdown cell is unusable for many inmates in wheelchairs because the door is too narrow, the mirror is too high, the toilet and lavatory lack any accessible features, and the window control is out of reach.

s. The Protection Tier cells appear to be identical to the Extended Lockdown cells. Therefore, the Protection Tier cell is also unusable for many inmates in wheelchairs for the same reasons.

t. Time Out Cell B has no accessible features. Therefore, it is unusable for many inmates in wheelchairs.

u. The entry doors to Nursing Units 1 and 2 are not accessible because they are too narrow through one leaf for many inmates in wheelchairs to use independently.

v. The doors from Nursing Units 1 and 2 to the yard lack sufficient maneuvering space beside the latchside of the doors for many inmates in wheelchairs to use independently.[407]

290. Viewing these areas in their totality, and based on his experience and understanding of the ADA and RA's program access requirements, Mazz concluded that Angola is not accessible to individuals with disabilities, or to visitors with disabilities.[408]

291. The Department does not dispute these findings. Its expert, Brian Nolan, reviewed Mazz's findings, including the photographs of each violation that were attached to his report.[409] He "substantiate[d] the items recorded in the . . . Mazz report as being violations of the 1991 and 2010 ADA Standards for Accessible Design."[410] Darryl Vannoy, the Warden of Angola, admitted that "Angola has a lot of work to do on a physical plant to be ADA, to meet the ADA requirements."[411] Similarly, former ADA Coordinator Donald Barr acknowledged that there were "access problems for wheelchairs within the main prison" at the time the Department of Justice conducted a review of Angola's facilities.[412] Finally, while Angola's own policies require the medical dormitories to be "handicap accessible,"[413] the Department

[407] *Id.* at 9-11; *see also id.* at 18-39 (Attachment 2 to PX 7).
[408] *Id.* at 11.
[409] PX 18 at PX18.0001.
[410] *Id.* at PX18.0002.
[411] JX 4, D. Vannoy Depo. at 71:18-20.
[412] JX 4, D. Barr Depo. at 39:5-9.
[413] JX 6-eee (LSP Directive 13.088) at 1.

has acknowledged that Angola is "operating Medical Dorms in dormitories designed for general population."[414]

292. The testimony of several Named Plaintiffs and Class members confirms that Angola's programs, services, and activities are difficult to access in these spaces. For example, Class member Benny Prine, who lives in a medical dormitory, indicated that only one wheelchair can fit in the bathroom at a time.[415] He also explained that his dorm houses a maximum of 86 people, approximately 25 of whom are in wheelchairs, but only one of the five showers is even intended to be handicap accessible.[416]Aaron Brent, a former health care orderly, testified that the showers in Ash 2 were not usable for patients with disabilities, in part because there were "showers you couldn't reach."[417]

293. Angola assigns inmate health care orderlies to the medical dorms and Wards I and II. The orderlies are charged with the task of assisting sick and disabled patients with the activities of daily living.[418] Health care orderlies are not assigned to other areas of the facility, such as the Camp F dormitories and the Transition Unit.[419] The health care orderlies assigned to the wards and medical dorms are not an adequate substitute for removing architectural barriers. Requiring patients with disabilities to rely on other inmates for assistance leaves them vulnerable to neglect, exploitation, or abuse. Tracy Falgout, who testified on behalf of the Department regarding the training and qualifications of health care orderlies, acknowledged that orderlies may have "different angles" when joining the program and may try to "strong-arm" vulnerable patients.[420] He further acknowledged a prison culture of "not being a rat," and that there may be consequences for patients or orderlies who report misconduct.[421] Falgout advises patients and orderlies to "figure out a way to get it to somebody who can take care of it," but admits that "sometimes it just is going to be what it is," and "somebody out there is not doing what they are supposed to be doing."[422] Falgout acknowledged that he is "continually training" new orderlies because "we do have that percentage of guys who don't play by the rules."[423] Falgout acknowledged that at least one orderly has been accused by a patient of sexual assault,[424] while admitting that such complaints generally would go to security, such that he might not be aware of other allegations.[425]

---

[414] PX 15 at 0002 (Proposal to Open EHCC Building Four").
[415] JX 4-q, B. Prine Depo. at 67:10-25.
[416] *Id.* at 78:12-79:12.
[417] JX 4-c, A. Brent Depo. at 32:10-33:10.
[418] JX 6-eee at 1-2; JX 6-vv (LSP Directive 13.076 – Use of Offenders in Health Care) at 0001-0002.
[419] Anticipated Trial Testimony of J. Tonubbee.
[420] JX 4 at 27:25-28:7.
[421] *Id.* at 28:12-16.
[422] *Id.* at 28:17-25.
[423] *Id.* at 34:2-4.
[424] *Id.* at 41:4-14.
[425] *Id.* at 33:12-18; 34:16-24; 42:1-13.

294. Several Class members testified about experiences in which they had difficulty obtaining help from their assigned orderlies. For example, class member Benny Prine testified that he struggles to convince most of the orderlies in his medical dormitory to push him to his call-outs unless he gives them something, even though they are being paid for their work.[426] On multiple occasions, he has attempted to push himself when no one would help him, only to be stopped by security.[427] Deceased Named Plaintiff Shannon Hurd testified via video deposition that many orderlies on Ward II did not fulfill their responsibilities and were simply in the program for the air conditioning that was available on the ward.[428] Brent testified that he had to report orderlies who did not perform their jobs and needed to be removed from the program.[429]

295. Additionally, the number of orderlies is insufficient to ensure meaningful access. Aaron Brent, a former health care orderly in Ash 2, testified that he and three other orderlies were responsible for 43 patients requiring assistance, including 29 or 30 in wheelchairs, and others who used walkers.[430] In addition to providing patients with assistance in performing the activities of daily living, such as bathing and getting in and out of bed, Brent and the other orderlies were responsible for distributing meals, changing bed linens, counseling patients regarding their medication, providing emotional support to patients, delivering patients to religious services, scheduled medical appointments and unscheduled emergency visits to the ATU, and actually attending appointments with patients.[431] Multiple Class members testified that the orderlies were short-staffed and that patients simply have to wait their turn for assistance. One Class member complained in an ARP of being unable to access services such as the library due to his "wheelchair pusher" being unavailable, only to be told that he should push himself.[432] Another Class member's request for a wheelchair pusher went completely ignored.[433]

296. Finally, the lack of accessible facilities puts patients at risk of injury, regardless of the availability of health care orderlies. Class member Benny Prine testified that he was being pushed down a ramp in his chair when a gap in the pavement caught one of the leg rests, bending it beyond repair and nearly flipping him out of the chair.[434] One wheelchair-bound patient reported falling out of his chair on the ramp to the West Yard kitchen at Main Prison.[435] Brent testified that multiple wheelchair-bound residents of Ash 2 had fallen off the raised walk along the side of the dormitory, requiring emergency transport to the hospital.[436]

---

[426] JX 4-q, B. Prine Depo. at 71:25-72:5, 74:10-14.
[427] *Id.* at 74:19-75:1.
[428] JX 4 (Deposition of Shannon Hurd) ("Hurd Depo.) at 60:25-61:4.
[429] JX 4 at 46:5-22.
[430] JX 4 (Brent Depo.) at 75:18-76:23.
[431] *Id.* at 34:7-19; 35:16-36:10; 42:2-14; 68:7-70:8; 75:17-76:4; 76:24-77:15.
[432] PX 231.1936-1940 (ARP of Larry Lofton).
[433] PX 231.1995-1996 (ARP of Tom Phillips).
[434] JX 4-q, B. Prine Depo. at 64:12-65:2.
[435] PX 231 at 2263-2265 (ARP of James Weber).
[436] JX 4–c, A. Brent Depo. at 78:4-80:21.

Brent even drew up plans for a guard rail, but his suggestion was ignored.[437] Similarly, patients who wish to shower or toilet independently may slip and fall, or an orderly rendering assistance may be unable to prevent a fall, placing both the orderly and patient at risk of injury. Numerous Class members with disabilities have filed ARPs reporting injuries sustained in showers lacking accessible features, or expressing concerns about the potential for injury.[438]

297. Even setting aside the risks, the lack of accessible showers and toilets forces individuals who otherwise would be able to shower and toilet independently to rely on the assistance of other inmates in the performance of these intimate functions. The photographs provided by Mazz show that even in the medical dorms, which are designated housing for individuals with disabilities, only one shower and one toilet have anything approximating accessible features, and even those are not compliant.[439] The prison's own policies appear to acknowledge the importance of providing facilities that enable patients with disabilities to perform self-care and personal hygiene with the same level of privacy afforded to other inmates within their security classification.[440]

298. The programs, services, and activities identified in Mazz's report either are not or cannot be made accessible by bringing them to the disabled individual. For example, the outdoor recreation areas cannot be brought inside, and the JPay stations, which are mounted to the wall,[441] cannot be moved to accessible areas for use by individuals in wheelchairs. Despite the name, medical services are not provided in the medical dorms,[442] and it goes without saying that the showers and toilets cannot be brought to a patient.

(2) Failure to Integrate Individuals with Disabilities

299. As discussed above, individuals with physical disabilities are clustered in the medical dormitories and Ward II.[443] The services provided to individuals in the medical dorms are insufficient to justify the practice of clustering them in one location. First, as explained above, the dorms were designed for the general population and are not accessible. Second, LSP policies indicate that certain medical services, such as dressing changes, are to be rendered in the medical dorms.[444] In practice, orderlies transport patients to the ATU for

[437] *Id.*
[438] *See, e.g.*, PX 231 at 2358-2364, 2437-2439 (ARP of James Weber); PX 231 at 1794-1809 (ARP of Cedric Howard); PX 231 at 1609-1613 (ARP of Shaundrick Gould); PX 231 at 1846-1855 (ARP of Ernest Jenkins); PX 231 at 1887 (ARP of Terry Kelly);
[439] PX 7.
[440] JX 7-b at 1 ("Equipment and facilities and the support necessary for inmates with disabilities to perform self-care and personal hygiene in a reasonably private environment will be provided as allowed by security.").
[441] PX 7 at 0016.
[442] JX 4–c, A. Brent Depo. at 73:25-74:7.
[443] JX 7b at 0001, JX 6-eee, at 0001-02. *See also* JX4, D. Barr Depo. at 49:10-18 (deaf inmates housed in medical dorms); JX 4, T. Falgout Aug. Depo. at 119:3-7 (blind inmates housed in medical dorms).
[444] LSP Directive 13.088 at 2.

these services. Neither doctors nor nurses make rounds in the medical dorms.[445] Health care orderlies in the dorms receive no supervision from medical staff.[446]Additionally, individuals with disabilities who are otherwise healthy are sometimes placed in the isolation cells on the ward due to the lack of accessible cells elsewhere in the prison.[447]

(3) Failure to Provide Reasonable Accommodations or Modifications

300. The Department has acknowledged its obligation to provide assistive equipment and devices and make other reasonable accommodations. Regulation B-08-010 provides that "[a]ccess to housing, programs, and services includes the initiation and provision of reasonable accommodations including, but not limited to facility modifications, assistive equipment and devices and interpreter services."[448] Falgout, testifying on behalf of the Department, acknowledged that this obligation extends to accommodations such as "amplification for hearing impairment, canes, walkers, [and] wheelchairs for physical disabilities."[449] However, Angola regularly denies such accommodations to individuals who need them.

a. Denial of Assistive Devices and Auxiliary Aids

301. Angola fails to provide qualified individuals with assistive devices, auxiliary aids, and adaptive training. For example:

a. The Department's own health care policies require the provision of hearing aids when medically necessary.[450] However, testifying on behalf of the Department, Tracy Falgout stated that Angola does not provide hearing aids in any circumstances.[451]

b. Plaintiffs' medical experts observed that the number of diabetic testing strips available at Angola was insufficient for the population.[452] Class member Adrian Dunn testified that he has been denied Accu-checks while housed in the outer camps at Angola and was "shooting [his] insulin blind."[453] On multiple occasions he had to make sick call in order to obtain the strips, which would take approximately two weeks.[454]

c. Class member Derrick Woodberry testified that he had been prescribed a donut and sitz bath for his debilitating hemorrhoids, but when Nurse Cynthia Park called

[445] JX 4-c, A. Brent Depo. at 73:25-76:4.
[446] JX 4,T. Falgout Aug. Depo. at 12:13-13:15; 14:1-6.
[447] JX 4, K. Hart Depo. at 31:15-33:3, 34:7-11.
[448] JX 5-d at pp. 1-2. *Accord* JX 7-a at 0002.
[449] JX 4, T. Falgout Depo. at 12:10-14.
[450] JX 5-a, at 0105 (HC-16).
[451] JX 4, T. Falgout Aug. Depo. at 108:18-20.
[452]
[453] JX 4-h, A. Dunn Depo. at 18:21-19:10.
[454] *Id.* at 20:25-22:12.

Central Supply, she was told that they would not order them unless Woodberry was placed on the ward.[455]

d. Karl Clomburg, who developed a hole in the bottom of his foot, had a pair of healing sandals taken away from him and replaced with a pair of diabetic shoes in the wrong size.[456] He also requested toe spacers to help with his hammer toe and was told by a nurse that the prison didn't carry them, but another patient in his dorm was given a set of spacers the same day.[457]

e. Testifying on behalf the Department, Falgout was unsure how often or when the last course in American Sign Language was offered at Angola.[458]

f. Both Falgout and former ADA Coordinator Donald Barr testified that they were unaware of any materials available in Braille, including books, the Request for Accommodation form, informational materials provided at intake, and materials informing inmates of their rights under the Prison Rape Elimination Act.[459]

g. Barr was not aware of any adaptive training given to prisoners who become blind while at Angola.[460] Falgout likewise could not recall any Braille classes being offered at the prison.[461] He recalled just one individual who had received adaptive training in the use of a tapping cane, because the individual did not trust the orderlies to move him around the prison.[462] Former ADA Coordinator Richard Peabody independently recalled that the only blind inmate who had received any accommodations, including a planned adaptive training on the use of a tapping cane, was an individual who had threatened or actually filed a lawsuit.[463]

h. For his part, Warden Barr did not even know the difference between a walking cane and a tapping cane, and he was not sure if tapping canes were provided by the prison.[464]

302. Rather than provide the appropriate accommodations, Angola often relies on its inmates, including untrained ones, to step in and provide assistance to disabled individuals. For example, former ADA Coordinator Richard Peabody described a "fairly informal" system in which blind individuals "generally will have someone in the dorm that's willing to help

[455] JX 4-u, D. Woodberry Depo. at 20:15-21:6, 41:6-42:15, 45:20-46:11.
[456] JX 4-f, K. Clomburg Depo. at 34:6-17.
[457] *Id.* at 63:14-64:20.
[458] JX 4, Falgout Aug. Depo. at 105:10-14.
[459] JX 4, D. Barr Depo. at 43:14-24, 52:2-11; JX4? (Aug. Falgout Tr.) at 98:8-22, 115:7-14.
[460] JX 4, D. Barr Depo. 17:4-17
[461] JX 4 (Aug. Falgout Tr.) at 115:4-6.
[462] JX 4 (Oct. Falgout Tr.) at 34:15-20, 35:8-16.
[463] *Id.* at 21:1-3, 24:5-17, 28:24-29:19, 35:19-25.
[464] JX 4, D. Barr Depo. at 42:24-43:7.

them."[465] Aaron Brent testified that his responsibilities included helping blind patients from their beds to the bathroom.[466] As stated above, forcing individuals with disabilities to rely on other inmates—especially untrained ones—for assistance with basic functions such as navigating their dormitory leaves those individuals vulnerable to neglect or abuse. Indeed, the use of untrained inmates violates Angola's own policies.[467]

b. Denial of Assistance with Insulin Administration

303. Class member Adrian Dunn testified that he was forced to administer his own insulin even though he had received no training on how to do it and could not see well due to his failing eyesight.[468]

c. Failure to Accommodate Disabilities in Work Assignments

304. Individuals with disabilities may request a restricted "duty status," which establishes limitations on the types of work they may be required to perform.[469] In practice, many individuals with disabilities face arbitrary denials or revocations of their duty status. For example, Dunn, who suffers from asthma and diabetes, had his out-of-field duty status revoked after 13 years, despite the fact that he continued to have regular asthma attacks that were exacerbated by dust.[470] Karl Clomburg, who developed a blister on his foot that limited his mobility, was denied a restricted duty status despite the podiatrist's recommendation that he stay off the foot, which caused the blister to develop into an ulcer that took four and a half years to heal.[471] Jason Hacker was denied a restricted duty status and forced to work in the field despite a medical determination that he was blind.[472] Testifying on behalf of the Department, former ADA Coordinator Richard Peabody admitted that this was "inappropriate" and that he had no explanation as to why Hacker was still in the field.[473] Michael Johnson testified that he suffers from blackouts due to a head injury and was issued a permanent duty status at Elayn Hunt Correctional Center, only to have it taken away at Angola, where he was told he would be written up if he refused to work in the field.[474]

305. Even when a patient is granted a restricted duty status, security officials, who determine job assignments, often misapply or fail to respect those restrictions. For example, Hymel

---

[465] JX 4, R. Peabody 4/22/15 Depo. at 27:25-28:17. Peabody stated that he had gained this understanding "just from talking to different inmates over time." *Id.* at 28:18-20.
[466] JX 4-c, A. Brent Depo. at 34:18-19.
[467] (LSP Directive 07.004) ("Only appropriately trained staff and inmates will be assigned to assist a disabled inmate who cannot otherwise perform basic life functions.").
[468] JX 4-h, A. Dunn Depo. at 16:23-18:6.
[469] JX 5-a at 281-283 (HC-15 – Duty Status Classification System); JX6-oo (LSP Directive 13.063 – Duty Status Classification System);
[470] JX 4-h, A. Dunn Depo. at 27:10-23; 28:18-29:25.
[471] JX 4-f, K. Clomburg Depo. at 26:14-30:7.
[472] JX 4-i, J. Hacker Depo. at 55:7-58:11.
[473] JX 4 R. Peabody 4/22/16 Depo. at 87:14-21.
[474] JX 4-j, M. Johnson Depo. at 10:5-21.

Varnado testified that he was required to lift heavy locker boxes as part of his job, despite having a duty status restriction of no heavy lifting.[475] Charles Butler similarly testified that security "very often" fails to respect his restricted duty status.[476] This is unsurprising, as security officers do not know how to interpret duty statuses when assigning jobs.[477] Testifying on behalf of the Department, Falgout acknowledged that it was "always a possibility" that security could misunderstand the medical staff's intent in issuing the duty status.[478] However, there are no checks on security to ensure that they are correctly interpreting and applying duty statuses.[479] Nonetheless, an individual who fails to perform his work in a satisfactory manner can be written up for an aggravated work offense and placed in lockdown.[480] Despite the potential for retaliation or discipline, Falgout could not think of any reason why an individual might be hesitant to report that his duty status is being violated.[481]

d. Failure to Accommodate Dietary Needs

306. Numerous Class members testified that they either were denied necessary accommodations in their diets, or were prescribed special diets but did not receive those diets in practice. Dunn testified that he is prescribed a diabetic diet, but frequently has to eat regular food due to what he presumes are paperwork mixups.[482] Clomburg testified that he rarely is able to eat vegetables, because the prison primarily serves cabbage and greens, which are not medically indicated for patients taking Coumadin.[483]Additionally, Class members who are prescribed special diets have observed that the food is often identical to the regular diet.[484]

e. Failure to Accommodate Disabilities When Transporting Patients

307. The prison transports patients to medical appointments in vehicles that are not equipped to accommodate their disabilities. Class members are anticipated to testify at trial regarding their experiences with inappropriate transportation. Additionally, Benny Prine, who uses a wheelchair, testified at deposition that he has been transported off-site for medical appointments on two occasions. Both times, he was forced to sit in the back of a regular van with his knees bent, when he normally kept one leg extended in his chair.[485] Hymel Varnado testified that he was transported to the hospital in a regular van, handcuffed and shackled, while suffering from a ruptured spleen and internal bleeding.[486] After surgery, he was

[475] JX 4-t, H. Varnado Depo. at 21:8-23:23.
[476] JX 4-d, C. Butler Depo. at 43:8-18; Anticipated Trial Testimony of Charles Butler.
[477] JX 4, T. Falgout Oct. Depo. at 45:16-18.
[478] *Id.* at 45:19-23.
[479] *Id.* at 46:9-12.
[480] JX 4 R. Peabody Depo. at 88:14-19.
[481] JX 4 T. Falgout Depo. at 61:11-16.
[482] JX 4-h, A. Dunn Depo.) at 22:13-17.
[483] JX 4-f, K. Clomburg Depo. at 58:19-59:8.
[484] JX 4-d, C. Butler Depo. at 32:6-25.
[485] JX 4-q, B. Prine Depo. at 84:3-86:6.
[486] JX4-t, H. Varnado Depo. at 31:21-33:1.

returned to Angola in the back of a car.[487] The Department has long been aware of this issue, as it was raised by the DOJ in January 2016 following its review of Angola's facilities.[488]

f. Lack of Accommodations in Prison Procedures

308. The testimony of the Department's own employees reveals that Angola regularly fails to accommodate individuals with disabilities when establishing and enforcing prison procedures. Former ADA Coordinator Donald Barr could not identify any accommodations made for deaf prisoners during pill call, sick call, or head count.[489] He further testified that no special consideration is given to individuals with disabilities in the prison's procedures for preventing and enabling reporting of prison rape, and he did not believe inmates with disabilities would be at special risk of abuse.[490] Testifying on behalf of the Department, Tracy Falgout could not identify any accommodations made for blind individuals during pill call,[491] and he did not know how a blind person would file an ARP.[492] Even in the medical dorms, Angola's evacuation plans include no provisions regarding the safe evacuation of individuals with disabilities.[493] Former health care orderly Aaron Brent described how patients in wheelchairs were at risk of falling off the ledge of the walk on Ash 2 during fire drills, and at least two patients had fallen off the ledge in the past.[494]

309. When an individual explicitly requests an accommodation with respect to prison procedures, he is often ignored. For example, when Class member Earl Peters requested an exemption from lifting his heavy locker box, he was simply told that this was "not an ADA issue."[495]

g. Lack of Accommodations in Discipline

310. Angola's ADA Coordinators and medical staff testified that they do not intervene in disciplinary decisions made by security, even if an individual's disability is the cause of the infraction or the disciplinary measure poses a risk to the individual. Tracy Falgout testified that it is up to security to determine whether a particular disciplinary measure may be used with a paraplegic, blind, or deaf individual.[496] As ADA Coordinator, he was not involved in deciding whether or how an individual with a disability would be disciplined, "because that's the job of security and the process of the disciplinary board."[497] Similarly, Warden Barr

[487] *Id.* at 33:11-34:13.
[488] PX 399 at 0004 (DOJ Letter) (noting that programmatic barriers include "the failure to provide accessible transportation to transport inmates with disabilities to the medical infirmary and other areas").
[489] JX 4, D. Barr Depo. at 50:9-51:7.
[490] *Id.* at 51:13-52:1.
[491] JX 4, T. Falgout at 119:22-24.
[492] *Id.* at 119:25-120:1.
[493] PX 16 at 0001-0014.
[494] JX 4-c, A. Brent Depo. at 78:4-80:21.
[495] JX 4 D. Barr Depo. at 19:16-22, 20:23-21:5, 21:15-22:3.
[496] JX 4, T. Falgout Aug. Depo. at 123:12-19.
[497] JX 4, T. Falgout Oct. Depo.) at 14:20-15:13.

testified that he did not get involved in disciplinary proceedings involving mentally ill individuals and would not be aware of any such determinations unless the disciplinary board decided to alert him.[498] Nurse Practitioner Cynthia Park likewise indicated that it is "not [her] situation to be able to intervene" in disciplinary decisions,[499] and because she is not security, it is not up to her whether a patient gets placed in a locked room, regardless of their medical condition.[500] This lack of oversight places individuals with disabilities at risk of harm. For example, Plaintiffs' medical experts noted the case of a paraplegic patient who was placed in a locked isolation room on the ward with no call system and no way to identify the nurses if his tracheal tube became clogged.[501] Nurse Karen Hart testified that the prison has no rules or policies about isolating patients with physical disabilities, and she had no concerns about the practice of placing patients with serious physical disabilities in lockdown rooms on the ward.[502]

(4) Discriminatory Methods of Administration

311. Angola employs methods of administration that result in discrimination against individuals with disabilities. Specifically, the prison (1) fails to adequately inform individuals of the procedures for requesting accommodations; (2) employs inadequate procedures for processing requests for accommodation; (3) fails to identify and properly track individuals with disabilities, including their requests for accommodations, duty statuses, and assistive devices; (5) assesses copays to individuals requesting accommodations; (5) fails to train its staff regarding the ADA; (6) fails to appoint and maintain a qualified ADA Coordinator; and (6) fails to maintain an ADA Advisory Committee as required by its own policies.

a. Failure to inform individuals of rights and procedures

312. Warden Richard Peabody, who served as Angola's ADA Coordinator until mid-2016, testified that he did not know what, if anything, was explained to individuals regarding disability accommodations during intake at Angola, or whether individuals were given any literature explaining their rights or the process for requesting accommodations.[503] He simply "assume[d]" that an individual could ask around, and "someone is going to tell him what he needs to do."[504] His successor, Donald Barr, did not know how individuals are made aware of their right to request an accommodation.[505] He suggested that individuals with disabilities should make sick call to find out what accommodations are available to them.[506]

[498] JX 4, D. Barr Depo. at 40:13-25, 41:15-24.
[499] JX 4, C. Park Depo. at 13:14-21.
[500] *Id.* at 14:4-19.
[501] PX 6 at 0081.
[502] JX 4, K. Hart Depo. at 40:8-41:2.
[503] JX 4, R. Peabody 4/22/15 Depo. at 14:20-15:2.
[504] *Id.* at 104:4-25.
[505] JX 4, D. Barr Depo. at 14:19-24.
[506] *Id.* at 48:9-15.

313. Tracy Falgout, who replaced Warden Barr as ADA Coordinator in late 2016, testified that the nurses who perform intake ask each individual if he has or needs any assistive devices,[507] and inform the individual of the procedure for requesting an accommodation.[508] But Plaintiffs' medical experts did not find "clear documentation of disability accommodations" in a single chart they reviewed, or "evaluations or assessments of needs in that respect,"[509] despite the Department's own policies requiring that disabilities identified at intake be documented in the medical record,[510] along with "individualized response plans in order to address the needs of specific offenders with disabilities."[511] And multiple Class members testified that they were not aware of the process for requesting accommodations.[512]

314. Signage placed throughout the prison is inadequate to inform patients of the procedures for requesting accommodations. The signs merely state that an "[a]uxiliary aid is available upon request" (without so much as defining the term "auxiliary aid"),[513] and list outdated contact information for the former ADA Coordinator.[514]

315. Angola's policies state that information regarding services for individuals with disabilities should be included in the Offender Information Booklet.[515] Neither of the informational pamphlets provided to individuals at intake includes information regarding disabilities or requests for accommodation.[516] Moreover, neither pamphlet is available in Braille.[517]

b. Inadequate procedures for requesting accommodations

316. A request for accommodation can take any form. An individual may—but need not—complete the Department's official Request for Accommodation form,[518] or he may file an

[507] JX 4, Falgout Aug. Depo. at 94:20-95:10.
[508] JX4, Falgout Oct. Depo. at 19:8-20:7.
[509] PX 6 at 0059 n.74.
[510] JX 12-f at 13-14.
[511] JX 7-a (LSP Directive 01.016) at 3-4. Falgout was unfamiliar with the concept of an individualized response plan. JX4, T. Falgout Oct. Depo. at 58:12-14.
[512] JX 4-h (Dunn Depo.) at 38:23-39:3.
[513] An "auxiliary aid" is defined as a communication aid for deaf or blind individuals. *See* 28 C.F.R. § 35.104. Ironically, the signage regarding auxiliary aids is not available in Braille. JX 4 (Oct. Falgout Depo.) at 57:22-58:8.
[514] JX 12-h (ADA Signage); JX4, Falgout Oct. Depo.) at 30:13-15.
[515] JX 7-a (LSP Directive 01.016) at 5.
[516] JX 8-j (Health Information Pamphlet and AU Board Handout); JX 4 Falgout Oct. Depo. at 30:16-22; 31:5-9; 32:10-33:6.
[517] JX 4, T. Falgout Oct. Depo. at 57:22-58:8.
[518] *See* JX 12-a at 1 (Form A-02-017-A).

ARP, write a letter, make sick call, or even make the request orally.[519] In any case, the Department is charged with knowledge of the request.[520]

317. In theory, the initiation of a request for accommodation should trigger a process whereby a member of the medical staff fills out a form titled "Inquiry in Response to an Offender Accommodation Request."[521] The form will contain a recommendation as to whether the requested accommodation is medically indicated, and it is returned to the ADA Coordinator for review and signature.[522]

318. In practice, many requests for accommodation never make it through this process. Despite the existence of the RFA form, the Department's regulations indicate that requests for accommodation should be made using the standard ARP process.[523] It does not reference the RFA form. Likewise, the Department's training materials instruct LSP staff to direct inmates to the ARP process if they wish to request an accommodation.[524] Former ADA Coordinator Peabody acknowledged that "a lot" of requests for accommodation are filed as ARPs.[525]

319. When an individual files an ARP seeking an accommodation, it is up to the ARP screening officer in the Programs Office to determine that the request implicates the ADA and should be routed to the ADA Coordinator's office.[526] Otherwise, the Coordinator's office will never see the request.[527] Warden Peabody testified that during his time as ADA Coordinator, an ARP involving a request for accommodation would be "treated just like every other administrative remedy procedure,"[528] and he never saw an ARP routed to his office.[529] He admitted that ARPs or other complaints would not come to him unless they included "magic words" such as disability or ADA, even if they might be legitimate accommodation requests.[530] He stated that there was "no excuse for it, other than we were not coordinating the two efforts together."[531] However, he was unsure how an officer would know that an ARP or informal request should be routed to him unless it explicitly mentioned the ADA.[532] Similarly, when testifying on behalf of the Department, Tracy Falgout indicated that he did

---

[519] JX 5-d at 3; JX 4, R. Peabody 7/25/13 Depo. at 14:4-15:8; JX 4, R. Peabody 4/22/15 Depo. at 32:1-14; JX 4, T. Falgout Oct. Depo. at 19:18-24, 29:12-18.
[520] *Id.*
[521] *See* JX 12-a at 2-5 (Form B-08-010-A).
[522] JX 4, Falgout Aug. Depo. at 88:9-90:7.
[523] JX 5-d at 3-4.
[524] JX 12-f at 14.
[525] JX 4, R. Peabody 7/25/13 Depo. at 12:21-24.
[526] JX 12-f at 14; JX 5-d at 4.
[527] JX 4, R. Peabody 7/25/13 Depo. at 19:12-24.
[528] JX4, R. Peabody 4/22/15 Depo. at 62:5-15.
[529] *Id.* at 63:2-4.
[530] *Id.* at75:23-77:1.
[531] *Id.* at 62:20-24.
[532] *Id.* at 32:15-33:12.

not know how ARPs were routed to his office, who was responsible for routing them, or whether that person had any familiarity with the ADA.[533]

320. Decision makers at all levels—from the ARP screening officer to the ADA Coordinator himself—fail to recognize requests as implicating the ADA. For example, Class member Earl Peters, who suffered from a hernia that limited his mobility, used the official RFA form to request an exemption from the rule requiring inmates to lift their locker boxes during inspections. His request was summarily denied without a medical review on the grounds that it was "not an ADA issue."[534] James Weber filed an ARP complaining that the medical dorms were not wheelchair-accessible, only to be told that this was "not a medical issue and would be better addressed through the classification/security department," as "[m]edical does not assign housing areas or dormitory areas."[535]

321. These responses are unsurprising, as even Angola's ADA Coordinators fail to recognize when medical issues implicate the ADA. For example, Peabody testified that he does not consider it "a true ADA issue" when an inmate cannot walk over a certain distance.[536] He admitted that "we're so used to inmates making medical requests for duty status based upon a medical condition that I don't necessarily see it as an ADA issue."[537] He did not think requests for restricted duty statuses should come to him, even though they "could be" considered requests for accommodations.[538] He indicated that "[t]his is a confusing issue for me and for staff as determining when something is an ADA request and when it isn't. Generally speaking, it gets treated as an ADA request when the inmate puts in something about ADA in the request and basically says he wants an accommodation."[539]

322. Even if the screening officer recognizes the ADA issue and routes the request to the ADA Coordinator's office, it does not always trigger the medical review called for by Form B-08-010-A. As late as 2013, ADA Coordinator Peabody was not even familiar with the form.[540] Many ARPs that were coded "ADA" do not include a completed Form B-08-010-A.[541] Even when Form B-08-010-A *is* completed, there typically is no signature or other evidence indicating that a medical professional evaluated the request, and the request is often

[533] JX 4, T. Falgout Oct. Depo. at 60:7-16.
[534] JX4, D. Barr Depo. at 19:16-22, 20:23-21:5, 21:15-22:3.
[535] PX 231 at 2358-2364.
[536] JX 4, R. Peabody 7/25/13 Depo. at 22:8-10.
[537] *Id.* at 22:21-24.
[538] JX 4, R. Peabody Depo. 4/22/15 at 55:3-12.
[539] *Id.* at 58:11-17.
[540] JX 4, R. Peabody 7/25/13 Depo. at 19:25-20:12.
[541] *See also* PX231.2563-2572 (ARP of Michael Birklett)); PX231.2200-2211 (ARP of John Thomas) (Dismissing ARP/RFA with one-sentence response); PX231.2604-2640 (ARPs of Bryan Alexander).

summarily denied, or the explanation accompanying the denial is not responsive to the request.[542]

323. Finally, even if the procedures are followed, a request may not be fulfilled. For example, Derrick Woodberry testified that he was approved to receive a donut and sitz bath, only to have Central Supply deny the nurse practitioner's request.[543]

c. Failure to identify and track disabilities

324. The Department's policies state that "[s]taff who are aware of or have reason to believe that an offender has a disability for which he may need accommodation are required to advise the unit ADA Coordinator, who will evaluate the circumstances to determine if auxiliary aids and services and reasonable accommodations are required."[544] However, in at least ten years of serving as ADA Coordinator, Warden Peabody was not once contacted by an employee indicating that an inmate had a disability and required assistance.[545]

325. The Department also requires Angola's ADA Coordinator to record information regarding all requests for accommodation in the Department's ADA database using Form B-08-010-B.[546] This database is woefully inadequate to effectively track individuals with disabilities, their requests for accommodation, the disposition of those requests, and the individual's duty status. The list shows the total number of each type of accommodation granted to individuals at Angola; separately, it lists the name of each individual who has received an accommodation.[547] It does not clearly show (1) the nature of the individual's disability, (2) the date of any accommodation requests, (3) the disposition of those requests, (4) the type of accommodation granted, or (5) the duty status of the individual.[548] Even after assuming the role of ADA Coordinator, Tracy Falgout did not recognize the first part of the list;[549] as for the second half, he described it as "an alphabetized master list of everybody who has requested ADA for one reason or another."[550] He admitted that the list would not give the viewer a full picture of each individual's disability and was not a tracking database for individuals.[551] He further acknowledged that the viewer would have no way of knowing whether an individual's needs were being met by looking at the list.[552]

---

[542] PX 231 at 1794-1809 (ARP of Cedric Howard); JX 4, D. Barr Depo. at 24:19-27:20, 27:25-28:3, 28:17-29:15, 30:8-14, PX231.2087-2015 (ARP of Richard Roussell); JX 4, D. Barr Depo. at 30:23-32:7.
[543] JX 4-u, D. Woodberry Depo. at 20:15-21:6; 41:6-42:15; 45:20-46:11.
[544] JX 5-d at 2.
[545] JX 4, R. Peabody 7/25/13 Depo. at 39:5-40:16.
[546] JX 5-d at 5-6, 11.
[547] JX 12-b.
[548] *Id.*
[549] JX 4, T. Falgout 10/26/16 Depo. at 37:17-38:4.
[550] *Id.* at 40:8-17.
[551] *Id.* at 41:8-42:6.
[552] *Id.* at 44:15-23.

326. Additionally, because many requests for accommodation are not properly routed to the ADA Coordinator, a large percentage of requests do not make their way into the tracking database. Peabody indicated that the database would not include any ARPs whatsoever.[553] Barr admitted that he was not involved at all in recording information in the database and did not know who was.[554] He did not know if oral requests or ARPs would be included in the database.[555] Similarly, Falgout acknowledged that an ARP would not be recorded in the database if the screening officer did not recognize the request as involving an ADA issue.[556]

d. Charging copays to request accommodations

327. LSP Directive 01.016, which establishes guidelines for requesting accommodations, indicates that "medical co-payments may be assessed for medical services."[557] Peabody acknowledged that patients are charged copays to access medical staff, and that requests for duty statuses, wheelchairs, and the like require patients to access medical.[558]

e. Inadequate staff training

328. Tracy Falgout testified that he was not aware of any formal ADA training for staff and simply noted that "[a]ll staff have the ability to review the policy."[559] The Director of Nursing, Sherwood Poret, stated that nursing staff do not receive training on the ADA.[560] Assistant Facilities Maintenance Manager Odis Ratcliff, who testified on behalf of the department regarding alterations to Angola's facilities, admitted that no one in his department receives training on the ADA's architectural accessibility requirements.[561] The Department's orientation materials focus almost exclusively on issues relating to hearing-impaired inmates.[562]

f. Failure to maintain a qualified ADA Coordinator

329. LSP Directive 01.016 states that "[t]he ADA coordinator shall possess the educational background, experience and skills necessary to carry out all of the duties and responsibilities of the position, and have knowledge and experience in dealing with the legal rights of persons with disabilities and the obligations of public entities under Federal and State

[553] JX 4, R. Peabody 4/22/15 Depo. at 65:10-66:15.
[554] JX 4, D. Barr Depo. at 23:20-24:12.
[555] *Id.* at 24:13-17.
[556] JX 4, T. Falgout 10/26/16 Depo.at 65:8-14.
[557] JX 7-a.
[558] JX 4 R. Peabody 7/25/13 at 28:10-29:4; 30:1-4, 17-20.
[559] JX 4 T. Falgout 8/8/16 Depo. at 93:16-22.
[560] JX 4 S. Poret 9/19/16 Depo. at 13:17-14:3.
[561] JX 4, O. Ratcliff Depo. at 9:4-11.
[562] JX 12-f.

disability laws."[563] However, the Department has stated that "[t]here are no specific qualifications of LSP's ADA Coordinator or interim ADA coordinator."[564]

330. Peabody indicated that the training he received to become ADA Coordinator was just "the basic training that we all went through." The only training he could identify was a four-hour refresher that all staff received, which "may have been" related to the DOJ's resolution agreement regarding hearing-impaired inmates.[565] He did not attend trainings regarding disability law,[566] and when asked how kept up with changes in the law, he admitted that he was not "kept in some sort of loop on that."[567] The lack of training showed: he was unfamiliar with the assessment form used to evaluate requests for accommodations, even though he believed it was his responsibility to complete the form,[568] and as discussed above, he routinely disregarded patients' disabilities as purely "medical" issues. Peabody did not know the identity of the Department-wide ADA Coordinator.[569]

331. Similarly, Barr received no ADA training other than the annual hour that all officers receive at the training academy.[570] He did not meet with his predecessor, Warden Peabody, to discuss the role,[571] or review any sort of manual.[572] Barr explained that "[t]he Warden just came to me and told me that he appointed me to that position and pretty much that was it."[573] When he took on the role, nothing changed in terms of his workload.[574]

332. Barr was unaware of basic information such as the availability of materials in Braille, including books and the RFA form.[575] He was not sure how a blind inmate would file an ARP,[576] and was unsure whether deaf inmates were permitted to work.[577]

333. Falgout, Angola's most recent ADA Coordinator, received no training or manual when he took office and did not discuss the role with his predecessor.[578] He was not familiar with the ADA Amendments Act or the Rehabilitation Act;[579] the individualized response plans for

---

[563] JX 7-a.
[564] PX 403.
[565] JX 4 R. Peabody 4/22/15 Depo. at 12:23-13:15.
[566] *Id.* at 13:16-19.
[567] *Id.* at 13:20-23.
[568] JX 4 R. Peabody 7/25/13 Depo. at 19:25-20:12; 21:4-7.
[569] *Id.* at 23:16-19.
[570] JX 4, D. Barr Depo. at 10:23-11:2, 16:13-23, 17:3.
[571] *Id.* at 11:3-4.
[572] *Id.* at 11:7-9.
[573] *Id.* at 11:15-17.
[574] *Id.* at 12:20-23.
[575] *Id.* at 43:14-24.
[576] *Id.* at 45:19-23.
[577] *Id.* at 49:5-9.
[578] JX 4, T. Falgout 10/26/16 Depo. at 8:2-19.
[579] *Id.* 11:15-12:3.

disabled inmates required by LSP Directive 01.016;[580] or the concept of an ADA transition plan as required by 28 C.F.R. § 35.150(d).[581]

g. Failure to maintain an advisory committee

334. LSP Directive 01.016 requires Angola to maintain an ADA Advisory Committee.[582] Neither the prison's ADA Coordinators[583] nor its past or present wardens[584] were aware of the existence of such a committee. The Department indicated that it has no documents relating to an advisory committee.[585]

(5) Overt Discrimination

335. Finally, Angola enforces certain policies that overtly discriminate against individuals with disabilities. For example, if an individual has a restricted duty status, he is automatically barred from participating in hobby craft, including low-risk activities such as painting.[586]

336. Similarly, Angola does not offer work assignments to individuals with certain disabilities. For example, all blind inmates are placed on no duty.[587] Inmates on no duty are not permitted to work and are unable to earn incentive wages,[588] yet they receive no discounts for phone calls or at the canteen.[589] Additionally, if an individual has a duty status restriction, he is not permitted to participate in Angola's work release program.[590]

IV. CONCLUSIONS OF LAW

A. Eighth Amendment Claim

(1) LEGAL STANDARD

[580] *Id.* at 58:12-14.
[581] *Id.* at 37:1-16.
[582] JX 7-a at 3-4.
[583] JX 4, T. Falgout 8/8/16 Depo. at 93:23-25; JX 4, T. Falgout 10/26/16 Depo. at 36:1-9.
[584] JX 4, D. Vannoy Depo. at 72:17-20; JX 4 B. Cain Depo. at 48:24-49:18.
[585] PX (Response to 7 RFP 2).
[586] JX 5-a (HC-15); JX 6-iii (Directive 09.036); RFA 10; JX 4, D. Barr Depo. at 44:14-16; JX 4 T. Falgout 8/8/16 Depo. at 107:23-108:1 (explaining that hobby craft is a privilege, not a right).
[587] JX 4, D. Barr Depo. at 44:6-13; JX 4 Peabody4/22/2015 Depo. at 53:22-54:7.
[588] JX 4, D. Barr Depo. at 44:6-13.
[589] *Id.* at 47:3-6.
[590] JX 4, T. Falgout 10/26/16 Depo. at 59:11-18. Work release allows inmates with fewer than two years left on their sentences to work outside the prison as "an integration back into the community." *Id.* at 59:19-25.

Prisoners "must rely on prison authorities to treat [their] medical needs" because "if the authorities fail to do so, those needs will not be met."[591] Accordingly, "[t]he Eighth Amendment's prohibition against cruel and unusual punishment requires prison officials to provide 'humane conditions of confinement,' ensuring that 'inmates receive adequate . . . medical care."[592]

"In the context of medical care, a prison official violates the Eighth Amendment when he acts with deliberate indifference to a prisoner's serious medical needs."[593] This inquiry consists of both an objective and a subjective test. The objective test requires showing that the prisoner has "serious medical needs,"[594] and "either has already been harmed or been 'incarcerated under conditions posing a substantial risk of serious harm.'"[595] The subjective test requires a showing that prison officials had requisite knowledge of the risk of harm and either disregarded it or failed to act reasonably to abate it.[596]

Importantly, Plaintiffs in the instant suit "do not base their case on deficiencies in care provided on any one occasion" to any single prisoner but instead contend that "systemwide deficiencies in the provision of medical . . . care . . . taken as a whole, subject sick prisoners in [Angola] to 'substantial risk of serious harm' and cause the delivery of care in [Angola] to fall below the evolving standards of decency that mark the progress of a maturing society."[597] Thus, in order to prevail on their Eighth Amendment challenge, Plaintiffs must prove (1) the existence of serious medical needs among members of the Class and (2) that Defendants were deliberately indifferent to a substantial risk of serious harm stemming from the inadequacies in Angola's medical care system.[598]

(2) The Objective Test

a. Serious medical needs

The Fifth Circuit has described a "serious medical need" as "one for which treatment has been recommended or for which the need is so apparent that even laymen would recognize that care is required."[599] Courts have recognized a wide range of conditions as constituting "serious medical needs" under the Eighth Amendment, including but not limited to "injuries" that cause "severe

[591] *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).
[592] *Palmer v. Johnson*, 193 F.3d 346, 351-52 (5th Cir. 1999) (quoting *Farmer v. Brennan*, 511 U.S. 825, 832 (1994)).
[593] *Domino v. Texas Dep't of Criminal Justice*, 239 F.3d 752, 754 (5th Cir. 2001).
[594] *Estelle*, 429 U.S. at 104.
[595] *Braggs v. Dunn*, 257 F. Supp.3d 1171, 1189 (M.D. Ala. 2017) (quoting *Farmer*, 511 U.S. at 834).
[596] *Farmer*, 511 U.S. at 844-45.
[597] *Brown v. Plata*, 563 U.S. 493, 505 n.3 (2011).
[598] *See, e.g., Carlucci v. Chapa*, 884 F.3d 534, 538 (5th Cir. 2018); *Lawson v. Dallas Cnty.*, 286 F.3d 257, 262 (5th Cir. 2002).
[599] *Gobert v. Caldwell*, 463 F.3d 339, 345 n.12 (5th Cir. 2006).

pain,"[600] broken bones,[601] ulcers,[602] open wounds,[603] severe chest pain,[604] HIV,[605] Hepatitis C,[606] cancer,[607] tuberculosis,[608] asthma,[609] diabetes and its complications,[610] severe arthritis,[611] Crohn's disease,[612] osteomyelitis,[613] neurological disorders,[614] serious back pain,[615] a dislocated shoulder,[616] serious ear infection,[617] the need for post-surgical care,[618] hemorrhoids requiring surgery,[619] seizure disorders,[620] and broken teeth.[621]

Moreover, because this is a Rule 23(b)(2) class action challenging Defendants' actions "on a ground[ ] generally applicable to the class"—that is, Defendants' provision of inadequate medical care at Angola—Plaintiffs must show that serious medical needs exist on a widespread wide basis, rather than on an individual basis.[622]

---

[600] *See, e.g., Thomas v. Carter*, 593 F. App'x 338, 342 (5th Cir. 2014).
[601] *Harris v. Hegmann*, 198 F.3d 153, 159-60 (5th Cir. 1999).
[602] *Lawson*, 286 F.3d at 262.
[603] *Gobert*, 463 F.3d at 349.
[604] *Mata v. Saiz*, 427 F.3d 745, 754 (10th Cir. 2005).
[605] *Brown v. Johnson*, 387 F.3d 1344, 1351 (11th Cir. 2004).
[606] *See Bender v. Regier*, 385 F.3d 1133, 1137 (8th Cir. 2004) (classifying hepatitis C as "unquestionably a serious medical problem."); *Loeber v. Andem*, 487 Fed. Appx. 548, 549 (11th Cir. 2012) ("That Hepatitis C presents a serious medical need is undisputed."); *Postawko v. Missouri Dept' of Corrs.*, No. 2:16-cv-04219, 2017 WL 1968317, at *7 (W.D. Mo. May 11, 2017) ("Plaintiffs' chronic HCV condition is a serious and harmful medical condition, which risks increasingly serious liver damage, among other bodily harms, to those who have it."); *Hoffer v. Jones*, 290 F. Supp. 3d 1292, 1299 (N.D. Fla. 2017) ("Plaintiffs (by diagnosis) and Plaintiffs' class (by definition) all suffer from chronic HCV. As a consequence, Plaintiffs and Plaintiffs' class are faced with substantial risks of serious harm.").
[607] *Rice v. Walker*, No. 06-3214, 2010 WL 1050227, *6 (C.D. Ill. Mar. 16, 2010).
[608] *Maldonado v. Terhune*, 28 F. Supp.2d 284, 290 (D.N.J. 1998).
[609] *Board v. Farnham*, 394 F.3d 469, 484 (7th Cir. 2005).
[610] *See Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575, 582 (3d Cir. 2003); *Carrion v. Wilkinson*, 309 F. Supp. 2d 1007, 1014 (N.D. Ohio 2004).
[611] *Christy v. Robinson*, 216 F. Supp. 2d 398, 413 (D.N.J. 2002).
[612] *Woulard v. Food Service*, 294 F. Supp. 2d 596, 603-604 (D. Del. 2003).
[613] *Gil v. Vogilano*, 131 F. Supp. 2d 486, 492 (S.D.N.Y. 2001).
[614] *Kenney v. Paderes*, 217 F. Supp. 2d 1095, 1099 (D. Haw. 2002).
[615] *Palermo v. Corr. Med. Servs., Inc.*, 133 F. Supp. 2d 1348, 1361 (S.D. Fla. 2001).
[616] *Higgins v. Corr. Med. Servs. of Ill.*, 178 F.3d 508, 511 (7th Cir. 1999).
[617] *Zentmyer v. Kendall Cnty., Ill.*, 220 F.3d 805, 810 (7th Cir. 2000).
[618] *Morales Feliciano v. Calderon Sierra*, 300 F. Supp. 2d 321, 341 (D.P.R. 2004); *Boretti v. Wiscomb*, 930 F.2d 1150, 1155 (6th Cir. 1991).
[619] *Jones v. Natesha*, 151 F. Supp. 2d 938, 944 (N.D. Ill. 2001).
[620] *Hudson v. McHugh*, 148 F.3d 859, 864 (7th Cir. 1998).
[621] *Carlucci*, 884 F.3d at 539.
[622] *See* Order Granting Class Certification, Rec. Doc. 394 at p. 2 (observing that "Plaintiffs request injunctive relief to abate the alleged systemic deficiencies in Defendants' policies and practices that subject all inmates to unreasonable risks of serious harm.").

b. Substantial Risk of Serious Harm

To show that Defendants have acted with deliberate indifference to the Class's serious medical needs, Plaintiffs must also establish the Class's "exposure to a substantial risk of serious harm."[623] "That the Eighth Amendment protects against future harm to inmates is not a novel proposition."[624] As both the Supreme Court and Fifth Circuit have made clear, prisoners need not wait until they are actually harmed until they can obtain an injunction to remedy unsafe conditions.[625] Nor must Plaintiffs show that the "likely harm [will] occur immediately."[626] Rather, for purposes of the Eighth Amendment, Plaintiffs "need only show that there is a substantial risk of serious harm."[627]

Moreover, in order to establish a substantial risk of serious harm, "it does not matter whether the risk comes from a single source or multiple sources."[628] "Multiple policies or practices that combine to deprive a prisoner of a 'single, identifiable human need,' such as [medical care], can support a finding of Eighth Amendment liability."[629] Indeed, the Fifth Circuit has long recognized that "the totality of circumstances concerning medical care" may violate the Eighth Amendment.[630]

(3) The Subjective Test

In order to prove an Eighth Amendment violation, Plaintiffs must also show that Defendants have a "sufficiently culpable state of mind."[631] "In prison conditions cases that state of mind is one of deliberate indifference to inmate health or safety."[632]

"Deliberate indifference is itself a two-prong inquiry."[633] "An official must both 'be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists' and 'he must also draw the inference.'"[634] Even where awareness is shown, an official will not be liable if he "responded reasonably to the risk."[635] Although "deliberate indifference entails something more

---

[623] *Gobert*, 463 F.3d at 345.
[624] *Helling v. McKinney*, 509 U.S. 25, 33(1993).
[625] *See, e.g., id.* at 33-34; *Ball v. LeBlanc*, 792 F.3d 584, 593 (5th Cir. 2015) ("To prove unconstitutional conditions, inmates need not show that death or serious injury has already occurred.").
[626] *Helling*, 509 U.S. at 33.
[627] *Ball*, 792 F.3d at 593 (quoting *Gates v. Cook*, 376 F.3d 323, 333 (5th Cir. 2004); *see also Wilson v. Seiter*, 501 U.S. 294, 304 (1991) ("*Some* conditions of confinement may establish an Eighth Amendment violation 'in combination' when each would not do so alone, but only when they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth or exercise[.]" (emphasis in original)).
[628] *Farmer*, 511 U.S. at 843.
[629] *Braggs*, 257 F. Supp. 3d at 1192 (quoting *Gates*, 376 F.3d at 333).
[630] *Williams v. Edwards*, 547 F.2d 1206, 1215 (5th Cir. 1977).
[631] *Farmer*, 511 U.S. at 834 (internal citation and quotation omitted).
[632] *Id.*
[633] *Ball*, 792 F.3d at 594.
[634] *Id.* (citing *Farmer*, 511 U.S. at 837).
[635] *Farmer*, 511 U.S. at 844.

than mere negligence, the cases are also clear that it is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result."[636]

"Whether a prison official had the requisite knowledge of a substantial risk of is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, and factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious."[637] Courts have found deliberate indifference in a variety of circumstances, including but not limited to "where the prison official (1) knows of a prisoner's need for medical treatment but intentionally refuses to provide it; (2) delays necessary medical treatment based on a non-medical reason; or (3) prevents a prisoner from receiving needed or recommended medical treatment."[638] Willful blindness to the risk posed to inmates is not a valid defense to a deliberate indifference claims.[639]

"In challenges to correctional institution's provision of medical care, evidence of systemic deficiencies can also establish the 'disregard' element of deliberate indifference."[640] "As an evidentiary matter, these systemic deficiencies may be identified by a 'series of incidents closely related in time' or '[r]epeated examples of delayed or denied medical care.'"[641] "[A]lthough one-off negligent treatment is not actionable, . . . frequent negligence, just like a single instance of truly egregious recklessness, may allow the court to infer subjective deliberate indifference."[642] Deliberate indifference may also be "demonstrated straightforwardly, through direct evidence that an administrator was aware of serious systemic deficiencies and failed to correct them."[643] Efforts to correct systemic deficiencies that "simply do not go far enough" when weighed against the risk of harm also support a finding of deliberate indifference,[644] because such insufficient efforts are not "reasonable measures to abate" the identified substantial risk of serious harm.[645]

Where unconstitutional conditions have persisted for a "long duration," it is easier to demonstrate a correctional official's knowledge of the deficiencies.[646] In other words, if plaintiffs show that a substantial risk of unreasonable harm was "longstanding, pervasive, [and] well-documented," and that "the circumstances suggest that the [prison officials] had been exposed to

---

[636] *Id.*. at 835.
[637] *Gates*, 376 F.3d at 333 (citing *Farmer*, 511 U.S. at 842).
[638] *Rouse v. Plantier*, 182 F.3d 192, 197 (3d Cir. 1999); *see also, e.g., Carlucci*, 884 F.3d at 538 (noting that "delay" or "denial of recommended medical treatment" supports a finding of deliberate indifference); *Lawson*, 286 F.3d at 263-64 (affirming finding of deliberate indifference where prison staff knew of and disregarded instructions for follow-up care).
[639] *See Farmer*, 511 U.S. at 843 n.8 ("a prison official "would not escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist").
[640] *Braggs*, 257 F. Supp. 3d at 1251 (citing *Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991).
[641] *Braggs*, 257 F. Supp. at 1251-52 (quoting *Rogers v. Evans*, 792 F.2d 1052, 1058-59 (11th Cir. 1986)).
[642] *Dunn v. Dunn*, 219 F. Supp.3d 1100, 1129 (MD. Ala. 2016).
[643] *Id.* at 1129.
[644] *Laube v. Haley*, 234 F. Supp.2d 1227, 1251 (M.D. Ala. 2002).
[645] *Farmer*, 511 U.S. at 847.
[646] *Alberti v. Sheriff of Harris Cnty.*, 937 F.2d 984, 998 (5th Cir. 1991).

information concerning the risk," then "such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk."[647]

B. Individual Practices That Can Violate the Eighth Amendment

Courts have recognized a variety of practices that may rise to the level of deliberate indifference of serious medical needs. Although not exhaustive, these precedents provide useful guidance in assessing whether a substantial risk of serious harm exists at Angola and, if so, whether Defendants were aware of such a risk and failed to reasonable respond.

c. Inadequate and Inappropriate Staffing

Courts have repeatedly recognized that deliberate indifference may be established "by proving that there are 'such systemic and gross deficiencies in staffing, facilities, equipment, or procedure that the inmate population is effectively denied access to adequate medical care.'"[648] As the Third Circuit has observed, "where the size of the medical staff at a prison in relation to the number of inmates having serious health problems constitutes an effective denial of access to diagnosis and treatment by qualified health care professionals, the 'deliberate indifference' standard . . . has been violated. In such circumstances, the exercise of informed professional judgment as to the serious medical problems of individual inmates is precluded by the patently inadequate size of the staff."[649]

d. Inadequate Access to Care

Courts have also repeatedly recognized that that barriers to meaningfully accessing medical care may violate the Eighth Amendment. For example, it is axiomatic that "[t]he denial or delay of treatment for serious medical needs violates the Eighth Amendment[.]"[650]

e. Inadequate Chronic Disease Program

The failure to provide "comprehensive and coordinate care" for "complex, chronic illness" may also help support a finding of an Eighth Amendment violation.[651]

f. Failure to Provide Specialty Care

---

[647] *Farmer*, 511 U.S. at 842-43; *see also Williams*, 547 F.2d at 1216 (concluding that the Eighth Amendment may be violated on a showing of "evidence of rampant and not isolated deficiencies").
[648] *Harris*, 941 F.2d at 1505 (quoting *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), *cert. denied*, 450 U.S. 1041 (1981)); *see also, e.g., Gates v. Collier*, 501 F.2d 1291, 1300-01 (5th Cir. 1974); *Free v. Grange*r, 887 F.2d 1552, 1556, (11th Cir. 1989).
[649] *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3rd Cir. 1979).
[650] *Carlucci*, 884 F.3d at 538; *see also Galvan v. Calhoun Cnty.*, 719 F. App'x 372, 376 (5th Cir. 2018) (holding that three-day delay in receiving necessary care for "excruciating pain" stated viable Eighth Amendment claim).
[651] *Glisson v. Ind. Dep't of Corr.*, 849 F.3d 372, 382 (7th Cir. 2017).

Courts have also routinely recognized that the failure to provide time access to specialty care and treatment may constitute deliberate indifference to serious medical needs.[652]

g. Denial of Necessary Medical Care Exclusively for Budgetary Reasons

Courts have also recognized that denying medically necessary treatment based exclusively on non-medical budgetary reasons may violate the Eighth Amendment.[653]

h. Inadequate Maintenance of Medical Records

"Medical records must be sufficiently organized and thorough to allow the provision of adequate care to inmates."[654] Accordingly, courts have also recognized that the Eighth Amendment is "implicated when a prison's inadequate, inaccurate and unprofessionally maintained medical records give rise to the possibility for disaster stemming from a failure to properly charge medical care received by prisoners."[655]

i. Inadequate Monitoring and Quality Control System

Courts have also recognized that lack of monitoring and meaningful quality control programs may contribute to a finding of a systemic Eighth Amendment violation.[656]

j. Inadequate Access to Emergency Care

---

[652] *See, e.g., Inmates of Occoquan v. Barry*, 717 F. Supp. 854, 862 (D.D.C. 1989) (Eighth Amendment violation found in part because "inmates wait months for appointments to specialty clinics"); *Morales Feliciano*, 13 F. Supp.2d at 193 ("Delays in obtaining appointments in off-site subspecialty clinics threatens the continuity of a patient's medical care.").

[653] *Hoffer*, 290 F. Supp. 3d at 1300 ("[T]his court finds as a matter of fact that FDC's failure to treat was due to a lack of funding . . . . Here, funding is no excuse for FDC's failure to provide treatment."); *id.*, n. 15 ("Of course, this Court recognizes that issues of funding might excuse some delay. For instance, if DAAs were released yesterday, this Court would not expect FDC to wave a magic wand and suddenly treat thousands of inmates overnight. But that is not the case. FDC has had since late 2013 to respond to this problem, and it has only just recently started doing what it should have done years ago."); *see also Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) ("Lack of funds for facilities cannot justify an unconstitutional lack of competent medical care and treatment for inmates."); *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 161 (D. Mass. 2002) ("It is not, however, permissible to deny an inmate adequate medical care because it is costly. In recognition of this, prison officials at times authorize CAT scans, dialysis, and other forms of expensive medical are required to diagnose or treat familiar forms of serious illness.").

[654] *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995); *see also Coleman v. Wilson*, 912 F. Supp. 1282, 1314 (E.D. Cal. 1995) ("A necessary component of minimally adequate medical care is maintenance of complete and accurate medical records.").

[655] *Dawson v. Kendrick*, 527 F. Supp. 1252, 1306-07 (S.D.W.V. 1981).

[656] *Madrid*, 889 F. Supp. at 1208 (finding Eighth Amendment violation where "medical staff and administrators have taken no effective steps to systemically review the care provided or to supervise the physicians providing it").

Courts have also recognized that the Eighth Amendment requires timely access to necessary emergency medical care.[657]

C. DEFENDANTS' POLICIES AND PRACTICES VIOLATE THE EIGHTH AMENDMENT

Plaintiffs have proven that Defendants' policies and practices concerning medical care at Angola violate the Eighth Amendment.

(1) Applying the Objective Test, Plaintiffs Have Demonstrated the Existence of Serious Medical Needs and a Substantial Risk of Serious Harm.

As explained above, in order to establish an Eighth Amendment violation for inadequate medical care, Plaintiffs must first present evidence establishing the existence of serious medical needs and a substantial risk of serious harm. "Put another way, plaintiffs must show that their serious medical need, if left unattended, poses a substantial risk of serious harm."[658] Plaintiffs have presented overwhelming evidence to prove this objective element of their claim.

1. Plaintiffs Have Proven That Serious Medical Needs Exist on a Widespread Basis.

Plaintiffs have amply shown that they and the members of the Class suffer from "serious medical needs."[659] Specifically, Plaintiffs presented substantial documentary, testimonial, and expert evidence—much of which is undisputed—demonstrating that they and the members of the Class suffer a litany of serious medical needs while imprisoned at Angola, including but not limited to cancer, HIV, Hepatitis C, hypertension, diabetes, cataracts, osteoarthritis, chronic pain, and fractured bones.[660] Just to name a few examples, Plaintiff Ian Cazenave suffers from sickle cell disease and (as a result of more than a decade of undertreatment) leg ulcers and osteomyelitis; Plaintiff Farrell Sampier suffers from transverse myelitis; former Plaintiffs Joseph Lewis and Shannon Hurd both died of cancer while at Angola;[661] and Class Member Charles Butler suffers from Hepatitis C, osteoarthritis, and high blood pressure.[662] The evidence further showed that a substantial number of Plaintiffs and Class members suffer from a variety of serious medical needs, as opposed to only one.

---

[657] *See Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982),*overruled on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995) ("If outside facilities are too remote or too inaccessible to handle emergencies promptly and adequately, then the prison must provide adequate facilities and staff to handle emergencies within the prison.").

[658] *Braggs*, 257 F. Supp. 3d at 1191 (internal quotation marks and citations omitted).

[659] *Gobert*, 463 F.3d at 345 n.12 (defining a "serious medical need" as "one for which treatment has been recommended or for which the need is so apparent that even laymen would recognize that care is required").

[660] *See supra* ¶¶ 33-53; PX 28 at 7-22;

[661] PX 6 at 0033 n. 43.

[662] Charles Butler Deposition Designations 9:16-9:18.

Plaintiffs have further demonstrated that such serious medical needs exist system-wide at Angola. The abundance of record evidence—including the Plaintiffs' and Class Members' medical histories,[663] the Plaintiffs' expert reports,[664] and Defendants' own internal records[665]—contradicts any contention to the contrary.

2. Plaintiffs Have Demonstrated that Defendants' Policies and Practices Create a Substantial Risk of Serious Harm to the Class.

As reflected in the Proposed Findings of Fact, Plaintiffs have also submitted overwhelming evidence showing that the totality of Defendants' policies and practices conspire to create a substantial risk of serious harm to prisoners at Angola.[666] The evidence and testimony compellingly demonstrates the following interrelated areas of inadequacy: (1) inadequate funding and inappropriate budget management; (2) inadequate and inappropriate staffing; (3) inadequate medical leadership; (4) failures to provide timely access to medical care; (5) inadequate chronic disease management; (6) failures to provide timely access to specialty care; (7) inadequate inpatient care; (8) inadequate medication administration; (9) inadequate diagnostic services; (10) failure to create, maintain and use adequate and reliable medical records; (11) inadequate facilities; and (12) inadequate monitoring and quality assurance.[667] Together, these inadequacies subject Plaintiffs and the Class to actual harm and to a substantial risk of serious harm—including worsening of symptoms, continued pain and suffering, and death.

a. Inadequate funding and inappropriate budget management

Angola is one of the DOC's highest-acuity prisons, meaning that its population has a greater and more acute need for medical care than the population of other prisons. Yet, as detailed in the Proposed Findings of Fact, Angola's budget for medical care is extremely low even in comparison to the low amount spent at other Louisiana correctional institutions.[668] These budgetary problems are further compounded by the fact that Angola's medical leadership has no meaningful involvement in budget allocation and management such to ensure that the budget reflects the medical needs of the facility.[669] The evidence further established that budgetary concerns frequently dictate decision-making regarding access to medical care and improvement in quality of care.[670] Combined with the

---

[663] *See* PX 28 at 7-22.
[664] PX 6; PX 28; PX 244.
[665] *See, e.g.,* PX 22 (reporting statistics on chronic diseases); PX 150
[666] *Gates*, 376 F.3d at 333 (recognizing that a combination of conditions may "have a mutually enforcing effect" that violates the Eighth Amendment); *see also, e.g.,* Williams, 547 F.2d at 1215; *Braggs*, 257 F. Supp. 3d at 1192.
[667] Rather than repeating verbatim the Findings of Fact regarding inadequacies in medical care, these Conclusions of Law incorporate those Findings by this reference and will summarize how those inadequacies contribute to a substantial risk of serious harm.
[668] *See supra* ¶¶ 64-69; PX 6 at 0027.
[669] *See supra* ¶¶ 66; PX 6 at 0012, 0027.
[670] *See supra* ¶¶ 67-69.

other deficiencies described herein, these inadequacies contribute to a substantial risk of serious harm.

b. Inadequate and Inappropriate Staffing

Plaintiffs also presented overwhelming evidence demonstrating that Angola has an inadequate number of qualified medical personnel, thereby further elevating the substantial risk of harm to the Class. Evidence showed that the excessively high caseloads of Angola doctors contributed to the poor quality of care and creates a risk that doctors have too little time to properly evaluate patients.[671] The failure of Angola physicians to timely and adequately examine patients, review diagnostic results, and implement specialists' recommendations further exacerbates the risk of harm to the Class.[672] Defendants' corresponding failure to provide a sufficient number of nurses compounds the risk of harm even further.

In addition, the evidence amply demonstrates the serious risk of harm stemming from Defendants' practice of providing medical care through unqualified staff, or even through fellow Class members.[673] This violates Defendants' Eighth Amendment obligation to ensure that prisoners receive timely, professional medical judgment from a qualified medical professional, and treatment recommended by a qualified medical professional for their serious medical needs. Defendants' exclusive reliance on doctors with restricted licenses and their concomitant failure to meaningfully supervise these doctors increases the likelihood of harm,[674] as does Defendants' reliance on LPNs, EMTs, and correctional officers for medical functions outside the scope of their qualifications.[675] That risk is compounded by Defendants' demonstrated failure to provide adequate supervision.[676]

c. Inadequate Medical Leadership

Deficient oversight and administration of the provision of medical care at Angola also increases the likelihood of a substantial risk of serious harm to the Class. As detailed in the Proposed Findings of Fact, Defendants have placed operational control over significant aspects of Angola's medical program in an Assistant Warden with no health care training and no degree above the high school level.[677] Further, the evidence demonstrates that Defendants have permitted Angola's putative Medical Director, Dr. Lavespere, to disclaim any meaningful oversight function, such as supervision or quality control.[678] Making matters worse, to the extent that Dr. Lavespere provides

---

[671] PX 6 at 0017.
[672] PX 6 at 0016-17.
[673] *See supra* ¶¶ 90-105, ; PX 6 at 0015, 0019-20, 0040-41, 0049-54.
[674] *See supra* ¶¶ 73-89; PX 6 at 0023-25.
[675] *Cooper v. City of Cottage Grove*, No. 6:13-cv-551-TC, 2014 WL 4187558, *6 (D. Ore. Aug. 21, 2014) (observing that EMTs "are not the equivalent of a physician or other medical professional").
[676] PX 6 at 0040-41.
[677] *Hartman v. Correctional Med. Servs., Inc.*, 960 F. Supp. 1577, 1582-83 (M.D. Fla. 1996) (holding medical provider could be found deliberately indifferent based on evidence that it permitted a person with only a master's degree and no processional licenses to have substantial authority over mental health system).
[678] PX 6 at 0012-14.

supervision to Angola's medical staff, his admitted skepticism of the medical problems reported by prisoners increases the likelihood that he will tolerate substandard care from other medical providers, which is evidenced by the inadequacies in both his and his providers' clinical care.[679] In sum, Plaintiffs have shown that Defendants' practice of maintaining deficient leadership over Angola's medical care increases the likelihood that the problems in medical care will persist.

d. Restrictions on and Inadequacies in Accessing Medical Care

Plaintiffs have also demonstrated the risk of substantial harm that stems from various policies and practices that impede access to competent medical care. Defendants' substantial reliance on EMTs to provide front-line medical evaluations during sick call—without timely access to nurses or providers or patients' medical records—increases the risk that Class members will not be properly diagnosed and treated, thereby resulting in needless and prolonged suffering. [680]

Moreover, Defendants employ numerous policies and practices that impose unreasonable barriers to accessing needed medical care. As detailed throughout the Proposed Findings of Fact, these barriers include: often prohibitively expensive co-pays for sick call and prescriptions; impractical pill call times; the threat of disciplinary charges for alleged malingering; and a headquarters review system that delays and withholds medical care. Whether or not these practices on their own would suffice to cause a substantial risk of serious harm, the totality of these barriers (along with the other inadequacies described herein) unquestionably increases the likelihood that Class members will not receive crucial medical care and treatment.[681]

e. Inadequate Chronic Disease Management

Although "[o]ne does not need to be an expert to know that [a] complex, chronic illness requires comprehensive and coordinated care,"[682] Defendants fail to maintain a meaningful chronic disease management program.[683] The deficiencies in Angola's chronic disease management increase the likelihood that Class members' symptoms will persist and worsen; that their underlying diseases will unnecessarily progress and become more complicated or even untreatable; and that their ability to complete daily functions will not improve or will deteriorate.[684] Far from remote, these potentially devastating consequences are tragically real and omnipresent at Angola, which is laid bare by the findings in Plaintiffs' expert report. As detailed in that report, Plaintiffs' experts "identified preventable deaths and inadequate care in almost every medical chart [they] reviewed,"[685] and that

[679] PX 6 at 0013-14.
[680] *See, e.g., Cooper*, 2014 WL 4187558, at *6 (observing that EMTs "are not the equivalent of a physician or other medical professional").
[681] *See, e.g., Wilson*, 501 U.S. at 304 (noting that conditions of confinement may have a "mutually enforcing effect" resulting in a violation of the Eighth Amendment).
[682] *Glisson*, 849 F.3d at 382.
[683] *See supra* ¶¶ 145-50; PX 6 at 0008, 0042-43, 0047.
[684] PX 6 at 0042.
[685] PX 6 at 0027.

chronic diseases in particular were inadequately controlled and treated on a system-wide basis, in many cases leading to patients' untimely deaths.[686]

f. Failure to Provide Timely Access to Specialty Care

Defendants' policies and practices that delay and restrict access to specialty care further exacerbate the risk that Class members will not receive necessary treatment.[687] As detailed above, such practices include but are not limited to (i) understaffing and reliance on unqualified personnel, which delays recognizing the need for chronic care; (ii) relying on DOC Headquarters both to schedule and review the "medical necessity" of specialty care; (iii) failing to track appointments; (iv) failing to ensure that prerequisite testing is completed; and (v) failing to provide disabled patients with proper transportation.[688]

The evidence also proves that Defendants routinely fail to ensure that specialists' and other outside providers' follow-up instructions are properly executed,[689] which further compounds the risk of unnecessary pain, suffering, and poor prognosis.[690]

g. Inadequate Inpatient Care

Deficiencies also infect Defendants' provision of inpatient care at Angola. Despite housing patients with the most severe medical needs, Angola's infirmary units are insufficiently and inadequately staffed by both providers and nurses,[691] thereby increasing the risk that the most debilitated patients will not receive necessary treatment.[692] In lieu of sufficient provider and nursing

---

[686] *See, e.g.,* PX 6 at 0033, 39-40, 47, 76; *see also supra* ¶¶ 33-47.
[687] *See Morales Feliciano*, 13 F. Supp.2d at 193 ("Delays in obtaining appointments in off-site subspecialty clinics threatens the continuity of a patient's medical care.").
[688] *See supra* ¶¶ 151-163; PX 6 at 0072-75; *see also Inmates of Occoquan*, 717 F. Supp. at 867 (Eighth Amendment violation found in part because "inmates wait months for appointments to specialty clinics"); *United States v. Michigan*, 680 F. Supp. 928, 1002 (W.D. Mich. 1987) (concluding that prison officials "may not allow . . . transportation concerns to override a medical determination that a particular inmate is in need of prompt treatment and must be transported to an appropriate facility"); *Morales Feliciano*, 13 F. Supp.2d at 178 (concluding that Eighth Amendment violation was supported by evidence that prison failed to provide necessary transportation to specialty clinics).
[689] *See supra* ¶¶ 160-63; PX 6 at 0074-75.
[690] *See, e.g., Lawson*, 286 F.3d at 262-63 (failing to properly execute follow-up medical instructions constituted Eighth Amendment violation); *Gil v. Reed*, 381 F.3d 649, 661-62 (7th Cir. 2004) (failure of prison doctor to follow outside providers' instructions could support a jury finding of Eighth Amendment violation); *Blankenship v. Obaisi*, 443 F. App'x 205, 209 (7th Cir.2011) (collecting cases finding that rejecting follow-up care instructions may support an Eighth Amendment violation).
[691] *See supra* ¶¶ 64-66; PX 6 at 0079-82.
[692] *See Anderson v. City of Atlanta*, 778 F.2d 678, 686 n.12 (11th Cir. 1985) (holding that Eighth Amendment violation "may be shown by proving a policy of deficiencies in staffing"); *White v. Cooper*, No. 08–CV–1321, 2009 WL 1230008, *4-5 (W.D. La. May 5, 2009) (holding that inmate stated a viable claim under the Eighth Amendment where prison understaffed medical infirmary); *cf Braggs*, 257 F. Supp. 3d at 1212 (noting that understaffing of mental health care workers "created a substantial risk of serious harm," including a "greater risk for continued pain and suffering").

care, Defendants employ inmate orderlies, supervised by custodial staff, to provide medically crucial services such as bathing, cleaning, and positioning, subjecting the most vulnerable Class members to a substantial risk of abuse and neglect.[693] This risk of harm is enhanced by Defendants' failure to provide safe and sanitary conditions in the infirmary. [694]

h. Inadequate Pharmacy Services and Medication Administration

As detailed in the Proposed Findings of Fact above, Defendants policies and practices regarding the provision of medication at Angola further contribute to the substantial risk of serious harm. For example, Defendants' effective prohibition on prescribing narcotics to many patients for whom narcotics are medically necessary increases the likelihood that those patients will continue to experience unnecessary pain and suffering.[695] Similarly, Defendants' policy of banning many HCV-positive patients from receiving antiviral therapy increases the likelihood that those patients will not only experience unnecessary pain and suffering but also an untimely death;[696] indeed, courts have recognized that "it is important to treat patients with HCV as soon as possible so that they can be cured of the virus before their liver becomes significantly diseased."[697]

Plaintiffs also established that Defendants' medication administration protocols create a substantial risk of serious harm. For instance, Defendants' reliance on correctional officers without adequate training to dispense medication creates a risk that patients will receive the wrong medication, will not receive medication at the appropriate time, or that other errors may occur that negatively impact the Class's health.[698]

i. Inadequate Diagnostic Services

The Court also finds that Defendants' systemic failure to provide and review diagnostic testing contributes to the substantial risk of serious harm for Class members. As explained above, evidence showed that Defendants fail to provide sufficient testing, such as glucose tests for

---

[693] *See supra* ¶¶ 167-74; PX 6 at 0081-82.
[694] *See supra* ¶ 172; PX 6 at 0081-82.
[695] *See supra* ¶¶ 176-78; PX 6 at 0084; *see, e.g., Grawcock v. Hodges*, No. 1:10–CV–345–RLM, 2012 WL 3245977, *3 (N.D. Ind. Aug. 6, 2012) ("Strict adherence to a policy that bans narcotic medications raises a question of fact as to whether the denier was deliberately indifferent to a serious medical need and whether having a policy against narcotic medications violates constitutional rights.").
[696] *See supra* ¶¶ 179-86; *see, e.g,* Rec. Doc. 438-8 at 30-31.
[697] *Hoffer v. Jones*, 290 F. Supp. 3d at 1304.
[698] *See supra* ¶¶ 188-96; PX 6 at 0050-51; *see also, e.g.*, JX 4-n, M. Murray Depo. at 56:19-24 (describing errors in medication administration); JX 4-d, C. Butler Depo. at 34:11-35:13, 36:18-37:2, 40:8-41:10 (describing Angola running out of medication and providing wrong medication); *Baker v. Litscher*, No. 17-CV-1275-JPS, 2017 WL 6001783, *5 (E.D. Wis. Dec. 4, 2017) (holding that Plaintiff stated a claim for Eighth Amendment violation where prison warden "knew of the risks inherent" to the policy of "using correctional officers to distribute medication . . . but nevertheless did not alter it").

diabetics[699] and colonoscopies of at-risk patients.[700] Failure to provide necessary diagnostic testing increases the likelihood of delayed diagnosis and treatment.[701]

j. Failure to Create, Maintain and Use Adequate and Reliable Medical Records

Courts have recognized that "inadequate, inaccurate and unprofessionally maintained medical records" pose a "grave risk of unnecessary pain and suffering."[702] Yet, Defendants' chaotic hybrid record system results in missing and unfiled records.[703] Moreover, Defendants' also maintain a practice of failing to ensure medical records are available during sick call, urgent, and walk-in evaluations.[704] Courts have recognized the risk of harm caused when "medical records are not always available at sick call" and when those records "do not always have the appropriate or required documentation of assessment of medical problems."[705] Defendants' policy of refusing to allow patients to see their own medical records further increases the risk of harm, because the prohibition impairs patients from understanding their conditions such to alleviate their own symptoms[706] and to provide outside providers with information about their condition when those providers lack access to records. Combined with the other inadequacies described herein,[707] Defendants' failure to maintain an adequate and readily accessible medical record system increases the likelihood of a substantial risk of harm.

k. Inadequate Facilities

---

[699] PX 6 at 0055.
[700] *See* PX 42 (Dr. Singh on 12/13/13: "Some of the offenders at LSP were waiting for CT scan and MRI or cancer care since late 2011. … As far as I know no [colonoscopies] were done at LSP for 2 years or longer. Once access has been restored, even then we can not get all 600 colonoscopies done immediately."); PX 26 (Ms. Lamartiniere: "[W]e will temporarily suspend the entering of screening referrals [for colonoscopies] until notified by [headquarters] to resume."); *compare* PX 4, J. Collins Depo. at 78:6-9 (Dr. Collins: "You had a screening colonoscopy when you hit 50. … That's basically the requirement."); PX 4-c, A. Brent Depo. at 56:23-57:21 (61-year-old Class member requested colonoscopy and was denied by multiple doctors); PX 4, K. Clomburg Dep. at 69:18-71:4 (similar).
[701] *Brown v. Coughlin*, 758 F. Supp. 876 (finding Eighth Amendment violation where, *inter alia*, prisoners' "condition was one which could easily be remedied by diagnostic testing").
[702] *Burks v. Teasdale*, 492 F. Supp. 650, 676, 678 (W.D. Mo. 1980).
[703] PX 6 at 0058-59; *see also, e.g.*, PX 4, K. Hawkins Depo. at 14:9-15:16 (acknowledging possibility of records getting out of order and EMARs not being included in paper record); *see also, e.g.*, PX 4, R. Lavespere Ind. Depo. at 65:11-66:7 (noting that most records from outside hospitals do not become part of the paper record); *see also, e.g.*, PX 4-f, K. Clomburg Depo. at 39:12-40:6, 45:6-18 (describing providers not putting information about treatment or condition in medical records); PX 4-q, B. Prine Depo. at 41:25-42:25, 45:9-46:7 (same).
[704] PX 6 at 0060; *see also, e.g.*, PX 4, K. Hawkins Depo. at 23:9-24:4 (EMTs don't bring medical records to sick call; records must be transported in vans).
[705] *Casey v. Lewis*, 834 F. Supp. 1477, 1503 (D. Az. 1993).
[706] PX 6 at 0060.
[707] For example, the potential for harm stemming from lack of access to medical records during sick call is compounded by Defendants' reliance on unqualified EMTs to conduct sick call.

As explained in the Proposed Findings of Fact, the evidence at trial also showed deficiencies in Angola's medical facilities, such as unsanitary and un-confidential examination rooms as well as a lack of necessary medical equipment.[708] Again, while it may be that these poor conditions in isolation may not establish constitutional harm, the evidence demonstrated that such inadequacies increase the potential harm to the Class.

l. Inadequate Monitoring and Quality Assurance

Finally, Defendants' failure to provide adequate monitoring and quality assurance in their provision of medical care at Angola contributes to and perpetuates a culture where deficient care goes unnoticed and unrectified.[709] The evidence at trial demonstrated that Defendants lack effective protocols to monitor provider care[710] and patient mortality.[711] Defendants' abdication of their responsibility to provide such meaningful monitoring threatens patient safety and increases the likelihood that deficient care will persist.[712]

Applying the Subjective Test, Plaintiffs Have Proven that Defendants Are Deliberately Indifferent to their Serious Medical Needs. The obviousness and severity of the risks to prisoner health and safety that are created by Defendants' medical policies and practices manifest Defendants' deliberate indifference. As explained *supra*, deliberate indifference can be satisfied by showing that the risk to prisoner safety is so apparent as to impute actual knowledge of that risk to prison officials.[713] This inference may be further buttressed by evidence that unconstitutional conditions have persisted for a "long duration."[714]

Such are the circumstances here. As the record evidence lays bare, the deficiencies in the provision of nearly all aspects of medical care at Angola are "long-standing, pervasive, [and] well-documented" such that Defendants must have recognized those deficiencies and their concomitant dangers to the thousands of people in their custody and care.[715] In cases involving similarly severe risks to prisoner safety, courts have found officials to be deliberately indifferent even where

---

[708] PX 6 at 0029-32.
[709] *Madrid*, 889 F. Supp. at 1209 ("Failure to institute quality control procedures has had predictable consequences: grossly inadequate care is neither disciplined nor redressed.").
[710] PX 6 at 002627.
[711] PX 6 at 0084; Thomas Rep. at 72.
[712] *See, e.g., Madrid*, 889 F. Supp. at 1209 ("Similarly, a system for review of the numerous avoidable inmate illnesses, as well as inmate deaths, would have underscored the systemic deficiencies in the [prison's] health care system."
[713] *See Farmer*, 511 U.S. at 842 (deliberate indifference can be from the very fact that the risk was obvious"); *Gates*, 376 F.3d at 343 (noting that the "obvious and pervasive nature" of various deficient prison supported the conclusion that prison officials were deliberately indifferent").
[714] *Wilson*, 501 U.S. at 300(1991).
[715] *Farmer*, 511 U.S. at 842.

plaintiffs did not present any additional evidence showing officials had actual knowledge of the risks to prisoner safety beyond the deplorable conditions themselves.[716]

But Plaintiffs do not rely exclusively on the obviousness of the risk of harm in order to prove Defendants' deliberate indifference. Rather, as outlined in the Proposed Findings of Fact, Plaintiffs presented substantial evidence—which the court credits—demonstrating that Defendants had actual knowledge of the risk of harm.[717] For decades, warnings of deficient care have come from a variety of different sources—the Department of Justice, outside consultants, and outside providers—but all put Defendants on notice of the same overarching concern: deficiencies in the provision of medical care at Angola place prisoners at a substantial risk of serious harm.[718] Far from vague, these warnings detailed specific inadequacies that placed prisoners in harm's way: delays in treatment, inadequate follow-up care, deficient treatment of chronic illnesses, inadequate sick call procedures, lack of adequately trained and sufficient numbers of staff, deficiencies in medication protocols, among others.[719] And yet, as the evidence unquestionably shows, these inadequacies and their corresponding risks of substantial harm persist to the present day.

However, the evidence further establishes that Defendants did not require these repeated warnings in order to comprehend the substantial risks stemming from their policies and practices. That is because the risk of harm was already reflected in Defendants' own records and known by their employees. As explained in the Proposed Findings, Defendants were aware of inadequate staffing, the potential risks of relying on unqualified staff, backlogs in treatment, and high patient mortality.[720] Moreover, Defendants were aware of how these deficiencies detrimentally impacted Angola's population, as evidenced by patients' frequent complaints about the quality of medical care.[721]

Yet, despite their awareness of the risks of harm, Defendants have failed to implement reasonable measures to abate that risk as required by the Eighth Amendment.[722] To the extent that the evidence shows that Defendants have taken any remedial measures whatsoever, the evidence also demonstrates that those measures "simply do not go far enough" when weighed against the risk

---

[716] *See, e.g., Gates*, 376 F.3d at 333 (affirming trial court's findings that the long-standing and obvious nature of several deficient prison conditions demonstrated prison officials' deliberate indifference to such conditions)' *Alberti*, 937 F.2d at 998 (holding that "there is little doubt" that officials were aware of unconstitutional conditions given decades of court involvement on the issue); *Ramos*, 639 F.2d at 572 (holding that prison officials were deliberately indifferent to the safety needs of inmates because officials provided inadequate levels of correction officer staffing).
[717] *See supra* ¶¶ 230-83.
[718] *See supra* ¶¶ 237-63.
[719] *See supra* ¶¶ 230-83.
[720] *See supra* ¶¶ 264-75.
[721] *See supra* ¶¶ 276-78.
[722] *Cf. Gates*

of harm to Class members.[723] Thus, such efforts do not constitute the constitutionally required "reasonable measures to abate" the risk of harm.[724]

In sum, the record is clear that Defendants "know[ ] of and disregard[ ] [the] excessive risk to inmate health [and] safety" at Angola, have failed to reasonably respond to that risk, and are thus deliberately indifferent in violation of the Eighth Amendment.[725]

a. Applying the Subjective Test, Plaintiffs Have Also Proven that Defendants are Deliberately Indifferent to the Serious Medical Needs of HCV-Positive Patients.

When prison officials know that prisoners are diagnosed with HCV, "there is no question that [they have] knowledge of a risk of serious harm."[726] Thus, if a defendant prison official knows that a prisoner has HCV, the only remaining analysis to establish deliberate indifference asks whether the Defendant disregarded the risk of serious harm to inmate health by more than mere negligence.[727]

In the context of prison health care, systemic deficiencies can also evidence deliberate indifference.[728] For example, repeated instances of delaying or denying medical care can indicate deliberate indifference by prison officials to the harm and suffering that result.[729]

When prison officials are aware of: (1) the availability and efficacy of DAA drugs for treating HCV, (2) that the standard of care for treating HCV requires treatment of *all* patients suffering from chronic HCV with DAA drugs, and (3) that failing to treat HCV increases the risks of medical issues while decreasing the efficacy of DAAs, but yet categorically deny DAA treatment to prisoners, they are acting with deliberate indifference.[730]

Because chronic HCV is a progressive disease, and delays in treating it with DAAs reduce the benefits associated with treatment, prison officials who deny DAA treatment to prisoners with chronic HCV on the basis of arbitrary test scores engage in the unnecessary and wanton infliction of pain to prisoners, increasing the risk of serious damage to their health.[731] This constitutes a deliberate disregard

---

[723] *Laube v. Haley*, 234 F. Supp.2d 1227, 1251 (M.D. Ala. 2002).
[724] *Farmer*, 511 U.S. at 847.
[725] *Farmer*, 511 U.S. at 837.
[726] *Hoffer v. Jones*, 290 F. Supp. 3d 1292, 1299 (N.D. Fl. 2017) ("There is no question that Defendant has knowledge of a risk of serious harm—Defendant knows that Plaintiffs and Plaintiffs' class are diagnosed with HCV.").
[727] *Id.*
[728] *Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991).
[729] *Id.*
[730] *See Postawko v. Missouri Dept' of Corrs.*, No. 2:16-cv-04219, 2017 WL 1968317, at *6 (W.D. Mo. May 11, 2017) (finding that plaintiffs plausibly alleged that defendants deliberately disregarded their serious medical need for DAA treatment of their HCV in light of the knowledge defendants had about DAAs and their refusal to treat HCV-infected prisoners with DAAs);
[731] *Postawko v. Missouri Dept' of Corrs.*, No. 2:16-cv-04219, 2017 WL 1968317, at *7 (W.D. Mo. May 11, 2017).

of the serious medical need of prisoners for DAA treatment.[732] Lack of funding is "no excuse" for failing to provide HCV-infected prisoners with DAA treatment.[733]

Plaintiffs have established that Defendants routinely and systemically failed to properly assess, diagnose and treat HCV for people who are incarcerated at LSP. Defendants delay and denial of care for HCV violates the Eighth Amendment.

V. Americans with Disabilities Act

A. DEFENDANTS' PRACTICES VIOLATE THE AMERICANS WITH DISABILITIES ACT AND REHABILITATION ACT

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[734] In order to make out a claim against a public entity under Title II, the plaintiff must show: (1) that he or she has a qualifying disability; (2) that he or she is being denied the benefit of services, programs, or activities or otherwise discriminated against by a public entity, and (3) that the discrimination is by reason of his or her disability.[735] "Violations of Title II are largely defined by its implementing regulations, which flesh out public entities' statutory obligations with more specificity, and are controlling authority unless they are arbitrary, capricious, or manifestly contrary to the statute."[736]

"Section 504 of the Rehabilitation Act prohibits disability discrimination by recipients of federal funding."[737] For all relevant purposes, Title II of the ADA and § 504 of the RA are identical.[738]

---

[732] *Id.*

[733] *Hoffer v. Jones*, 290 F. Supp. 3d 1292, 1300 (N.D. Fl. 2017) ("[T]his court finds as a matter of fact that FDC's failure to treat was due to a lack of funding . . . . Here, funding is no excuse for FDC's failure to provide treatment."); *id.*, n. 15 ("Of course, this Court recognizes that issues of funding might excuse some delay. For instance, if DAAs were released yesterday, this Court would not expect FDC to wave a magic wand and suddenly treat thousands of inmates overnight. But that is not the case. FDC has had since late 2013 to respond to this problem, and it has only just recently started doing what it should have done years ago."); *see Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) ("Lack of funds for facilities cannot justify an unconstitutional lack of competent medical care and treatment for inmates.")

[734] 42 U.S.C. § 12132.

[735] *Hale v. King*, 642 F.3d 492, 499 (5th Cir. 2011).

[736] *Hernandez v. Cty. of Monterey*, 110 F. Supp. 3d 929, 935 (N.D. Cal. 2015) (quoting *Cohen v. City of Culver City*, 754 F.3d 690, 695 (9th Cir. 2014)) (quotation marks omitted).

[737] *Frame v. City of Arlington*, 657 F.3d 215, 223 (5th Cir. 2011).

[738] *See id.* ("The ADA and the Rehabilitation Act generally are interpreted *in pari materia*.")

State prisons such as LSP are "public entities" within the purview of the ADA.[739] LSP therefore must comply with Title II of the ADA.

The DOC receives federal financial assistance.[740] Thus, the DOC must comply with the RA.[741]

B. The subclass consists of qualified individuals with disabilities.

The ADA and RA protect individuals with "qualifying disabilit[ies]."[742] A person has a qualifying disability if he or she has a physical or mental impairment that substantially limits one or more major life activities.[743] "Major life activities" include, but are not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[744] A major life activity also "includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."[745] The record clearly demonstrates that the subclass consists of qualified individuals with disabilities.

C. Angola Denies Programmatic Access to and Discriminates Against Individuals with Disabilities

Appendix A to the Title II regulations states that

> [D]etention and correctional facilities are unique facilities under title II. Inmates cannot leave the facilities and must have their needs met by the corrections system, including needs relating to a disability. If the detention and correctional facilities fail to accommodate prisoners with disabilities, these individuals have little recourse, particularly when the need is great (e.g., an accessible toilet; adequate catheters; or a shower chair). It is essential that corrections systems fulfill their nondiscrimination and program access obligations by adequately addressing the needs of prisoners with disabilities, which include, but are not limited to, proper medication and medical treatment, accessible toilet and shower facilities, devices such as a bed transfer or a shower chair, and assistance with hygiene methods for prisoners with physical disabilities.[746]

Indeed, "[b]ecause of the unique nature of correctional facilities, in which jail staff control nearly all aspects of inmates' daily lives, most everything provided to inmates is a public service, program or

---

[739] *See, e.g., Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) ("[S]tate prisons fall squarely within the statutory definition of 'public entity'.").
[740] *Ball*, 988 F. Supp. 2d at 684 n.104; La. Rev. Stat. 36:401(B)(4).
[741] *Pace v. Bogalusa City Sch. Bd.*, 403 F.3d 272, 282-85 (5th Cir. 2005) (en banc) (42 U.S.C. § 2000d-7 "conditions receipt of federal funds . . . on the State's waiver of Eleventh Amendment immunity" for suits under the RA).
[742] *King*, 642 F.3d at 499.
[743] 42 U.S.C. § 12102(1)(A); 28 C.F.R. §§ 35.104, 36.104; 49 C.F.R. § 37.3.
[744] 42 U.S.C. §12102(2).
[745] *Id.*
[746] 28 C.F.R Part 35, Appendix A.

activity, including sleeping, eating, showering, toileting, communicating with those outside the jail by mail and telephone, exercising, entertainment, safety and security, the jail's administrative, disciplinary, and classification proceedings, medical, mental health and dental services, the library, educational, vocational, substance abuse and anger management classes and discharge services."[747] Based on the record, the Court concludes that individuals with disabilities are denied the benefits of Angola's services, programs, and activities, and are subjected to discrimination.

1. Architectural Barriers to Angola's Programs, Services, and Activities

Public entities such as correctional facilities, must "take reasonable measures to remove architectural and other barriers" that deny access to the entity's services, programs, or activities.[748] "[E]limination of architectural barriers was one of the central aims of the [ADA] . . . ."[749] Under its ADA rulemaking power, the DOJ has promulgated rules requiring public entities such as prisons to comply with certain architectural accessibility standards.[750] Those regulations include 28 C.F.R. §§ 35.150-152, which require new construction or alterations to meet either the Uniform Federal Accessibility Standards ("UFAS") or the 1991 or 2010 ADA Accessibility Guidelines ("ADAAG," sometimes referred to as the "1991 Standards" and "2010 Standards"), depending on the date of construction or alteration.[751] If construction or alteration commenced after 1992, "the regulations require compliance with specific architectural accessibility standards."[752]

If a facility has not been altered since the enactment of the RA and ADA regulations, it nonetheless must operate each service, program, or activity so that, when viewed in its entirety, the service, program, or activity is readily accessible to and usable by individuals with disabilities.[753] As an alternative to strict compliance with the ADA standards, an entity may comply with this requirement through methods such as "redesign or acquisition of equipment, reassignment of

---

[747] *Hernandez*, 110 F. Supp. 3d at 935-36; *see also Yeskey*, 524 U.S. at 210 ("Modern prisons provide inmates with many recreational 'activities,' medical 'services,' and educational and vocational 'programs,' all of which at least theoretically 'benefit' the [inmates]."); *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1068 (9th Cir. 2010) (noting that jails provide inmates "with various positive opportunities, from educational and treatment programs, to opportunities to contest their incarceration, to the fundamentals of life, such as sustenance, the use of toilet and bathing facilities, and elementary mobility and communication"); *Phipps v. Sheriff of Cook Cty.*, 681 F. Supp. 2d 899, 916 (N.D. Ill. 2009) (collecting cases holding that in the prison setting, "services, programs, and activities" include facilities such as showers, toilets, and sinks); Jaros v. Ill. Dep't of Corr., 684 F.3d 667, 672 (7th Cir. 2012) (collecting cases).

[748] *Tennessee v. Lane*, 541 U.S. 509, 531 (2004) (citing 42 U.S.C. § 12131 (2)).

[749] *Alexander v. Choate*, 469 U.S. 287, 297 (1985).

[750] *See generally* 42 U.S.C. § 12134(a) (requiring Attorney General to promulgate regulations); *Frame*, 657 F. 3d at 232 ("DOJ's regulations . . . simply apply Title II's nondiscrimination mandate.").

[751] The UFAS, promulgated to enforce the RA, are "nearly identical" to the 1991 ADAAG Standards. *Greer v. Richardson Indep. Sch. Dist.*, 472 F. App'x 287, 291 n.2 (5th Cir. 2012).

[752] *Lane*, 541 U.S. at 532.

[753] 34 C.F.R. §104.22(a); 28 C.F.R. § 35.150(a).

services to accessible buildings, assignment of aides to beneficiaries, home visits, [or] delivery of services at alternate accessible sites."[754]

It is not enough for the entity to provide *some* access to individuals with disabilities; rather, it must provide "meaningful access" to the programs and services that are offered.[755] As the Tenth Circuit observed in *Chaffin*,

> [E]ven under the less stringent program accessibility standard, the facilities as a whole must be "*readily* accessible." . . . .A violation of Title II "does not occur only when a disabled person is completely prevented from enjoying a service, program, or activity. . . . If a [facility's] wheelchair ramps are so steep that they impede a disabled person or if its bathrooms are unfit for the use of a disabled person, then it cannot be said that the [facility] is 'readily accessible.'" [756]

The Title II regulations also include specific requirements for correctional facilities. Specifically, jails and prisons must "ensure that qualified inmates or detainees with disabilities shall not, because a facility is inaccessible to or unusable by individuals with disabilities, be excluded from participation in, or be denied the benefits of, the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity."[757] As part of that commitment, facilities must "implement reasonable policies, including physical modifications to additional cells in accordance with the 2010 Standards, so as to ensure that each inmate with a disability is housed in a cell with the accessible elements necessary to afford the inmate access to safe, appropriate housing."[758]

Even under the more flexible "program access" standard applicable to existing constructions, courts "rely on the ADAAG for guidance" in determining whether a facility's programs are accessible.[759]

---

[754] 28 C.F.R. 35.150(b)(1).

[755] *See, e.g., Lane*, 541 U.S. at 533 (no "meaningful right of access" to second-floor courtroom where wheelchair users had to crawl up stairs); *Chaffin v. Kan. State Fair Bd.*, 348 F.3d 850, 857 (10th Cir. 2003) (barriers to accessible seating, restrooms, and parking prevented "meaningful access" even though wheelchair users were able to attend), *overruled on other grounds by Verizon Md. Inc. v. Pub. Serv. Cpmm'n of Md.*, 535 U.S. 635, 645 (2002).

[756] 348 F.3d at 860 (citations omitted); *see also Saunders v. Horn*, 959 F. Supp. 689, 697 (E.D. Pa. 1996) (allegation that prison did not provide "readily accessible bathroom and shower facilities" stated a claim under Title II's program access requirement).

[757] 28 C.F.R. § 35.152(b)(1)

[758] *Id.* § 35.152(b)(3). Courts have construed "cells" to include dormitories and other housing arrangements in the correctional setting. *See, e..g.*, *Hernandez*, 110 F. Supp. 3d at 935; *Barhite v. Brown*, No. 1:14-CV-218, 2014 WL 2918550, at *25-26 (W.D. Mich. June 26, 2014); *Manemann v. Texas Dep't of Criminal Justice*, No. CIV.A. H-12-2239, 2014 WL 905876, at *8 (S.D. Tex. Mar. 7, 2014).

[759] *Greer*, 472 F. App'x at 292 n.3; *see also, e.g., Pascuiti v. N.Y. Yankees*, 87 F. Supp. 2d 221, 226 (S.D.N.Y. 1999) ("[E]ven though only new construction and alterations must comply with the Standards, those Standards nevertheless provide valuable guidance for determining whether an existing facility contains architectural barriers."); *Flynn v. Doyle*, 672 F. Supp. 2d 858, 879 (E.D. Wis. 2009) (holding that "evidence regarding the alleged failure to meet the UFAS/ADAAG standards could still be relevant in the context of a 'program accessibility' case" because "[a] program could be

The Court concludes that the nearly 200 undisputed architectural barriers identified by Plaintiffs' expert, Mark Mazz, deprive individuals with disabilities of meaningful access to Angola's programs and services. Both the physical characteristics of the surveyed areas and the testimony of Class members show that individuals with mobility impairments lack ready access to many of the prison's basic programs, services, and activities, including toilets, showers, medical care, communication devices, drinking fountains, and most programs outside the dormitories themselves. Here, as in *Chaffin*, the individual barriers combine to impede Class members' access to programs and services throughout the prison. From bathrooms to recreational areas to medical facilities, Defendants have failed to make programs and services "readily accessible."[760]

The Court further concludes that Angola has failed to make its programs, services, and activities accessible to individuals with disabilities through alternative methods. Because Mazz limited his survey to areas designated for use by individuals with disabilities—in other words, the prison's *most* accessible areas—the Department cannot reassign the services offered in those areas to accessible buildings, or deliver the services at alternative accessible sites. Nor can the programs, services, and activities identified in his survey be brought to the disabled individual. For example, the prison cannot bring the recreation yards, showers, or JPay stations to a patient. Finally, for the reasons stated in the findings of fact, the Court concludes that the assignment of inmate health care orderlies to the ward and medical dormitories is insufficient to render Angola's programs "readily accessible."[761]

2. Failure to Integrate Individuals with Disabilities

Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"[762] In the correctional setting, facilities must "ensure that inmates or detainees with disabilities are housed

---

rendered inaccessible if it is held in an inaccessible facility"); *Gathright-Dietrich v. Atlanta Landmarks, Inc., 435 F. Supp. 2d 1217, 1226 (N.D. Ga. 2005)* (concluding that in existing constructions, the existence of architectural barriers should be determined using the standards as a guide, although the Defendant may have more flexibility in determining how to address the barrier); *Brown v. Cty. of Nassau*, 736 F. Supp. 2d 602, 616-18 (E.D.N.Y. 2010) (using the standards, in conjunction with other evidence, to determine the existence of barriers that violate the "program access" standard).

[760] 28 C.F.R. § 35.150(a).

[761] *Cf. Armstrong v. Brown*, 857 F. Supp. 2d 919, 933 (N.D. Cal. 2012) ("Reliance on other prisoners for access to basic services, such as food, mail, showers and toilets by prisoners with disabilities leaves them vulnerable to exploitation and is a dangerous correctional practice."); *Wright v. N.Y. State Dep't of Corr. & Cmty. Supervision*, 831 F.3d 64, 73-75 (2d Cir. 2016) (noting that mobility assistance program was ineffective because it required disabled individuals to "seek out and rely upon the cooperation of other inmates," exposed disabled inmates to a risk of neglect, and was "fundamentally in tension with the ADA and RA's emphasis on independent living and self-sufficiency," even in the prison setting); *Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1269 (D.C. Cir. 2008) (noting that the ADA and RA emphasize that for disabled individuals the "enjoyment of a public benefit is not contingent upon the cooperation of third persons"); *Flynn v. Doyle*, 672 F. Supp. 2d 858, 878-79 (E.D. Wis. 2009) (plaintiff could state ADA claim even if she availed herself of the assistance of wheelchair pushers to traverse treacherous paths on prison grounds).

[762] 28 CFR 35.130(d).

in the most integrated setting appropriate to the needs of the individuals."[763] Specifically, prisons must not "place inmates or detainees with disabilities in designated medical areas unless they are actually receiving medical care or treatment."[764] The goal is to "enable[] individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[765]

For the reasons stated in the findings of fact, the Court concludes that the Department failed to integrate individuals with disabilities.[766]

3. Failure to Provide Reasonable Accommodations or Modifications

Title II requires public entities to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."[767] Reasonable accommodations include actions such as the transfer of an inmate or the provision of a shower chair,[768] or the provision of accessible transportation.[769]

For the reasons stated in the findings of fact, the Court concludes that the Department failed to provide reasonable accommodations and modifications.[770]

4. Discriminatory Methods of Administration

"A public entity may not . . . utilize criteria or methods of administration: (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or] (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; . . ."[771].

Because Title II regulations require public entities to accommodate individuals they identify as disabled, correctional facilities must implement some form of disability tracking system in order to comply with the ADA.[772]

---

[763] 28 C.F.R. § 35.152(b)(2).
[764] *Id.*
[765] 28 C.F.R Part 35, Appendix B.
[766] *See supra* ¶ 299.
[767] 28 CFR 35.130(b)(7)(i); *see also Garrett v. Thaler*, 560 F. App'x 375, 382 (5th Cir. 2014) ("Title II imposes an obligation on public entities to make reasonable accommodations or modifications for disabled persons, including prisoners.").
[768] *Schmidt v. Odell*, 64 F. Supp. 2d 1014, 1033 (D. Kan. 1999).
[769] *Allah v. Goord*, 405 F. Supp. 2d 265, 279 (SDNY 2005); *accord Gorman v. Bartch*, 152 F.3d 907, 913 (8th Cir. 1998).
[770] *See supra* ¶¶ 300-10.
[771] 28 CFR 35.130(b)(3).
[772] *Armstrong v. Davis*, 275 F.3d 849, 876 (9th Cir. 2001), *abrogated on other grounds by Johnson v. California*, 543 U.S. 499, 504-5 (2005).

Additionally, Title II requires public entities employing 50 or more people to "adopt and publish grievance procedures providing for prompt and equitable resolution of complaints alleging any action that would be prohibited by this part."[773] The entity must "designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities" under the Title II regulations, "including any investigation of any complaint communicated to it alleging its noncompliance" with the regulations.[774] The entity must "make available to all interested individuals the name, office address, and telephone number of the [designated] employee or employees."[775]

For the reasons stated in the findings of fact, the Court concludes that the Department utiliz4ed discriminatory methods of administration.[776]

5. Overt Discrimination or Denial of Programmatic Access

"(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability --**(i)** Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;"28 C.F.R. § 35.130.

For the reasons stated in the findings of fact, the Court concludes that the Department overtly discriminates against individuals with disabilities by, among things, denying disabled individuals the opportunity to obtain a job or to participate in hobby craft or work release.[777]

VI. PERMANENT INJUNCTION FACTORS

"To be entitled to a permanent injunction for a constitutional violation, a plaintiff must show (1) that there has been such a violation, (2) the existence of continuing irreparable injury if the injunction does not issue, and (3) the lack of an adequate remedy at law." Roy v. City of Monroe, No. 16-cv-1018, 2018 WL 4120013, at *9 (W.D. La. Aug. 29, 2018) (quoting Causeway Med. Suite v. Ieyoub, 905 F. Supp. 360, 266 (E.D. La. 1995); see generally eBay Inc. v. MercExchange, L.L.C., 547 U.S. 388, 391 (2006) (setting out four-factor permanent injunction test). Based on the facts and law detailed above, the permanent injunction factors are plainly satisfied:

First, as explained above, Defendants have violated Plaintiffs' constitutional and statutory rights.

Second, "[w]hen an alleged deprivation of a constitutional right is involved, … most courts hold that no further showing of irreparable injury is necessary." 11A Wright & Miller, Fed. Prac. & Proc., § 2948.1 (3d ed. 1998); accord, e.g., Cole v. Collier, No. 14-cv-1698, 2017 WL 3049540, at *43 (S.D. Tex. July 19, 2017) (Eighth Amendment violation is irreparable injury). The evidence conclusively demonstrates that Plaintiffs have suffered—and, more importantly, face an ongoing risk of suffering—irreparably injury. Specifically, all Class members face a risk of being irreparably

[773] 28 C.F.R. § 35.107(b).
[774] 28 C.F.R. § 35.107(a).
[775] *Id.*
[776] *See supra* ¶¶ 311-34.
[777] *See supra* ¶¶ 335-37

deprived of their rights under the Eighth Amendment; and all Subclass members face a risk of being irreparably deprived of their rights under the ADA and RA.

Third, remedies available at law, such as monitory damages, are inadequate to compensate for these injuries. Class members' injuries include preventable death, unremitting pain, and the progression of treatable medical conditions. Subclass members' injuries include, among other things, the inability to access crucial programs and services ranging from medical care to religious worship to safe bathrooms. Monetary damages cannot adequately compensate these irreparable injuries and would not ensure that similar constitutional violations would not be committed in the future. See, e.g., Ball v. LeBlanc, 988 F. Supp. 639, 688 (M.D. La. 2013), aff'd in rel. part, 792 F.3d 584.

Fourth, the balance of hardships weighs decisively in favor of Plaintiffs. Defendants expose all Class members at an ongoing risk of life-altering, irreversible harm to their health, extreme suffering, and death; they also deny Subclass members their rights under federal law to be free from discrimination on the basis of disability, and to obtain reasonable accommodations for their disabilities. Defendants' custodial and sovereign interests do not outweigh Class members' rights under the Eighth Amendment and the ADA and RA, and the relief that Class members request does not trench on Defendants' cognizable interests in any way.

Finally, the public interest will be served by a permanent injunction. The public has a strong interest in enforcing the protections of the Eighth Amendment, the ADA, and the RA for all individuals, regardless of their carceral status. The principle that all people shall be free from cruel and unusual punishment is one of the defining principles of our civil society. A system that subjects people within the custody of the government to medical practices that fall grotesquely short of contemporary standards of care and denies timely access to diagnosis and treatment of serious medical needs subverts that principle and injures the public as a whole. Moreover, the public interest is always served by government officials following the law, as the injunction in this case will ensure.

VII. RELIEF

Plaintiffs have proven that the pervasive, systematic deficiencies in the provision of medical care at Angola expose Class members to a substantial risk of serious harm, and that Defendants were deliberately indifferent to that risk. Plaintiffs have also proven that Defendants' policies and practices violate the rights of the ADA Subclass under the Americans with Disabilities Act ("ADA") and the Rehabilitation Act ("RA"). Defendants' health care system and treatment of inmates with disabilities are hereby **DECLARED** constitutionally inadequate due to the systematic inadequacies described herein. These systematic inadequacies include, but are not limited to, inadequate and inappropriate staffing; inadequate access to care; inadequate chronic disease program; failure to provide specialty care; inadequate treatment of emergency conditions; inadequate nursing and infirmary care; inadequate medication administration; inadequate diagnostic services; inadequate policies and procedures; inappropriate budget practices; inappropriate facilities; and inadequate monitoring and quality assurance.

Defendants are further **DECLARED** in violation of the ADA, as amended by the Americans with Disabilities Amendments Act ("ADAAA") and RA due to architectural barriers to programs, services, and activities; failure to integrate individuals with disabilities; failure to provide

reasonable accommodations or modifications; discriminatory methods of administration; and overt discrimination. Accordingly, Defendants are enjoined to remedy the substantial risk of serious harm to Class members and the violation of Subclass members' rights under the ADA and the RA.

IT IS HEREBY ORDERED that Defendants shall create a plan to correct the violations of the Eighth Amendment, ADA, and RA as identified herein. Given that the violations involve a substantial risk of serious of harm and loss of life, and that Defendants have been aware that their policies and practices were constitutionally deficient for more than 20 years,[778] it is essential that the parties move swiftly to begin to correct the systematic deficiencies. Defendants shall submit their proposed plan to the Court within 30 days of the issuance of this Order, along with a timeline for completing each item listed in the plan. The proposed relief must be both immediate and long-term. Plaintiffs shall comment on, propose alternatives to, or oppose any part of Defendants' proposal within 30 days. The Court shall thereafter evaluate and order any remedy it deems appropriate and consistent with the PLRA in order to correct the violations.[779]

Defendants' proposed plan shall include, among other things:

Medical Staffing Provisions

- a plan to identify and revise all the policies, directives, protocols, and regulations implicated by this order, and to provide appropriate training for all staff on all revisions;
- a plan to ensure sufficient staffing of both physicians and mid-level providers, in light of the size and medical acuity of the inmate population, in order to provide Plaintiffs with timely and appropriate access to qualified and competent providers for routine, urgent, emergent, and specialty health care;
- a plan to substantially increase nursing staff, particularly on the Nursing Units;
- an organizational chart and detailed job descriptions for all medical staff positions, including the position of a health services administrator to oversee all health care services at LSP who will have input in development of the health care budget and approval authority over health care spending;
- a temporary plan to provide substantially increased monitoring and supervision of physicians and nurses with disciplinary histories and a plan to eliminate the hiring of physicians and nurses with disciplinary histories;
- a plan for only hiring providers who are appropriately trained and credentialed for the type of care they will be privileged to provide, with a particular emphasis on hiring providers with appropriate specialties to treat patients with chronic diseases and other common primary care conditions;
- a plan for the timely completion of annual written health care staff performance evaluations, including appropriate measures to address unsatisfactory evaluations;

[778] *See* PX 17 (Consent Decree in *Lynn v. Williams*).
[779] *See* 18 U.S.C. § 3626(a)(1)(A); *Plata*, 131 S. Ct. at 1937-40.

- a plan for training applicable health care and custodial staff on all portions of the plan relevant to their job duties.

Clinical Provisions

- a plan for all medical complaints and conditions to be reviewed by an appropriate and qualified medical professional;
- a plan for every patient presenting to the ATU to receive a physical examination, review of recent medical records, and thorough medical assessment by a provider;
- a plan to have registered nurses (RNs) with access to Plaintiffs' complete medical records perform all sick call other than requests solely for a duty status or medication renewal;
- a plan to re-evaluate and lower the cost of sick call and emergency sick call such that it is aligned with the wages earned by inmates;
- a plan to eliminate the practice of overruling any recommendation from an outside specialist, which is not required by the reasonable use of a formulary, and to ensure the specialist recommendations and any other medically appropriate follow up care is provided;
- a plan to ensure that there is no delay in sending patients to the hospital when it is medically necessary, to timely review and make a determination as to all requests for routine and urgent specialty care, and to ensure approved specialty services are delivered timely and as clinically indicated;
- a plan that brings any denials of requests for routine and urgent specialty care into accordance with community standards, and ensures the denial and the reason for the denial are documented in the patients' medical records and communicated in writing to the patient and the requesting physician;
- a plan to revise chronic care protocols to align with current national standards for chronic care, including chronic care guidelines for all major chronic conditions;
- a plan to have nursing staff distribute medication rather than security officers and to document medication administration contemporaneously;
- a plan to bring the roles and performance of all EMS Personnel into conformance with the Louisiana Board of Emergency Medical Services Scope of Practice Matrix, including the requirement that EMS Personnel practice under the supervision of a physician and that the facility maintains documentation of biennial training on any optional modules performed by any EMS Personnel;
- a plan to provide medical providers and Plaintiffs with supplies necessary for medically adequate care;
- a plan to ensure basic sanitary conditions that do not promote the spread or exacerbation of diseases or infections, particularly on the nursing wards and in the assisted living dormitories;

- a plan to have nursing staff provide sick call and pill call on site for Plaintiffs in the assisted living dormitories, and to conduct daily rounds to examine patients and provide supervision, instruction, and assistance to the inmate health care orderlies;
- a plan to have all inmate health care orderlies on the infirmary and nursing wards be supervised by licensed nursing staff, and for qualified medical personnel, rather than orderlies, to perform activities of daily living on the infirmary and Nursing Units;
- a plan to ensure to ensure Do Not Resuscitate orders are properly discussed with patients and not proposed to patients with altered mental status in the midst of life-threatening emergencies;
- a plan to revise policies to ensure timely and adequate mortality reviews by an unaffiliated physician with sufficient detail as to the cause of death and the relevant medical and treatment history;
- a plan to implement an electronic medical records system that includes adequate documentation of all medical encounters, including records from outside providers and medication administration records, and that makes medical records readily accessible to Class members upon request;
- a plan to reform LSP's Continuous Quality Improvement ("CQI") program to include participation by the Medical Director, Assistant Warden for Health Services, and all medical departments, and to empower the CQI program to develop, implement, and monitor the effectiveness of quality improvement plans.

ADA Provisions

- a job description for an ADA Coordinator and a plan to provide that individual the necessary training and time to meet the job requirements;
- a plan for the creation of an effective and comprehensive system for tracking individuals with disabilities and ensuring that they are accommodated appropriately in all aspects of their incarceration;
- a plan for the creation of a comprehensive database which captures all requests for accommodations (including letters, ARPs, RFAs, and verbal requests), as well as their status, disposition and any reasons therefor, and supporting documentation;
- a plan to provide training for all staff and healthcare orderlies about the ADA and compliance therewith by a qualified outside vendor;
- a plan to remove all access barriers to programs, services, and activities by eliminating the architectural barriers identified by Plaintiffs' ADA expert or the ADA monitor (discussed below);
- a plan for revising the duty status policy to provide for individually-tailored restrictions, a more robust classification system, and a process by which inmates can request a new or modified duty status without relying on the sick call system;
- a plan to train security personnel on the proper application of and compliance with duty status restrictions;

- a plan to ensure individuals with disabilities are transported safety in vehicles that adequately accommodate their disabilities both within and outside the facility;
- an evacuation and emergency response plan that accommodates all inmates with disabilities in all facilities where such inmates are housed or receive any programs, benefits, or services.

IT IS FURTHER ORDERED that Defendants shall within 30 days of this order

- ensure that medical staff play no role in the enforcement of security measure, except where ensuring that Class members' medical needs or disabilities are respected in disciplinary proceedings;
- cease the use of gastrointestinal lavage ("stomach pumping") and forced catheterization in emergency medical situations, unless indicated by specific evidence of drug overdose documented in writing;
- eliminate the use of malingering as a security charge
- cease reporting of EMS Personnel through the security chain of command rather than the medical chain of command, except to provide security during medical transport;
- cease reporting of inmate health care orderlies through the security chain of command, rather than the medical chain of command, in the performance of their job duties;
- ensure that all patients in the infirmary or Nursing Units are within sight and/or sound of a provider or nurse at all times;
- in medical dormitories, cease the use of inmate health care orderlies to provide any services other than assistance with Activities of Daily Living;
- cease discriminating in the provision of programs, services, and activities against inmates with a disability based upon the existence of the disability.

IT IS FURTHER ORDERED that the parties will formulate and agree to a plan for information-sharing, which will enable Plaintiffs to have ongoing and thorough access to the Class members and to obtain the information needed in order to evaluate the plan produced by Defendants and the implementation thereof.

IT IS FURTHER ORDERED that the Court will appoint three monitors to evaluate the implementation of the plan: one doctor, one nurse, and one ADA monitor. The monitors will visit the facility regularly, but at least 3 times per year, to conduct thorough review of the facility and of records selected by the monitors. The monitors shall have wide and full access to staff, Class members, documents, and anything else necessary for them to complete their review. The monitors shall also schedule regular conference calls with LSP staff between these visits in order to gather information and monitor compliance. The parties will have two weeks from the date of this Order in which to come up with agreed-upon candidates, subject to the Court's approval. If they are unable to agree, each party will submit a list of no more than three names per monitor position with

resumes to the Court within a week and the Court will select the monitors. Any disputes between the parties regarding the adequacy of any current or revised policies, procedures, protocols, training programs, staffing plans, or other items required by this Order will be submitted to the appropriate monitor for resolution, if the parties cannot reach agreement. In the event that either party is dissatisfied with the monitor's written resolution of any such dispute, that party may move the Court for relief. All costs incurred by the Parties in the enforcement of the Court's order will be paid by Defendants.

IT IS FURTHER ORDERED that Plaintiffs are the prevailing party in this case, and have leave to submit an initial Motion for Attorneys' Fees within 30 days of this order.

Respectfully submitted by:

/s/ Mercedes Montagnes
Mercedes Montagnes, La. Bar No. 33287
Amanda Zarrow (*pro hac vice*)
Nishi Kumar, La. Bar No. 37415
The Promise of Justice Initiative
636 Baronne Street
New Orleans, LA 70113
Telephone: (504) 529-5955
Facsimile: (504) 558-0378
Email: mmontagnes@thejusticecenter.org

Jeffrey B. Dubner (*pro hac vice)*
P.O. Box 34553
Washington, DC 20043
Telephone: (202) 656-2722
Email: Jeffrey.dubner@gmail.com

Daniel A. Small (*pro hac vice*)
Cohen Milstein Sellers & Toll PLLC
1100 New York Avenue NW, Suite 500
Washington, DC 20005
Telephone: (202) 408-4600
Facsimile: (202) 408-4699
Email: dsmall@cohenmilstein.com

Bruce Hamilton, La. Bar No. 33170
ACLU Foundation of Louisiana
P.O. Box 56157
New Orleans, Louisiana 70156
Telephone: (504) 522-0628
Facsimile: (504) 613-6511

Email: bhamilton@laaclu.org

Miranda Tait, La. Bar No. 28898
Advocacy Center
600 Jefferson Street, Suite 812
Lafayette, LA 70501
Telephone: (337) 237-7380
Facsimile: (337) 237-0486
Email: mtait@advocacyla.org

Jamila Johnson, La. Bar No. 37953
Meredith Angelson, La. Bar No. 32995
Jared Davidson, La. Bar No. 37093
Southern Poverty Law Center
201 Saint Charles Avenue, Suite 2000
New Orleans, LA 70170
Telephone: (504) 486-8982
Facsimile: (504) 486-8947
Email: jamila.johnson@splcenter.org
meredith.angelson@splcenter.org
jared.davidson@splcenter.org

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on October 3, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send a notice of electronic filing to all CM/ECF participants.

Dated : October 3, 2018

/s/ *Mercedes Montagnes*
Mercedes Montagnes