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' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

7. 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]

8. 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]

9. Defendant Tracy Falgout is the Assistant Warden for Health Services ("Assistant Warden") 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 of certain classes of employees, medical records, and any kind of staffing issues."[9]

10. Defendant Stacye Falgout is the Chief Nursing Officer for the DOC and has held that position since approximately October 2011. She reports directly to the Statewide Medical Director (previously 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]

11. 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]

12. Defendant Cynthia Park is a Nurse Practitioner at Angola and has held that position since October 2014. She is responsible for the medical care of the patients in the outcamps, as well as Nursing Unit 2 and all HIV, cancer, and hospice patients.[12]

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[6] UF ¶¶ 4-7; *see also* JX 4-rr, R. Lavespere Depo. at 11:7-12:9; JX 4-ff, J. Collins Depo. at 10:16-11:6, 129:3-6; JX 4-bbb, R. Singh Depo. at 8:15-20.
[7] UF ¶ 4; *see also* JX 4-bbb, R. Singh Depo. at 24:15-22.
[8] UF ¶ 5; JX 4-ss, J. Leblanc Depo. at 23:9-24:5.
[9] UF ¶ 6; JX 4-nn, S. Lamartiniere Depo. at 9:4-17, 10:13-16; Oct. 24 Testimony of Tracy Falgout at 156:19-22.
[10] JX 4-hh, S. Falgout Depo. at 7:12-22, 9:3-5, 13:10-18; Oct. 17 Testimony of Stacye Falgout at 124:22-126:5; *see also* UF ¶ 8.
[11] UF ¶ 9; *see also* JX 4-yy, Poret Depo. at 4:15-19.
[12] JX 4-uu, C. Park Depo at 6:5-8, 8:5-9:17.

III. OVERVIEW OF DISCOVERY

13. Plaintiffs filed suit on May 20, 2015.[13]

14. Discovery in this case took place from mid-2015 until September 2016 except for a few enumerated documents.[14]

15. In the fall of 2015, Defendants produced to Plaintiffs a list of inmates who had died, which was supplemented in January 2016.[15]

16. Plaintiffs requested medical records for all patients with chronic illnesses and all patients who had passed away between particular dates.[16] Defendants refused, leading to a compromise in which Defendants produced medical records for several dozen current and former Class members, largely produced in spring 2016.[17]

Plaintiffs' site viTm.0013 Tc64 540.1801 Tm.0005 7.02 360eraln8n1:V 17Defendants' site vi

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IV. OVERVIEW OF MEDICAL CARE PROVIDED BY DEFENDANTS

20. Class members are housed in the following locations:

[13] Rec. Doc. 1.
[14]
[15] Oct. 15 Testimony of Susi Vassallo atT140:2-9.
[16] *See generally* Rec. Doc. 80-1.
[17] *See generally* Rec. Doc. 80-1.
[18] PX 6 atT0004
[19] DX 13 atT02842;
[20] *See generally* Rec. Doc. 166 and PX 6 at 1.
[21] Rec. Doc. 116
[22] *See* Oct. 15 Testimony of Susi Vassallo atT140:2-9.
[23] PX 6 atT0011, 17-18, 50-51, 84; Oct. 15 Testimony of Danny Prince atT94:15-95:8; UF ¶ 11-12.

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.

d. Four remote “outcamps,” named Camps C, D, F, and J.

e. Death row and administrative management. The outlying camps and death row combined house 3041 individuals.

21. DOC is responsible for providing or arranging all medical care for all Class members.[24] Due to their incarcerated status, Class members have no ability to obtain medical care other than that which DOC provides or arranges.

22. 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.[25]

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

a. Medical providers:[27] At the time of Plaintiffs' expert site visit, Angola had only four physicians and one nurse practitioner, in addition to Dr. Lavespere, the Medical Director, which is largely consistent with what Angola's table of organization permits for medical staffing.[28] 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.[29]

b. Nurses: Angola has 53 permanent nursing positions and four temporary positions. This comprises approximately 22 registered nurses ("RNs"), 30 licensed practical nurses ("LPNs"), two certified nurse assistants ("CNAs"), and one respiratory therapist.[30]

c. Emergency Medical Services ("EMS") personnel: Angola has approximately 35 emergency medical technicians ("EMT") positions, and employed 22 as of September 2016.[31] EMS personnel generally have three levels of training and licensure: basic EMTs; advanced EMTs; and paramedics.[32] 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.[33]

d. Correctional officers: Defendants use correctional officers (i.e., prison guards) to administer medication in most housing units, including the so-called medical dormitories.[34]

25. 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

[27] 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.
[28] PX 6 at 0017; JX 1 at 00002.
[29] Oct. 22 Testimony of Randy Lavespere at 26:14-18; PX 6 at 0017; UF ¶ 10; JX 1 at 00001-02.
[30] Oct. 22 Testimony of Randy Lavespere at 30:2-17; PX 6 at 0018-19; JX 1 at 00001-02.
[31] JX 1 at 00002; Oct. 22 Testimony of Randy Lavespere at 32:13-15.
[32] Except where the Proposed Findings of Fact and Conclusions of Law specifically distinguish between EMS levels, Plaintiffs will use "EMT

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 HSR in a box for the provider responsible for the relevant housing unit. Class members are typically charged $3.00 for routine sick call.[35]

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 main 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.

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.[48] Numerous courts have relied on his opinions, including the Fifth Circuit. [49]

b. Dr. Susi Vassallo: Dr. Susi Vassallo: Dr. Vassallo is a board-certified emergency room physician and medical toxicologist. She actively practices as an attending physician in the emergency room of Bellevue Hospital, a large urban emergency department in New York City , and frequently practices at various sites in rural Texas. She is Clinical Professor of Emergency Medicine at the New York University

[48] JPTO at 9-10; Oct. 9 Testimony of Mike Puisis at 94-96.

[49] *See, e.g., Shepherd v. Dall. Cty.*, 591 F.3d 445, 450-51, 456 (5th Cir. 2009) (relying on Dr. Puisis'

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 evaluated correctional health care systems in nine states, including Louisiana, Mississippi, Texas, and New York. She has also been retained by the Department of Homeland Security to review medical care delivery at its detention facilities.[50] The Fifth Circuit has relied on her reports in

29. 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 47 patients,[54] selected to represent a sample of patients who had died and/or had chronic medical conditions that required recurring medical care. Across these 47 patients, they reviewed thousands of encounters between Class members and Defendants' medical personnel.[55] In addition to their sample, they reviewed the medical records of ten Named Plaintiffs, in response to Defendants' experts' reports.[56]

30. During their site visit and in their analysis of Defendants' practices, each expert focused on subtopics relevant to their particular expertise. Specifically, the experts divided their focuses and testimony along the following lines:

    a. Dr. Puisis was principally responsible for evaluating LSP's chronic care, specialty care, infirmary care, organizational structure, staffing, budget, healthcare operations, medical records, laboratory, mortality review, and quality improvement.[57]

    b. Dr. Vassallo was principally responsible for evaluating emergency care and the work performed by EMTs.[58]

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summary judgment); *Flynn v. Doyle*, 672 F. Supp. 2d 858, 862-63 (E.D. Wis. 2009) (relying on Ms. LaMarre's findings to deny Defendants' motion for summary judgment); *Henderson v. Thomas*, 913 F. Supp. 2d 1267, 1302 (M.D. Ala. 2012) (finding that Ms. LaMarre's testimony "merits substantial weight" given breadth of experience); *Farrell*, 2004 Cal. Super. LEXIS 2978, *2 (relying on a report by Ms. LaMarre and Dr. Puisis, as neutral experts jointly selected by both parties, in issuing a consent decree).

[54] This comprises 40 non-named-plaintiff patients discussed in the opening report and seven non-named-plaintiff patients in the supplemental chart reviews submitted with the rebuttal report. *See* PX 6; PX 410. One patient in the opening report was inadvertently reviewed by both Dr. Puisis (as Patient #4) and Dr. Vassallo (as Patient #36), with both making similar observations and conclusions. Plaintiffs are only counting this patient once in all numbering in this brief. Additionally, four of the patients given anonymized numbers in the opening report were named plaintiffs and do not count toward the sample, as were three patients discussed in the rebuttal supplement. These patients are not counted in all references to the experts' sample.

[55] *See* Oct. 9 Testimony of Mike Puisis at 122:24-23:19; Oct. 11 Testimony of Mike Puisis at 56:13-58:9; Oct. 16 Testimony of Madeleine LaMarre at 148:17-24; Oct. 15 Testimony of Susi Vassallo at 139:1-12.

[56] *See* PX 28 at 0007-23.

[57] Oct. 9 Testimony of Mike Puisis at 101:8-13.

[58] Oct. 15 Testimony of Susi Vassallo at 138:21-25.

c. Ms. LaMarre was principally responsible for evaluating access to care, chronic disease management, pharmacy, medication administration, policies and procedures, clinical spaces and sanitation, and health information management.[59]

31. Although the experts divided up the principal responsibilities for these topics, there was substantial overlap across their observations. Each expert reviewed the complete medical histories of more than a dozen patients, and therefore each expert reviewed hundreds or thousands of encounters spanning sick call requests, chronic care, specialty care, inpatient care, nursing care, and emergency care.[60]

32. Plaintiffs' medical experts produced a 90-page principal report,[61] accompanied by 183 pages of chart reviews; two rebuttal reports, totaling 38 pages;[62] and 24 pages of supplemental chart reviews produced prior to the rebuttal deadline.[63] Over the course of these reports they also reviewed the records of 10 named plainti

broken, including access to care, medication administration, chronic care management and infirmary care.

LSP patients do not have timely access to a medical professional who is qualified to diagnose and treat their serious medical needs. LSP patients are not provided the most basic and essential elements of adequate health care access. This includes timely access to a qualified medical professional who has access to the patient's medical record, and examines the patient in an adequately equipped and supplied examination room that provides privacy and confidentiality. Inmates are also punished for seeking medical care.

At LSP, emergency medical technicians (EMTs) and paramedics are front line staff for screening and treatment of patients with routine (sick call) and urgent health care needs. However, instead of conducting sick call in a medical setting, EMTs openly conduct sick call in inmate housing units without the patient's medical record, adequate medical equipment or supplies, and without privacy or confidentiality. Thus, it is not surprising that virtually all EMT assessments are inadequate. Moreover, EMTs are not licensed to diagnose and treat medical conditions and patients are not provided access to a professional medical judgment. Physicians are supposed to clinically supervise EMTs, however this does not meaningfully occur.

With respect to urgent care access, we found that EMTs and paramedics independently manage patients with acute and life-threatening conditions and in most cases, a physician never examined the patient during the acute event. As a result, these patients did not receive timely diagnosis and treatment, including being sent to an outside hospital. This resulted in many preventable deaths.

With respect to chronic disease management, we found that LSP chronic disease guidelines are completely inadequate and not based upon nationally recognized clinical practice guidelines. LSP physicians do not perform history and physical examinations pertinent to the patient's diseases, timely address abnormal laboratory tests, assess medication adherence, and monitor the patient in accordance with the patient's disease control. In fact, in many records we reviewed, the physician did not examine the patient. Predictably, this resulted in patients' chronic diseases being poorly controlled and increasing their risk of harm.

The medication administration process does not ensure that patients timely receive their medications. Health care understaffing has resulted in correctional officers administering medications, for which they are not trained and licensed. Medication administration records are unreliable and even show that staff document administering medications to patients after they have died. In medical housing units, inmates are used to administer medications to other inmates.

With respect to infirmary care, LSP does not have clinical criteria for admission to the infirmaries. This has resulted in medically unstable inmates being admitted to the infirmary instead of being sent to a hospital, resulting in preventable deaths. Physicians do not perform adequate medical evaluations. Health care understaffing

has resulted in inmates being used to provide direct patient care in the infirmary and medical housing units, in violation of correctional standards.

…

> that they can be charged with a disciplinary for malingering, and that's really not appropriate for any healthcare professional to be doing.[66]

(2) Reliability and Credibility of Plaintiffs' Experts

36. Plaintiffs' experts testified reliably and credibly about Defendants' medical practices and their implications for the risk of harm to Plaintiffs.

37. Each expert testified knowledgably about the subjects on which they focused and the patients they had examined or reviewed. Their testimony was corroborated by the medical records underlying their review, which were introduced in full into the record.

38. Similarly, each expert testified reliably and credibly about the standards within the medical profession for the types of care on which they opined. Their testimony was amply supported by reference to clinical guidelines, published practice standards, textbook guidance, and, where appropriate, their own experience and observations as professionals in correctional medicine.

39. Defendants did not move to exclude any of Plaintiffs' experts under Rule 702. Nor did Defendants' experts dispute the vast majority of Plaintiffs' evaluations of the records they reviewed; as discussed *infra* ¶¶ 132133, of the 47 patients in Plaintiffs' experts' sample, Defendants' experts commented on only three, and did not seriously dispute Plaintiffs' experts' analysis even there.

40. Instead, Defendants' questions and arguments, as well as their experts' testimony, suggest five principal criticisms of Plaintiffs' experts. None of these criticisms have merit.

a. *Plaintiffs' Experts' Sampling Methodology Was Reliable*

41. First, Defendants assert that Plaintiffs' experts "cherry-picked" their sample of class members.[67] However, the sample employed a standard, reliable methodology known as "judgment sampling" or "targeted sampling." As Dr. Puisis explained:

> We chose records of people who had serious medical conditions or potentially serious medical conditions. And the reason for doing that is that we want to test the program to ensure that people with a serious medical condition would be appropriately treated, under the assumption that if someone with a serious medical

[66] Oct. 16 Testimony of Madeleine LaMarre at 149:16-150:24; *see also* Oct. 9 Testimony of Dr. Mike Puisis at 123:20-124:10 (summarizing conclusions); Oct. 10 Testimony of Mike Puisis at 46:16-48:17 (same); Oct. 15 Testimony of Susi Vassallo at 141:23-143:25 (same); Oct. 16 Testimony of Susi Vassallo at ..

> condition was appropriately treated, then others probably would also be so appropriately treated.[68]

42. Or, as Ms. LaMarre put it:

> What I do is select records that would most likely inform me about patients who use the healthcare system regularly. So I select patients with chronic diseases, because I know there will be medical provider visits, they'll get medications. In many cases they'll get specialty services. I'll select records of patients who have been hospitalized. I will request to review mortality records to see what happened preceding their death, to see if care was timely and appropriate.[69]

43. Judgment sampling has been recognized as reliable in numerous cases, including cases about correctional practices in particular.[70] 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.'"[71]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.[72]

44. Both of Defendants' experts endorsed this methodology. Dr. Moore explained that she "pull[s] charts of people that have gone to the emergency r000-ior case:

"Suicide," etc.).[78] This information would not allow the kind of "cherry-picking" Defendants assert, and there is no evidence whatsoever that Plaintiffs' experts used (or even had available) any other information that would allow cherry-picking.

49. Rather, as Dr. Vassallo explained:

> I had no idea what the care was going to be when I chose the chart. … I want to know when somebody gets to the hospital, why they got there and how they got there. My choice of charts could have resulted in a completely different finding that

were longstanding and not a momentary lapse in an otherwise well-performing system. The sample included ample evidence that the problems continued to the end of the discovery period, with at least 26 reviews of medical records from 2015-2016.[85] Had Plaintiffs' experts limited themselves to *only* that time period, they would have reduced the reliability of their conclusion that these problems were longstanding and systemic.[86]

53. Although Defendants do not challenge the robustness of the sample, and present no statistical or other expert basis on which to do so, it bears noting that the sample is more than robust enough to shed light on the care that Defendants provide at a systemic level. As explained above, 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 over time.

54. To the extent Defendants implied that care might have materially improved over the course of the discovery period, all three experts testified that they saw no change in the inadequate care over time.[87] As Ms. LaMarre concluded, "During the period of time that [the experts] reviewed, care remained poor. … My assessment is that it's an inadequate system and it really hasn't improved."[88]

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other errors as well, including failure to promptly transport the patient to a hospital; failure to conduct a neurologic examination; conducting an x-ray that was not indicated rather than transporting the patient; failure to document properly the medical care in the ATU and the associated observations; and failure to properly sedate the patient during transport.[91] Neither Defendants nor their experts disputed any of Dr. Vassallo's conclusions; at most, they pointed out on cross that Patient #44 survived the mistreatment without deficits.[92]

56. But it is what happened to Patient #44 upon his return from the hospital that is most troubling, and most confirmatory of the findings in the remainder of the sample. On May 23, 2016, Patient #44 tested positive for hepatitis-C antibodies.[93] Even though he saw an LSP physician a week later,[94] and even though Dr. Lavespere initialed the lab results at an undated time,[95] there is no evidence anywhere in the record that the positive finding was discussed with the patient, that he received CDC-recommended follow-up tests,[96] or that he received *any* treatment or education for this highly contagious disease. Patient #44's records go as late as September 26, 2016[97]—some of the very latest medical records produced by Defendants—and as of that time, more than five months had passed without any acknowledgment or follow-up of his apparent Hepatitis C, much less treatment.

57. Given that medical records that could not plausibly be alleged to be cherry-picked show multiple kinds of poor care and are wholly consistent with the findings throughout the sample, Defendants would need strong evidence of cherry-picking to disregard the remainder of the findings. They provided none, and their argument is thus unavailing.

b. *Plaintiffs' Experts' Chart Reviews Were Reliable*

58. The most emphatic part of Defendants' cross-examinations was an attempt to impeach the experts' assessment of their case studies by asking them about specific pages in the medical records. While the implication of the individual line of inquiries was often unclear, the general purpose appeared to be to suggest that the case studies were "bad, unfair, slanted, and biased,"[98] or, at a minimum, that Plaintiffs' experts "lack[ed] proficiency with the specific

[91] *Id.* at 168:14-173:9.
[92] Oct. 16 Testimony of Susi Vassallo at 95:4-5.
[93] DX 744 at 3.
[94] *Id.* at 19.
[95] *Id.* at 3.
[96] *Id.* (laboratory informing Defendants that "[t]he CDC recommends that a positive HCV antibody result be followed up with a HCV Nucleic Acid Amplification test").
[97] *Id.* at 2.
[98] Oct. 10 Testimony of Mike Puisis at 71:10-11.

disclosed by Defendants when they used the incident at trial.[105] These add nothing whatsoever to Defendants' argument. Defendants also identified four times over an 18-month period when EMTs or providers noted that Patient #1 missed or had been missing his blood pressure medication.[106] But these records show that "long pill call lines" were responsible for his failure to receive his medication.[107] As discussed infra ¶ 415, this shows fault not on the part of Patient #1 but on the part of LSP, which made no effort to address the issue.[108]

b. Patient #5: Defendants focused first on the patient's weight loss, showing that in the course of a progressive weight loss of 22 pounds, there was one record where his weight went up two pounds between visits.[109] This shows nothing more than the fact that in progressive, wasting weight loss, there may be momentary upticks from appointment to appointment. (Indeed, it may show even less; it may simply show that Defendants have multiple scales that are calibrated slightly differently.) Moreover, Defendants' portrayal of the weight loss story was significantly misleading, as it inexplicably stopped just before a record showing that the patient had lost an additional 34 pounds—even though Defendants proffered a different record from the same date.[110] Defendants also highlighted that the patient died of a complication from a surgery performed by an outside provider,[111] but Dr. Puisis had not suggested the immediate cause of death was LSP's fault. Rather, he faulted the two-year failure to investigate the patient's worsening weight loss and abdominal pain, which left the patient's cancer undiagnosed until it was terminal.[112]

c. Patient #11: Defendants identified and Dr. Puisis acknowledged that on one occasion the records document communication between an LSP provider and an outside specialist.[113] Defendants' counsel asserted that Dr. Puisis's "write-up ignores that, doesn't it?," and that Dr. Puisis "never told the Court or any of the parties in your report that there were communications with the outside providers."[114] This is demonstrably false: Dr. Puisis's chart review explicitly discusses this exact document and states "The doctor spoke with another physician [presumably a surgeon] who

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[105] *See* Oct. 10 Testimony of Mike Puisis at 145:16-19; *see* JX 10-w at 51364-65.
[106] Oct. 10 Testimony of Mike Puisis at 146:14-147:24; *see* JX 10-w at 51335, 51338, 51341, 51347.
[107] Oct. 10 Testimony of Mike Puisis at 147:7-23; JX 10-w at 51335, 51338.
[108] Oct. 10 Testimony of Mike Puisis at 148:16-149:13.
[109] Oct. 10 Testimony of Mike Puisis at 178:5-179:23.
[110] *See* JX 10-bbb at 55581 (Oct. 30, 2014 Physician's Clinic note); *compare* Oct. 10 Testimony of Mike Puisis at 179:24-180:8 (asking about a different Oct. 30, 2014 record that did not show the patient's weight).
[111] Oct. 10 Testimony of Mike Puisis at 181:2-19.
[112] *See* PX 6 at 0075-76, 112-17; *see infra* ¶ 275.
[113] *Id.* at 0024-25; *see* JX 10-r at 16153.
[114] Oct. 11 Testimony of Mike Puisis at 25:11-21.

said that no further surgery was planned."[115] Indeed, Dr. Puisis specifically discussed the specialist appointments in his direct testimony.[116] Defendants also elicited that

evaluation for curable secondary hypertension, Defendants' counsel said "I just showed you where they got a no-show where he refuses to go. I mean, get him to the clinic where they've got the specialist coming

f. Patient #20: Defendants established that this patient, who had serious mental health needs, sometimes refused care.[137] This was acknowledged in Ms. LaMarre's chart review, which specifically said that [d]ocumentation in the record shows that in some instances the patient refused HIV specialty care."[138] The report then went on to say that "[t]here is no documentation that the patient was ever counseled on the benefits of HIV treatment and risks of refusing care"[139]—and, indeed, Defendants' lengthy presentation on the patient's refusals did not show any evidence of counseling. Defendants also seemed to suggest that, under defense counsel's interpretation of an x-ray and a test result, there was no indication that the patient was suffering the massive internal bleeding from which he died on January 13, 2015.[140] Ms. LaMarre rejected this interpretation,[141] and Defendants presented no medical evidence to suggest that it was correct—much less that it accounted for the patient being treated solely by EMTs overnight when found to be severely anemic, with severe abdominal pain and three days of blood-black stool, as well as other life-threatening abnormal vital signs.[142]

g. Patient #22: Defendants sought to make three points with this patient. First, they asserted that the patient made no complaints of abdominal pain between August 2012 and September 2013.[143] In fact, the patient complained of abdominal pain in August, September, October, November, and December of 2012, before dying in December 2012 after a CT scan showed

psychiatrist rather than attempting to diagnose or treat his worsening symptoms.[148] Far from undermining Plaintiffs' experts' findings, this tragically illustrates their concern that Defendants' staff do not believe their patients;[149] after all, the patient's symptoms were not psychosomatic but the product of an undiagnosed cancer that was rapidly and torturously killing him.[150]

h. Patient #28: Defendants showed two notes: an August 4, 2015 note in which a specialist prescribes oxygen for the patient "during exertion" (which for the patient meant as little as six minutes of walking), and an August 28, 2015 note in which Dr. Lavespere allowed the patient to have "portable O_2 bottle for trips only."

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was confined to a wheelchair[167]—simply shows how Defendants' failure to accommodate patients with disabilities impedes Subclass members' access to medical care.[168]

62. Defendants also made much of Dr. Puisis's initial failure to remember that he reviewed the records of Shannon Hurd.[169] This was understandable, as Defendants' questions were misleading from the beginning. Defendants' counsel claimed that Dr. Puisis "[g]ave lots of opinions about him yesterday and today" and "closed by talking about him,"[170] when in fact Dr. Puisis had not mentioned him once in his testimony. Defendants' counsel repeatedly portrayed the case study he was talking about as being in the experts' report, when in fact it was in their rebuttal report.[171] Dr. Puisis repeatedly asked for the patient's number because of his understandable misunderstanding that defense counsel was asking about one of the patients in the anonymized sample.[172] Defendants' counsel did not give Dr. Puisis an opportunity to review Mr. Hurd's summary in the rebuttal report, and repeatedly took down documents before Dr. Puisis had had a chance to review them.[173]

63. Dr. Puisis credibly testified that he realized his error "immediately" upon beginning to read the writeup of Mr. Hurd after the second day of trial concluded.[174] He explained on both cross-examination and redirect that he had not reread the rebuttal report in preparation for trial, because he "was paying attention to the patients in the main report."[175] Given that the experts did not consider the named Plaintiffs as part of their sample, so that they could test

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[167] *Id.* at 07697; *see* Oct. 15 Testimony of Otto Barrera at 9:17-11:3 (describing black-box restraints).
[168] *See infra* ¶¶575585 (discussing failures to accommodate).
[169] *See* Oct. 10 Testimony of Mike Puisis at 51:5-70:25; Oct. 11 Testimony of Mike Puisis at 4:8-11:3.
[170] Oct. 10 Testimony of Mike Puisis at 51:21-22.
[171] *See, e.g.*, *id.* at 54:15-19; *see also* Oct. 11 Testimony of Mike Puisis at 40:25-41:1 ("I thought he was talking about the—you know, the summary investigative report.").
[172] *See, e.g.*, Oct. 10 Testimony of Mike Puisis at 51:8 ("Can you—is that one of the first 14?" … "If you can refer to the patient number."); *id.* at 54:17 ("If you give me the number, I would know for sure … ."). It appears that Dr. Puisis may have misheard "Page 18" as "Patient 18," further adding to the confusion. *See id.* at 51:18-20 (Q: "It'd on page 18 of your chart review. You don't know who I'm talking about?" A: "That record was reviewed by Ms. LaMarre."). Ms. LaMarre reviewed Patient 18.
[173] *See, e.g., id.* at 65:14-16 (The Court: "Counsel, he said he wanted to look at the medical records. If you want him to look at the medical records and you want to cross-examine him, you can."); *id.* at 67:20-22 (Plaintiffs' counsel: "If he's going to be doing this … he should be giving Dr. Puisis the full document."); *id.* at 67:25-68:1 (The Court: "He said he wanted to look at the record before testifying as to this gentleman … ."); *id.* at 69:15-16 (The Court "Leave [the document] on there; let the man answer the question, for heaven's sakes."); Oct. 11 Testimony of Dr. Mike Puisis at 41:8-11 (Q: "Before Mr. Archey asked you questions about the discussion of Mr. Hurd in the rebuttal report, did you have the opportunity to read what he was showing you?" A: "No.").
[174] Oct. 11 Testimony of Mike Puisis at 41:15-19.
[175] *Id.* at 41:20-25; *see also* Oct. 10 Testimony of Mike Puisis at 57:5-6.

the adequacy of care without relying on patients

weight in Mr. Hurd's as his starting point—exactly what Defendants seem to be saying he should have done.

b. Defendants' plain inaccuracies cloud a deeper problem with their assertions. Dr. Puisis never suggested that Mr. Hurd's weight between May 2012 and September 2013 should have prompted an examination of Mr. Hurd's symptoms and an attempt to diagnose them. Rather, the first time Dr. Puisis expresses concern is November 4, 2013, when Mr. Hurd had so far lost 15 pounds and was about to begin two years of a nearly unremitting decline of another 50 pounds.[184] Defense counsel claimed that Mr. Hurd "had no weight loss until at least the middle of 2015,"[185] but that is demonstrably untrue.[186]

c. *Side pain*: Defendants next asserted that Mr. Hurd never complained of left-sided pain prior to October of 2015.[187] Mr. Hurd complained of left-sided pain stretching from his arm to his foot, specifically referencing his lower torso, repeatedly in January 2012, July 2013, and August 2013.[188]

out by the records. On even the most Defendant-friendly reading of the medical records, accepting unexplained notes that Mr. Hurd did not show up for appointments around this time,[202] Mr. Hurd's refusals lasted just one month, not seven months.[203] There is no explanation in the medical records whatsoever for Defendants' failure to take these blood tests over the following six months, despite Mr. Hurd's numerous, increasingly dire requests for help.[204] Indeed, the undisputed evidence shows that Mr. Hurd asked Defendants to reschedule the bloodwork after missing the June 11 and June 26 tests—wh

the records are disorganized, hard to read, and missing relevant documents.[209] Most records include dozens if not hundreds of encounters with EMTs, correctional officers, nurses, physicians, and outside specialists. It would be remarkable if Plaintiffs' experts managed to synthesize these tens of thousands of pages into two hundred pages of reports without missing a single detail.

67. These hypothetical small errors would do nothing to take away from the mountain of evidence showing inadequate care that the medical records contain and Plaintiffs' experts reliably evaluated. The experts identified literally hundreds of encounters and medical decisions or omissions that they concluded fell below the standard of care that were not disputed in *any* way by Defendants—neither factually nor as a difference of expert interpretation.[210] As Plaintiffs' experts explained, neither sporadic examples of good care, nor isolated minor errors in chart reviews, can overshadow the myriad evidence of substandard care discussed below.[211]

c. *Plaintiffs' Experts Applied Reliable Standards*

i. Clinical Standards

68. To evaluate the adequacy of care in the records they reviewed, Plaintiffs' experts used what they referred to interchangeably as "contemporary standards," "clinical standards," and "community standards."[212] As Dr. Puisis explained, "for diabetes, we would use as a benchmark the American Diabetes Association standards of diabetic care; for hypertension, the National Heart, Lung, and Blood [Institute] hypertension standards, et cetera."[213] Such standards provide guidelines for medical treatment of the relevant condition, from the signs and symptoms for use in diagnosis to recommended testing to the appropriate range for medication dosage.

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[209] *See, e.g.*, Oct. 11 Testimony of Mike Puisis at 58:10-59:4; *see also* Oct. 16 Testimony of Susi Vassallo at 110:20-11:8 ("[S]ometimes we had a record of one date; 60 pages later, we were back to the same episode of care.").

[210] *See infra* ¶¶ 132133 (discussing Defendants' experts failure to dispute the vast majority of case studies in Plaintiffs' experts' sample).

[211] *See, e.g.*, Oct. 11 Testimony of Mike Puisis at 51:3-6, 57:16-58:9; Oct. 16 Testimony of Susi Vassallo at 111:16-112:1.

[212] *See* Oct. 10 Testimony of Mike Puisis at 80:2-13 ("[W]e see it as the same."); Oct. 9 Testimony of Mike Puisis at 103:4-104:20; *see also, e.g.*, Oct. 10 Testimony of Mike Puisis at 82:3-18; PX 6 at 0042-43.

[213] Oct. 9 Testimony of Mike Puisis at 103:8-11.

They assert that NCCHC guidelines are "aspirational" standards rather than actually prevailing standards.[221] This argument is unpersuasive, for several reasons.

a. First and most importantly, the ultimate question is not whether Defendants comply with privately created guidelines, but whether they provide constitutionally adequate clinical care as measured by the clinical standards discussed above. As detailed at length *infra* ¶¶ 150-405, Plaintiffs have proven that Defendants frequently do not provide constitutionally adequate care. The NCCHC and ACA standards are useful aids in identifying practices that contribute to those inadequacies, but they are not dispositive of any issue in this case.[222]

b. Second, it is undisputed that the NCCHC guidelines are widely looked to and relied upon by experts in correctional medicine.[223] Indeed, experts on both sides of the case have opined that NCCHC standards are superior to ACA standards. Dr. Puisis testified that he believes that the NCCHC "is a better standard set."[224] Defendants' expert Dr. Moore testified that NCCHC standards are "authoritative," and represent "a minimal level" of care; indeed, she stated that she trusts NCCHC "explicitly [sic]."[225] She further contradicted Defendants' other expert in her opinion that they are "not aspirational."[226]

c. Third, the provenance of the two sets of standards suggests that the NCCHC is more reliable. The NCCHC grew out of a survey by the American Medical Association and is "principally dedicated to healthcare."[227] The ACA, by contrast, is "principally a custody organization."[228] Its accreditation reviews focus mainly on custodial aspects, rather than medical aspects.[229] The ACA is comprised of correctional personnel; Warden Cain served on its executive committee, and Secretary LeBlanc served on its Standards Committee and Commission of Accreditation.[230] Without any aspersion of motives, an association of personnel who could be held accountable for falling short of reigning standards has a natural incentive to err on the side of setting standards too low, rather than too high.

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[221] *See* DX 14 at 02923-24.
[222] *See Gates v. Cook*, 376 F.3d 323, 337 (5th Cir. 2004) ("While compliance with ACA standards may be a relevant consideration, it is not *per se* evidence of constitutionality.").
[223] Oct. 9 Testimony of Mike Puisis at 105:2-25.
[224] *Id*. at 106:11-13.
[225] Oct. 23 Testimony of Jacqueline Moore at 151:9152:1.
[226] *Id.* at 151:17-18.
[227] Oct. 9 Testimony of Mike Puisis at 105:1-106:13.
[228] *Id.* at 106:3-4.
[229] *See* Oct. 25 Testimony of Tracy Falgout at 32:5-11.
[230] Oct. 12 Testimony of James LeBlanc at 190:2-24; JX 4-ss, J. LeBlanc Depo. at 33:9-16.

Indeed, even Dr. Moore believes that the ACA is "more political" than the NCCHC.[231]

d. Fourth and finally, any suggestion that Plaintiffs' experts cherry-picked "aspirational" standards is belied by the fact that Plaintiffs' experts did *not* cite the American Public Health Association's ("APHA") Standards for Health Services in Correctional Institutions, which "are probably a higher level of standard."[232] Dr. Puisis has served on the APHA committee revising its standards, but he and the other experts chose

temperature, or concerned medical care at prisons and jails where inmates tend to be

of a physician in many settings.[245] Family nurse practitioners, like Ms. LaMarre, are "qualified to medically evaluate, diagnose, and treat common occurring illnesses like hypertension, diabetes, et cetera."[246]

81. Indeed, Defendants employ a nurse practitioner as the principal provider for nearly 1100 inmates, in addition to Ward 2, and all HIV, cancer, and hospice patients.[247] Dr. Lavespere testified that he "absolutely [does] not" treat the nurse practitioner any different from the doctors, aside from some general supervision.[248] It is hard to understand how Defendants can argue that a nurse practitioner is incapable of opining on whether clinical standards are met while simultaneously relying on a nurse practitioner to provide care that meets those standards.

e. *Plaintiffs' Experts Did Not Demonstrate Any Bias*

82. Defendants also accused Plaintiffs' experts of being "advocates." They argued that

> [W]hat we saw in Plaintiffs' case was three experts who self-identify as advocates. That's what they are, that's what they say, and that's [sic] not necessarily anything wrong with that but their testimony has to be viewed through the [prism] of an advocate. They're here because they want to see change. They're not here necessarily because they think it's constitutional or not. They write books and they write papers about how they believe prisoners should be treated.[249]

83. As an initial matter, the experts' credentials belie this characterization. Each expert has been retained by both inmates and corrections systems; each has worked in, or worked closely with, correctional medical systems.[250] They have been relied upon by courts, correctional systems, the Department of Justice, and the Department of Homeland Security for their expertise in their fields.[251]

That said, the first sentence of Defendants'

concerned for their patients" and "tak[e] care of the patients"; physicians should adhere to "the best practices model"; that physicians acting as patient and public health advocates "should try to improve" medicine in prisons; and that he has tried to improve medicine in prisons.[253] (Defendants did not elicit any such testimony from Dr. Vassallo, or present any other evidence that she "self-identif[ies] as [an] advocate[]."[254])

overwhelmingly supports a finding that this dire assessment is the product of conscientious, reliable, and learned expert analysis, not bias. Defendants presented no evidence that any of the experts had a history of reaching similarly scathing conclusions in other cases, despite their extensive track records. Rather, all signs suggest that their conclusions were dramatic because the problems they discovered were extreme by the standards of the countless

"there's no way … you can reasonably do [a thorough review of LSP] in one day."[275] Dr. Thomas claimed that in that one day, he toured the REBTC, the two nursing units, and four or five housing units; observed sick call in some areas and at least one emergency procedure; reviewed at least three or four medical records showing specialty consultations, more than five records of inmates with chronic conditions, and at least four or five infirmary charts, along with sick call requests and MARs; spent several hours with Dr. Lavespere; and interviewed over 100 inmates.[276] Even assuming all this activity actually occurred—which can only be taken on faith, given Dr. Thomas's choice not to take any notes and inability to remember virtually any details—it was necessarily and evidently performed at a cursory level that severely detracts from the rigor and reliability of Dr. Thomas's findings.

97. Dr. Thomas's testimony was also troublingly inconsistent with his deposition and his report. During cross-examination, inconsistencies on significant topics were repeatedly pointed out. In his trial testimony, he testified that he arrived at the prison at 7:10 am and saw everything he wanted to; but in his deposition he testified that he wanted to make sure he got to the prison at 4 or 5 to observe sick call, and implied that he did in fact arrive in time to do so.[277] At trial, he claimed that he knew which policies and procedures he had reviewed, but in his deposition said he couldn't identify them.[278] In his deposition, he testified that he was not basing his opinions on any disagreements with the Plaintiffs' experts' chart reviews that were not in his report; at trial he refused to say the same.[279] Perhaps most glaringly, he testified at trial and stated in his report that he was *told* about an incident involving an EMT's use of an Epi-Pen, while in his deposition he testified that he witnessed it and even described its "distressing" nature to the people around him.[280]

98. In at least one significant regard, Dr. Thomas's testimony also appeared to be materially inconsistent with his opinion in a previous case. A significant focus of his testimony on direct examination was patients' refusals of medical care.[281] His view, as affirmed on cross-examination, was that "poor outcomes because [of] the refusals are, in [his] view, not the

102. Rather than being rooted in any identifiable sources that are appropriate for an expert to rely on, most of Dr. Thomas's standards seemed to be his own beliefs. Indeed, his views were sometimes directly contradicted by Defendants' other expert, Dr. Moore. Dr. Thomas asserted that the NCCHC standards Plaintiffs cited were "aspirational";[291] Dr. Moore denied

changes by Dr. Lavespere, not a visit to a wound care specialist.[300] And Dr. Thomas stated in his report that Mr. Cazenave's "most recent [radiological] studies" showed a "new cardiomegaly," when the cardiomegaly was actually observed in 2013—nearly three years earlier—and Dr. Thomas was unaware of anybody at LSP identifying it as a problem in that time.[301]

c. Similarly, Dr. Thomas opined that named Plaintiff Otto Barrera "has been seen regularly in the Oral and Maxillofacial clinic," when LSP's records themselves say that he had been "lost to follow-up" since early 2014.[302]

control process could be improved, and mortality reviews should be conducted by an outside physicians.[309]

108. Finally, Dr. Thomas acknowledged that "conditions of confinement in corrections improve largely as a result of litigation,"[310] contradicting the assertion in his report that improvements at LSP are "best brought about by incremental administrative action."[311]

(2) Dr. Jacqueline Moore

109. Dr. Moore holds a Ph.D. in nursing and has been certified by the NCCHC as a registered nurse and correctional health professional.[312] She has previously overseen the NCCHC accreditation program and has worked on the NCCHC standards committee.[313] She has served as a Court-appointed monitor in several states, and been retained by the Department of Justice to assist them in prosecuting cases in Georgia and Mississippi.[314]

110. 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 produced a 31-page report[315] and testified at trial.[316] The Court admitted Dr. Moore as an expert in the administration of correctional healthcare.[317]

111. Dr. Moore's conclusions were distinctly more limited than the other experts'. Dr. Moore's overall opinion was that LSP was "meeting ACA standards of accreditation" and "doing a great volume of services at the facility."[318] She did not (and, indeed, was not proffered to) opine on the quality of care provided at LSP or whether that care meets contemporary standards. As such, her testimony is principally helpful to determine whether the practices that Plaintiffs' experts concluded contributed to a risk of harm to patients (a) exist and (b) deviate from contemporary practices.

112. On this front, Dr. Moore corroborated Plaintiffs' experts' conclusions more than she contradicted them. Among her many findings supportive of Plaintiffs' conclusions:

a. EMTs are used more at Angola than anywhere Dr. Moore has ever seen.[319]

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[309] *Id.* at 54:12-55:19.
[310] *Id.* at 116:18.
[311] DX 14 at 02944.
[312] JPTO at 11-12.
[313] Oct. 23 Testimony of Jacqueline Moore at 129:24-130:8.
[314] *Id.* at 132:8-133:12.
[315] DX 13.
[316] *See generally* Oct. 23 Testimony of Jacqueline Moore at 126:11-174:19.
[317] *Id.* at 134:22-135:10.
[318] *Id.* at 138:5-7.
[319] *Id.* at 154:10-11.

b. Most facilities use nurses to perform sick call, rather than EMTs.[320]

c. Physicians did not timely follow up on sick call.[321]

d. LSP's EMT protocols could be enhanced, and EMT Plaintiffs' experts did a fairly good job of identifying EMT protocols where that needed to be done.[322]

e. Defendants do not properly document chronic care, which causes problems for nurses.[323]

f. When drafting her report, Dr. Moore found that records were missing periodic health assessments.[324]

g. LSP is the only maximum security facility, or facility of its size, that Dr. Moore has ever seen that uses security officers to distribute medication.[325]

h. Use of orderlies is "not always the best thing."[326]

i. LSP has insufficient examination rooms, and cell-side sick call examinations posed a concern for lack of privacy.[327]

j. LSP's record-keeping has numerous problems; nursing encounters were not tracked, and both the staffing plan and budget were difficult to understand.[328]

k. Dr. Moore saw no evidence that physicians with restricted licenses were being monitored, and no evaluation of physicians with clinical criteria.[329]

l. LSP's quality improvement program lacked physician involvement, studied the same thing over and over again, and could have been more robust.[330]

m. The medical department should have a healthcare administrator rather than a deputy warden.[331]

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[320] *Id.* at 155:8-9.
[321] *Id.* at 155:15-17.
[322] *Id.* at 154:15-155:5.
[323] *Id.* at 159:6-8, 162:10-22.
[324] *Id.* at 158:17-19; *but cf. id.* ("That was what I believed at the time I wrote my report. I've since learned something different.").
[325] *Id.* at 160:8-19
[326] *See id.* at 161:12-19.
[327] *Id.* at 155:6-7, 158:2-4.
[328] *Id.* at 159:1-5, 6-8, 162:19-22, 166:10-12.
[329] *Id.* at 164:9-21.
[330] *Id.* at 149:5-13.

n. LSP's demographics are not unusual, and most prisons are built in remote locations like LSP is.[332]

113. By contrast, in the whole of Dr. Moore's testimony, there are few places where she disagreed with Plaintiffs' experts' findings in any material way. The only examples of note were:

a. Dr. Moore testified that LSP's chronic care guidelines were "sufficient."[333] In her expert report, however, it is clear that she meant that the number of chronic diseases for which LSP maintained guidelines was sufficient—not that the guidelines themselves were sufficient.[334] On the guidelines' actual substance, she agreed with Plaintiffs' experts that they could be "enhanced."[335] Moreover, as noted above, she found that Defendants do not properly document chronic care and do not always follow chronic care policies.[336]

b. Dr. Moore testified that the staff she met were "very, very dedicated,"[337] and provided similar assessments in her report.[338] As the Court observed, that type of character judgment is "not helpful" to the trier of fact.[339] More importantly, Dr. Moore acknowledged that such statements were generally repeating the opinions of other Defendants.[340] Her praise for Ms. Lamartiniere, for example "was not [Dr. Moore's] opinion, that came from Dr. Singh," and her praise for Major Cashio "came from Sherwood [Poret]."[341] In contrast, Plaintiffs' experts' assessments of staff competency and attitudes, where relevant, were based not on secondhand statements by co-Defendants but on a review of their documented work performance and of specific statements or actions.

C. Trial Witnesses

114. The Court had the opportunity to assess the credibility and demeanor of all witnesses at trial. Below are proposed credibility determinations for each of Plaintiffs' fact witnesses, as well as for one of Defendants' fact witnesses, Dr. Lavespere.

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[331] *Id.* at 139:9-23, 163:5-8.
[332] *Id.* at 153:1-154:3.
[333] *See id.* at 147:14-20.
[334] *See* DX 13 at 02865.
[335] *Id.*; Oct. 23 Testimony of Jacqueline Moore at 147.
[336] Oct. 23 Testimony of Jacqueline Moore at 159:6-8, 162:10-15.
[337] *Id.* at 138:7-8.
[338] *See id.* at 167:13-168:7.
[339] *Id.* at 138:13-14.
[340] *Id.* at 168:8-16.
[341] *Id.* at 168:8-11, 12-16.

Sampier had instead been put on palliative care, but Mr. Sampier had never heard of that program.[355] Mr. Sampier also testified that he was not given proper accommodations, such as hygiene wipes, protective gloves, a paraplegic-appropriate wheelchair, and other additional equipment.[356]

b. Anthony Mandigo gave credible testimony about the lack of appropriate treatment for sickle cell anemia and its symptoms at LSP. Among other things, he testified about the severe discomfort he has experienced as a result of sickle cell pain, and the relief brought by access to prescribed narcotic medication.[357] He further testified that he has not been able to receive narcotic pain medication other than when he has been on the medical ward or hospitalized, and that has inhibited his ability to manage his pain and avoid a sickle cell crisis.[358] This testimony was corroborated by Dr. Puisis, Dr. Jones and Dr. Dhand, who testified to the intensity of sickle cell pain, that narcotic pain medication is necessary for sickle cell patients to avoid a worsening of their symptoms, which can be fatal, and to the "cruelty" of failing to treat patients experiencing this pain.[359] Cross-examination merely served to emphasize that the effective treatment for pain management he was able to access before incarceration is not available to him at LSP.[360]

c. Drs. Catherine Jones and Monica Dhand also provided credible testimony regarding their personal experiences and observations treating Angola patients admitted to University Medical Center (UMC) in New Orleans. Both Drs. Jones and Dhand have

regarding Angola patients not accessing necessary follow-up care[364] and pain medications.[365] This testimony was consistent with some of the observations made by Plaintiffs' medical experts regarding poor quality of care at Angola, medical record and some contemporaneous concerns expressed in emails.[366] Although Drs. Jones and Dhand testified had interacted socially with Plaintiffs' counsel, they also testified credibly that this relationship did not impact their testimony.[367]

d. Lawrence Jenkins, testified credibly about the state of hepatitis C treatment at LSP.[368] Mr. Jenkins, who is 62 years old and has been diagnosed with hepatitis C, volunteered in the facility's hospice program, looking after terminally ill inmates.[369] He observed the symptoms and signs of people dying from liver complications associated with hepatitis C, but testified LSP provided him no education on how hepatitis C is contracted or transmitted, the symptoms of the disease, or on the progression of the disease.[370] Mr. Jenkins received a course of treatment for hepatitis C that was ineffective.[371] He was subsequently told by the nurse at the hepatitis C clinic that he would have to wait in line for further treatment owing to the cost of the treatment and the number of other inmates with hepatitis C, and because he had previously received treatment.[372] Mr. Jenkins' testimony was uncontradicted by any other testimony or medical record. In fact, Mr. Jenkins' testimony was supported by that of class member witness Charles Butler who also testified he had been told he would not receive treatment because of costs.[373] While Defendants' counsel asked Mr. Jenkins questions about the progression of his hepatitis C, they introduced no evidence disputing that he had chronic hepatitis C or that Defendants did not treat it after the initial failed treatment regimen. Further, this inquiry is of limited relevance, as the American Association of Liver Disease recommends every patient with

[364] Oct. 11 Testimony of Catherine Jones at 127:24-128:23; Oct. 11 Testimony of Monica Dhand at 165:24-166:3.
[365] Oct. 11 Testimony of Catherine Jones at 132:6-135:22; Oct. 11 Testimony of Monica Dhand at 166:4-167:6.
[366] *See, e.g.*, PX 6 at 0021 (discussing delays in accessing care); *id*. at 0038-39, 0074-78 (noting trends and examples of failure to provide and defects in follow-up care).
[367] *See* Oct. 11 Testimony of Catherine Jones at 139:11-140:13, 158:15-17; Oct. 11 Testimony of Monica Dhand at 169:11-19, 178:12-14.
[368] *See generally* Oct. 11 Testimony of Lawrence Jenkins at 180-202.
[369] *Id.* at 181:11-182:15.
[370] *Id.* at 187:10-19, 184:13-23; *see also* Rec. Doc. 517-4 at 16 (AM. ASS'N FOR THE STUDY OF LIVER DISEASES & INFECTIOUS DISEASES SOC'Y OF AM., RECOMMENDATIONS FOR TESTING, MANAGING, & TREATING HEPATITIS C (2015)) ("All persons with HCV [hepatitis C] infection should be provided education on how to avoid HCV transmission to others.").
[371] Oct. 11 Testimony of Lawrence Jenkins, 185:5-17.
[372] *Id.* at 186:8-187:3; 198:12-19.
[373] Oct. 15 Testimony of Charles Butler at 57:10-58:3.

chronic hepatitis C be treated for hepatitis C.[374] Additional evidence supports Mr. Jenkins' testimony—particularly the logs of treatment of patients with hepatitis C which show that LSP treated only between 2.9% and 6.2% of its known hepatitis C population each year between 2013 and 2016 with direct acting antiviral medicine.[375]

e. Francis Brauner testified credibly about the ten years he spent on the hospital wards at Angola between 2005 and 2015.[376] He described the unsanitary conditions on the hospital ward as "deplorable," and recalled open garbage cans, dirty bathrooms, and dirty bandages left on the floor.[377] This testimony is consistent with the findings of Plaintiffs' medical experts, who discussed the inadequate staffing and hygiene on the hospital wards in their report.[378] This is also consistent with the testimony of other Plaintiff witnesses who spent time as patients on the hospital wards.[379] Mr. Brauner also testified credibly as to his own experience arriving at Angola paralyzed from the waist down, and being locked in an isolation room off the nursing ward, which Defendants do not dispute.[380] Mr. Brauner also testified credibly, and Defendants did

Defendants did not dispute his testimony that his bedsore was stage 4, the size of "the bottom of a liter bottle," and open "to the bone" at the time he left Angola,[382] nor his testimony that the bedsore improved "like night and day" when he started receiving appropriate specialty care for his wounds after his release.[383] Counsel for Defendants tried to point out on cross-examination that Mr. Brauner still had open wounds 7-8 months after receiving that treatment, but he clarified his testimony to include the fact that his wounds had significantly decreased in size and become stage 3 sores during that several-month period, in contrast to 10 years of inadequate treatment at Angola.[384]

f. John Tonubbee's testimony was credible in a number of ways. Notably, the 76-year-old Mr. Tonubbee has been a Class A Trustee at the prison since 1982.[385] This means that Defendants have considered him trustworthy enough to grant him the lowest security class for over thirty years.[386] He testified about several persistent medical issues, including his need for knee replacements, a bunion that causes severe pain in state-issued shoes, and the hernia he had been living with for over a decade. Mr. Tonubbee's medical records support his testimony that his knees had been swollen and painful since at least 2005.[387] On an October 19, 2015 form, an orthopedic doctor indicated that all non-operative treatments have been exhausted and the condition affects activities of daily life.[388]

education regarding his Hepatitis C diagnosis.[418] Mr. Butler's testimony was also

Where Dr. Lavespere's testimony could be checked against record evidence, it was at times overstated, if not disingenuous. For instance, he testified that after EMTs perform sick call, they put the patients' completed forms in the doctors' boxes and those "10 to 20 [forms] a day for each physician" "should be reviewed every day."[429] However, the sick call forms themselves directly refute this statement, as explained in more detail below. Countless sick calls in the medical records have no date or signature from a provider whatsoever.[430] Those that do have a provider signature are often dated several days later, usually with no notes.[431]

Dr. Lavespere also testified that there was an annual review conducted at the end of each year since at least 2009, when he started working at Angola.[432] He testified that the evaluation process included "a lot of paperwork" and was "a very important piece of information," and that his review was performed "by [his] medical director."[433] Dr. Lavespere's testimony thus suggested that he performed an annual extensive evaluation of the medical performance of the physicians under his supervision.

However, the evidence in the record and Dr. Lavespere's deposition testimony shows that the "performance evaluation and review" that he is referring to more accurately resembles an elementary school report card.[434] The "performance evaluation and review" entails four pages of generic employee performance questions, none of which are specific to the duties of a physician, and requires only a rating (the three choices being "exceptional performance," "achieves expectations," and "unsatisfactory performance") with only cursory comments, if any, provided by

[429] Oct. 22 Testimony of Randy Lavespere at 59:13-60:4. Defendants' counsel also referred to Dr. Lavespere's assertion that sick call forms are reviewed by doctors the same day they are submitted repeatedly during the cross-examination of Plaintiffs' experts. Oct. 17 Testimony of Madeleine LaMarre at 9:7-11:19 ("Q: … [T]he EMT gets the Health Services Request and then a doctor signs off on it within 24 hours, correct?" … "Q: … Are you aware that the EMT takes the Health Services Request, puts it in the box, and the doctor signs off on it within that next day?" … "Q: So if every doctor comes in here and testifies that these Health Services Requests are placed in a box, I look at them that day and sign off on them, you have a basis to dispute that?").

[430] *See* Oct. 23 Testimony of David Thomas at 99100:12-103:35, 107:25-114:5; JX 10-cc-2 at 25457, 25474, 25501, 25703, 25706, 25714-15, 25718-19; *see also* JX 10-a-1 at 00064 (no signature), 00081 (no date), 00100 (same); JX 10-zz at 53828 (same), 53831-32 (same); JX 10-b at 02532 (same), 02556 (same), 02596 (same).

[431] Oct. 23 Testimony of David Thomas at 99-114; JX 10-cc-2 at 10-25470, 25488, 25490-91, 25508, 25512, 25457.

[432] Oct. 22 Testimony of Randy Lavespere at 10:25, 24:12-14.

[433] *Id.* at 24:12-15.

[434] *See, e.g.*, JX 4-rr, R. Lavespere Depo. at 82:11-22; PX 63 at 0001-07.

the supervisor.[435] As reflected in the record and acknowledged by both Dr. Lavespere and Warden Lamartiniere, Dr. Lavespere's annual review, such as it was, was conducted by Warden Lamartiniere, who has no medical background or expertise—not, as Dr. Lavespere suggested, "[his] medical director."[436]

In addition, Dr. Lavespere's testimony regarding the care he provided to specific patients in Plaintiffs' experts' sample lacked credibility and added little if anything to the contents of the paper record.[437] He has previously testified that he does not write down notes when he evaluate or treats patients because he does not "need all that," even when he sees up to 76 patients in one day.[438] Despite his practice of seldom taking notes, at trial, Dr. Lavespere purported to be intimately familiar with the medical records and medical history of each of the patients in the medical sample that Plaintiffs' experts had reviewed and attempted to undermine their findings.[439] To the extent this testimony was intended to reflect his actual recollection, rather than simply the contents of the documents, it strains credulity to believe that he could remember specific treatment provided on specific days, as he sometimes purported to do. Moreover, as was shown on cross-examination, the care that Dr. Lavespere testified to was also overwhelmingly reflected in the experts' chart reviews.[440]

Dr. Lavespere's candor regarding the interpretation of medical records was seriously undermined by his willingness to allow counsel to misrepresent medical records of

note.[443] Similarly, during Dr. Thomas's examination, Plaintiffs showed that Plaintiff Ian Cazenave had not been sent to a wound care specialist despite repeated referrals from outside providers.[444] On re-direct, Defendants' counsel presented two documents as showing "regular wound care follow-up as ordered by the outside providers."[445] In fact, the records did not show the wound care specialist visits ordered by outside providers, but wound care performed by EMTs *at Dr. Lavespere's direction*.[446] Despite the fact that Dr. Lavespere was in the courtroom when these records were discussed, had represented that he was extremely familiar with the care and the medical records of that patient, and was passing extensive notes to Defendants' counsel throughout trial, neither Dr. Lavespere nor Defendants' counsel felt the need to correct the record of their own accord on either occasion.

Another example of the unreliability of Dr. Lavespere's trial testimony is illustrated by his unsuccessful attempt to explain the state of the unsanitary and cluttered clinical exam rooms that were pictured in Plaintiffs' expert report. Initially, Dr. Lavespere tried to testify that all the pictures of the cluttered clinical rooms were actually of "his room," or a second office that he used (in addition to his 'actual' office) to perform his daily duties of being medical director, which is why there were charts "stacked up everywhere" including on the patient examination tables.[447] He testified that his actual office was "way in the back of the building" and he chose to turn a clinical room into a second office in order to be "accessible."[448] On cross-examination, Plaintiffs' counsel showed Dr. Lavespere a picture of a yet another cluttered clinical room and he attempted to claim that it was "one of the ones he use[d]" when he "rotate[d] offices" to accommodate a specialty doctor, but asserted that he would not have been using both clinical spaces as offices on the same day.[449] However, when confronted with the fact that all the pictures were in fact taken on the same day, Dr. Lavespere finally backed down and conceded that the pictures could in fact be "typical of how the clinical spaces look."[450] His original claim was further contradicted by Dr. Vassallo's credible testimony that she observed patient care in an examination room that "looked just like those pictures," where "the examination room bed was full of charts."[451]

Dr. Lavespere has also shown a willingness to contradict his prior testimony when it proves harmful. During his deposition, Dr. Lavespere testified no less than seven

[443] *See* Oct. 22 Testimony of Randy Lavespere at 216:4-217:21; JX 10-ddd-3 at 56892.
[444] *See* Oct. 23 Testimony of David Thomas at 95:13-98:15.
[445] *Id.* at 117:12-118:5.
[446] *See* JX 10-k-1 at 10140, 10144.
[447] Oct. 22 Testimony of Randy Lavespere at 77:7-79:1.
[448] *Id.* at 79:1-6.
[449] *Id.* at 181:1-17.
[450] *Id.* at 181:19-182:3.
[451] Oct. 25 Testimony of Susi Vassallo at 83:9-13.

times that trying to figure which of the "offenders" was lying to him was the biggest challenge of his job as Medical Director, and that he believed roughly half of his patients were not telling him the truth.[452] He expressed his belief that some of his patients "don't want to be better."[453] This, in turn, led Plaintiffs' experts to characterize Dr. Lavespere's practice of disbelieving his patients as "the epitome of unprofessionalism."[454] At the class certification hearing, Dr. Lavespere tried to say that his deposition testimony "should have been placed in the context" of the subset of people working in the field lines because "that population there is very difficult in who's telling me the truth."[455] He went on to analogize the situation to "when you wake your kid up and they tell you they don't want to go to school."[456] This explanation was false, as Dr. Lavespere's deposition testimony about his offenders' supposed manipulativeness was not limited to patients working on the farm. For example, Dr. Lavespere testified in his deposition that "there are offenders out here that want you to take their medicine so their blood pressure will go up so they can have a stroke so they can say, You took my medicine."[457]

At trial, Dr. Lavespere tried yet a third version of this testimony. Now, his broad testimony about disbelieving his patients was limited to "determining when it comes to pain, who's telling me the truth."[458] He also tried to state that during the time Plaintiffs took his deposition he was working in the ATU more and had to figure out who was telling him the truth because he was involved in doing duty statuses, but that now he was on more administrative work so he didn't "have that issue much anymore."[459] When impeached with his deposition testimony, Dr. Lavespere fell back on his own time in prison as a last resort. He testified that in his role as a medical director he used "things" that he "learned from the inside," that he "witnessed firsthand, and that "you don't learn by reading a book or writing a book" to know "what the name of the game is."[460] Ultimately, the "name of the game" for Dr.

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[452] JX 4-qq, R. Lavespere Depo. at 7:20, 12:14-14:7; JX 4-rr, R. Lavespere Depo. at 18:1-3, 18:6-8, 19:19-22, 19:3-17, 20:2-3. While Dr. Lavespere maintained at the class certification that he was "not an expert" in taking depositions, the Court itself acknowledged that "he's testified in this Court a dozen times." Oct. 22 Testimony of Randy Lavespere at 199:16-17.
[453] JX 4-rr, R. Lavespere Depo., at 52:7-8.
[454] PX 6 at 0014.
[455] Nov. 2 Class Certification Hearing at 39:24-25, 40:8-9.
[456] *Id.* at 40:10-18.
[457] JX 4-rr, R. Lavespere Depo. at 51:23-52:2.
[458] Oct. 22 Testimony of Randy Lavespere at 170:3-4.
[459] Oct. 22 Testimony of Randy Lavespere at 194:10-13. When confronted with the fact that he had just testified that he, in fact, had more administrative responsibilities at the time of his deposition and not less, Dr. Lavespere lashed out at Plaintiffs' counsel and claimed that "[a]fter this trial I won't have ya'll, y'all's part of my job which takes up about 50% of it." *Id.* at 194:20-23.
[460] *Id.* at 196:20-23.

Lavespere is to assume his patients are trying to get more favorable job assignments.[461]

Perhaps the most telling reflection on Dr. Lavespere's credibility was his blatant animosity and unprofessional demeanor towards Plaintiffs, Plaintiffs' counsel, and Plaintiffs' experts throughout the entirety of trial.[462] On multiple occasions, he took the opportunity to express his anger towards Plaintiffs' counsel for doing nothing more than filing the complaint and serving discovery requests in the normal course of litigation.[463] He criticized Plaintiffs' experts for not observing his "daily interaction with offenders," when he himself instructed Plaintiffs' experts to stop observing clinic examinations.[464] And when asked whether he had been sued previously as a result of the difficulty getting hernia and cataract surgeries, Dr. Lavespere inexplicably began to verbally barrage Plaintiffs' counsel's about her husband's legal practice.[465] In particular, Dr. Lavespere exhibited untoward hatred of Plaintiffs' expert Dr. Puisis, whose report and testimony this Court has credited throughout the case. During a brief break in trial proceedings, Dr. Lavespere made an aggressive and troublesome threat regarding Dr. Puisis in the public bathroom of the Courthouse.[466] When asked about this threat on cross-examination, Dr. Lavespere angrily attacked Dr. Puisis' character and qualifications ba

EIGHTH AMENDMENT CLAIM

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

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

118. 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.

119. 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.

120. These problems go as far back as the discovery period goes, and were continuing as of the very end of the discovery period.[468] As Ms. LaMarre concluded, "During the period of time that [the experts] reviewed, care remained poor. … My assessment is that it's an inadequate system and it really hasn't improved."[469] Some of the very latest medical records reveal significant failures to provide timely access to a physician, appropriately treat chronic diseases, follow up on positive test results, or appropriately respond to medical emergencies.[470] The evidence proves that the risk of harm is persistent, long-standing, and ongoing.

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he even be called an expert with that type of report? No, he shouldn't. And I'm very angry with him. Yes, I sure am.").1,0300030003000300030003000300030003o.00037002.0003 Tw

126. A similar pattern occurs in emergency situations. A patient presents with an emergent medical need, either a sudden onset 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. As Dr. Vassallo summarized, "multiple times … patients did not … receive a diagnosis and did not receive the proper workup for serious medical complaints that resulted in their death or a delayed transfer to the hospital, which resulted in significant harm.[476]

127. 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. As Dr. Puisis concluded, it was not a close question whether clinical standards of care were met.[477] Rather, as Ms. LaMarre observed:

> [W]hat was really, really striking about LSP is the … lack of an adequate comprehensive healthcare program that ensured that patients got timely care for their serious medical problems. I was struck by just the sheer number of encounters where patients presented with signs and sy

129. Because Plaintiffs' experts' case studies are discussed at length below in the sections on specific deficient practices, they will not be repeated here. Suffice it to say, the case studies and the underlying records amply justify the experts' concern and their conclusion that LSP's medical system is one of the worst they have ever observed. They show year-plus delays in following up on test results suggesting cancer;[480] management of soon-to-be-fatal symptoms by EMTs for 24 hours without a physician ever seeing the patient;[481] prescription of medications that are affirmatively contraindicated and significantly increase the risk of harm;[482] and desultory care even in the infirmary, where the sickest patients are housed.[483]

130. As discussed above, Plaintiffs' experts' testimony about their findings was credible and reliable, and their report accurately represented the body of evidence in the tens of thousands of pages of medical records before the Court. While Defendants sought to undermine this evidence through cross-examination, their efforts were unpersuasive, as discussed above.

131. Stunningly, Defendants' experts did 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 38 case studies in Plaintiffs' experts' opening report in which they identified serious medical error.[484] The other 35 findings of serious harm and medical error in the opening report are simply unrebutted, as are the eight sample cases discussed in the supplemental chart reviews.[485]

132. Even where Dr. Thomas does discuss Plaintiffs' experts' case studies,[486] his comments underscore, rather than undermine, Plaintiffs' findings. He does not materially dispute any of Plaintiffs' medical experts' findings in any of them. Specifically:

    a. Patient #15 was 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

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heart attack, but I think you can for sure that it was … either potentially [preventable] or preventable.").

[480] *See, e.g., infra* ¶ 275.a

[481] *See, e.g., infra* ¶ 229.

[482] *See, e.g., infra* ¶ 254.a-254.b.

[483] *See, e.g., infra* ¶ 283.

[484] DX 14 at 02938-40.

[485] *See* PX 410. Defendants did not respond to the supplemental case studies submitted with Plaintiffs' rebuttal report at all, even though the Court granted them the opportunity to depose Plaintiffs' experts on those chart reviews. *See* Rec. Doc. 353 at 6.

[486] Curiously, Dr. Thomas did not address Plaintiffs' experts' case studies, the core of their opinions, at trial. A two-page section of Dr. Thomas's report is Defendants' only expert response to Plaintiffs' experts' review of the sample. *See* DX 14 at 02938-40.

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.[487]

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."[488] 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 was 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,

contributed to his death."[490] 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."[491] 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.[492]

f. Plaintiffs' medical experts concluded 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 concluded that without these errors, "his death was likely preventable."[493] 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]."[494] Of course, there is no requirement that Plaintiffs prove to a "certainty" that

[490] PX 6 at 0037.
[491] DX 14 at 02938-39.
[492] PX 6 at 0039-40, 53, 56, 83-84, 86, 200-208.
[493] *Id.* at 0039-40.
[494] 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 his death would have been prevented," PX 6 at 0086—is similar in substance, even if Dr. Thomas's actual quotation is inaccurate.

any particular death was caused by medical error; the point of the case studies is to

at trial.[497] They each credibly testified and detailed the harm that Defendants' inadequate medical care and mismanagement has done to many of their Angola patients, including rendering illnesses untreatable, causing significant unnecessary pain, and possibly shortening Class members' lives.

139. Dr. Jones and Dr. Dhand have each worked at UMC for approximately ten years.[498] In that capacity, both doctors routinely treat patients from Angola.[499] In their numerous years treating Angola patients, Dr. Jones and Dr. Dhand have observed a number of trends, which substantiates Plaintiffs' claim that the Class is subjected to a substantial and systemic risk of serious harm. Specifically, and as set forth in more detail below, the doctors identified the following problematic trends evincing inadequate medical care at Angola:

a. *Delays in medical care.* Both Dr. Jones and Dr. Dhand testified that their patients from Angola are delayed in accessing necessary medical care.[500] Typically, these patients are already suffering from serious chronic illnesses, such as cancer, HIV, heart disease, Hepatitis C, sickle-cell disease.[501] When patients arrive at UMC from Angola, they are frequently presenting with symptoms so severe that they are "out of control."[502] Indeed, according to Dr. Jones, her patients from Angola present with symptoms so severe that she would normally expect a patient from the general population to have already sought treatment before reaching that level of severity.[503] Dr. Dhand likewise testified that "almost all" of her patients from Angola report experiencing delay in their treatment before arriving at UMC.[504] According to both doctors, such delays in treatment materially obstructs their ability to provide effective treatment and therefore may detrimentally impact the prognosis of their patients from Angola.[505]

[497] *See* Oct. 11 Testimony of Catherine Jones at 111 *et seq.*; Oct. 11 Testimony of Monica Dhand at 159 *et seq.*
[498] Oct. 11 Testimony of Catherine Jones at 113:15-19; Oct. 11 Testimony of Monica Dhand at 160:8-10.
[499] Oct. 11 Testimony of Catherine Jones at 115:19-116:3; Oct. 11 Testimony of Monica Dhand at 160:11-24.
[500] Oct. 11 Testimony of Catherine Jones at 121:13-123:25; Oct.11 Testimony of Monica Dhand at 162:21-163:18.
[501] Oct. 11 Testimony of Catherine Jones at 115:22-116:5, 122:7-21; Oct. 11 Testimony of Monica Dhand at 162:5-164:18.
[502] Oct. 11 Testimony of Catherine Jones at 116:14.
[503] *Id.* at 117:8-13.
[504] Oct. 11 Testimony of Monica Dhand at 162:21-163:5.
[505] Oct. 11 Testimony of Catherine Jones at 122:22-123:25; Oct. 11 Testimony of Monica Dhand at 163:19-164:10.

b. *Failure to provide follow-up care.* As set forth in more detail below, Dr. Jones also credibly testified that their patients from Angola routinely do not receive the necessary specialty follow-up care that they prescribe upon discharge.[506]

c. *Failure to provide medically necessary medications and treatments.* Both Dr. Jones and Dr. Dhand also testified that their patients from Angola are often denied necessary medications, such as opiates, notwithstanding the fact that those are the effective pain treatments for serious illnesses such as cancer and sickle cell disease, which may cause prolonged sickle-cell crises and detrimentally impact cancer prognosis.[507] Both doctors also testified that their patients from Angola do not receive necessary physical therapy upon discharge.

d. *Inadequate medical records.* Dr. Jones also testified that the medical records sent from Angola with her patients' medical records are rarely complete, which can impair UMC doctors' ability to provide treatment.[508]

140. In contrast to Defendants' witnesses and cross-examinations, which repeatedly sought to blame problems on Class members' supposed refusal of care, both Dr. Jones and Dr. Dhand also testified that patients from Angola are cooperative, that they do not refuse treatment, and that they have never observed a patient from Angola malingering.[509]

b. *Named Plaintiffs' Medical Records*

141. 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.[510] 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. Over a two-year period, physicians never conducted a proper physical examination or took a relevant history, because sick call request after sick call request stopped at the EMT level without any evidence of a provider reviewing it or taking any action and providers did not take appropriate steps when they did see Mr. Hurd.

[506] Oct. 11 Testimony of Catherine Jones at 123:14-127:23.
[507]

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 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.[511]

b. Joe Lewis: Like Mr. Hurd, Mr. Lewis made years of sick call requests complaining of symptoms such as chronic cough, hoarseness, and loss of voice, even informing medics that he had a family history of cancer.[512] According to Plaintiffs' medical experts, these symptoms indicated "potentially serious medical conditions" that were "consistent with laryngeal cancer." Yet in response to these requests, 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. In all, physicians' treatment of Mr. Lewis's concerns were "below standard of care."[513]

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 specializes in treatment of blood diseases. Despite being imprisoned at Angola for 18 years, Mr. Cazenave did not meet with a hematologist

[511] PX 28 at 0018-22; Oct. 23 Testimony of David Thomas at 99:11-116:5; *see generally* JX 10-cc (Shannon Hurd medical records). Defendants' efforts to rebut Plaintiffs' evaluation of Mr. Hurd's care are discussed *supra* ¶¶ 62-67, 103. Mr. Hurd passed away after the close of discovery. His preservation deposition is in the record before the Court, *see* JX 4-u through 4-y.
[512] *See* JX 10-gg-1 at 31263; *see generally id.* at 31263-82, 31289-96, 31306-07.
[513] PX 28 at 0017.

until he was hospitalized in 2016. Plaintiffs' medical experts have noted that "[Mr. Cazenave] hadn't had a transfusion in 10 years and [had] never taken hydroxyurea both of which are . . . especially needed for persons with severe sickle disease and leg ulcers." Even once Mr. Cazenave saw specialists, prison physicians failed to properly document and act upon the specialists' recommendations, failing to send him to a wound care specialist despite numerous requests by physicians over a period of nearly six months.[514]

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 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

a. Francis Brauner: Mr. Brauner testified that when he arrived at Angola, he was paralyzed from the waist down as a result of a back injury.[519] Despite his paralysis, security placed him in a locked isolation room on the nursing ward, out of sight and sound of the nursing staff and without any way to call to them for assistance.[520] After 30 days in the isolation cell, Mr. Brauner went into septic shock from an infected bedsore on his tailbone and had to be rushed to the hospital for emergency surgery.[521] During his ten years at Angola, he developed additional bedsores that progressively got worse without appropriate wound care.[522] When he was released in

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.[530]

e. 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.[531]

f.

b. 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."[534] Angola's response was to schedule "one educational training" to "train nurses to perform better exams and to refresh on some basic anatomy."[535]

c. Dr. Singh and Secretary LeBlanc, who inform

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. For comparison, only three other states recorded 500 or more deaths per 100,000 inmates for even a single year, with none surpassing 528 deaths.[545]

c. While a direct comparison with other states is of limited utility, as Dr. Puisis explained,[546] the difference in trends is instructive. Compared to Louisiana's upward trend, the national average has been essentially flat for more than a decade. Few other states exhibited anything remotely resembling the relentless rise in mortality

[545] *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 4 . 2 0 a b

that Louisiana has seen, and none of them exhibited an increase anywhere close in magnitude.[547]

d. While Defendants' counsel suggested that an aging population might be responsible for LSP's and Louisiana's high mortality rate,[548] Dr. Moore testified that LSP's demographics are not particularly unusual and other facilities have the same or higher levels of infirmary care.[549]

e. These statistics reinforce 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."[550]

them. 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).

154. 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

reduce problems on an ongoing basis.[558] As a result, Angola's ailing medical system is incapable of diagnosing its own life-threatening conditions.

(1) Staffing Practices Contributing to the Substantial Risk of Serious Harm

156. 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."[559]

157. 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.[560]

158. Plaintiffs' experts were "struck by the lack of adequate staffing such that they're using correctional officers to administer medications. They are using inmates in the infirmary to deliver hands-on care which is not appropriate, and it's a sign that they have inadequate healthcare staffing."[561] They reliably concluded Angola's lack of "adequate healthcare staffing" denies patients "adequate access to care and access to a physician. Physicians do not evaluate patients even when they are notified."[562] Ms. LaMarre identified this as one of the primary issues making Angola "one of the worst prisons" she had ever reviewed because of the level of harm,[563] and Dr. Vassallo testified that the staffing practices "resulted in significant harm and even death."[564]

159. As detailed *supra* ¶ 24, 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.

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[558] *See e.g.*, PX at 0087-90.
[559] PX 6 at 0016.
[560] *Id.* at 0016-0027.
[561] Oct. 16 Testimony of Madeleine LaMarre at 150.
[562] *Id.* at 225-26.
[563] *Id.*.
[564] Oct. 15 Testimony of Susi Vassallo at 142.

a. *Providers*

160. In addition to Dr. Lavespere, Angola has five provider-level medical professionals: four physicians and one nurse practitioner.[565] With a population of approximately 6,400,[566] that averages out to 1,280 patients per provider. As Plaintiffs' medical experts have credibly opined, "[t]ypically, a physician can reasonably provide care to approximately 600 to 800 inmates depending on medical acuity."[567] This is a "rough guideline, but … around 800 patients per provider is generally, in male facilities, a reasonable number."[568] In areas requiring significant care, such as medical dormitories and infirmaries, the number may be at the low end of the range or significantly lower.[569] 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."[570]

161. Providers' caseloads appear even more concerning when looked at on the level of individual providers:[571]

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.

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 1,241 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 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."

162. Plaintiffs' medical experts' opinion that these caseloads are excessive and leave providers with "inadequate time to properly evaluate patients"[572] 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.

163. 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.[573] This is a long-standing problem; Dr. Singh noted the inadequacy of staffing as early at 2010—and staffing levels since that time have stayed flat, even as the population of patients increased by roughly 1,000.[574]

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[572] PX 6 at 0017.

[573] JX 4-bbb, R. Singh Depo. at 263:5-9; *see also* JX 4-ff, J. Collins Depo. at 91:21-92:14 (former Medical Director Jason Collins acknowledging that Angola could use "a few more hands" on any given day).

[574] *See* PX 67; PX 6 at 0017; *see also* PX 147 (nursing director describi

164. Defendants' expert Dr. Moore similarly acknowledged "physician manpower shortages" and "backlogs … due to a shortage in physician staff.[575] While Dr. Moore testified that it is difficult to determine appropriate staffing levels for a facility,[576] Plaintiffs' experts did not claim otherwise or purport to give any magic number for staffing.[577] On the basic question of whether staffing was insufficient, there appeared to be no real disagreement between the two sides' experts.

165. 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"). Angola's medical director testified at trial that he actively recruits physicians through the organization that monitors the treatment and compliance of impaired physicians who are under a LSBME consent order.[578]

166. 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."[579]

167. 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.[580]

168. "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."[581]

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[575] DX 13 at 02857, 02865.
[576] Oct. 23 Testimony of Jacqueline Moore at 141:23-142:5.
[577] PX 244 at 0003.
[578] Oct. 22 Testimony of Dr. Lavespere at 24:23-25:11, 178:2-21.
[579] PX 6 at 0021-22.
[580] *Id.* at 0022-23.
[581] *Id.* at 0021.

169. 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."[582] Neither Angola nor DOC headquarters maintain any of the standard information identified above. DOC Chief Nursing Officer Stacey Falgout acknowledged that DOC headquarters did not keep credentialing information and that LSP should "keep the file" and "review all the licenses, verification, have a CV on file, the application."[583] In fact, as Dr. Thomas admitted, "they have little in them except licensures."[584] Specifically, LSP's credentialing files contain only the state personnel application, in which "the only

possessed more complete credentialing files.[591] As Ms. Falgout testified, this is not the case: the incomplete LSP files are the only files that exist.[592]

As Plaintiffs' medical experts note, "[t[his is particularly disturbing because inmates have no choice about their provider."[598] 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.[599] For this reason, the NCCHC standards "specifically state that hiring physicians with licenses restricted to practice in correctional institutions is not in compliance."[600]

176. 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.[601] As he acknowledged, "primary care doctors with clear licenses are not going to work for the salary that is being offered."[602] 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.[603] Moreover, as Dr. Moore testified, staffing at prisons is generally "very challenging,"[604]

177. While both sides' experts agreed that disciplinary histories do not inherently disqualify a physician from practicing in a prison,[605] they also agreed that having an entire staff of disciplined physicians is rare if not non-existent.[606] The *only* example of another facility where all physicians had been disciplined that either side could name was in California—*prior* to the

[598] PX 6 at 0025.
[599] *See* Oct. 9 Testimony of Mike Puisis at 220:4-23.
[600] PX 6 at 0024-25.
[601] JX 4-ccc, D. Vannoy Depo. at 38:19-23.
[602] *Id.* at 38:24-39:2.
[603] JX 4-bbb, R. Singh Depo at 238:9-16; *see also* JX 4-ss, J. LeBlanc Depo. at 26:9-10 (acknowledging that "pay has a lot to do with" DOC's hiring of physicians with disciplinary histories).
[604] Oct. 23 Testimony of Jacqueline Moore at 154:4-6.
[605] *See* Oct. 9 Testimony of Mike Puisis at 218:18-25 ("I don't believe that that's necessarily an impediment."); Oct. 23 Testimony of David Thomas at 25:1-2 ("It depends on what the restrictions are, but quite a few good physicians have restrictions on their license.").
[606] *See* Oct. 9 Testimony of Mike Puisis at 220:24-22:7; Oct. 23 Testimony of David Thomas at 83:14-23.

court's finding that the medical care there was constitutionally deficient.[607] As Dr. Puisis noted, having an entire staff of physicians who have required discipline makes it "much more difficult to ensure that … any difficulties with respect to the characterological issues that may arise are going to be addressed."[608]

178. Defendants suggested at trial that LSBME's sanctions would have allowed these physicians to practice at a hospital.[609] It is unclear whether this is an accurate interpretation of the LSBME restriction of physicians to an "institutional, prison, or other structured setting pre-approved by the Board, in its sole discretion";[610] the word "institutional" could as easily be read through the canon of *noscitur a sociis* to mean prison-like facilities where persons are institutionalized, like certain mental health or rehabilitation facilities. But that ambiguity aside, the issue is largely academic, as the physicians would need to obtain privileges to practice at a hospital, placing a check on hiring that, in practice, prevents them from serving there.[611]

2010, only one such report, based only on Dr. Singh's review of patient charts and a video conference with Dr. Lavespere, appears to have ever been submitted.[613]

181. 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.

b. *Nurses*

182. Angola is staffed by 55 nurses, including 22 RNs, 30 LPNs, two medical assistants, and one respiratory therapist.[614] 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.[615]

183. 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* ¶¶ 285289, 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.[616]

184. 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 *infra*

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 presenter, it should be an RN, because "[g]enerally, LPNs lack the requisite training to perform medical assessments required to adequately facilitate telemedicine."[618] Moreover, while telemedicine is "useful for most specialties," it is "not useful when you need to touch the patient … when you need to really examine, palpate, it's more difficult. It's nearly impossible with telemedicine."[619] This makes Defendants' heavy use of telemedicine and their reluctance to shoulder the costs of transporting patients for offsite care concerning.[620]

186. 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.

c. *EMTs*

187. 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."[621] This is a major contributor to the catastrophically inadequate care Class members frequently receive.

188. EMTs are trained and licensed "to respond to medical emergencies and perform an initial triage of the patient."[622] While the four levels of EMTs have different amounts of training, even paramedics have significantly less training than doctors or registered nurses.[623]

189. EMTs' typical function is "to provide stabilization and transportation in the pre-hospital setting."[624] They do not manage patients for extended periods of time, unless that is part of getting a patient to a hospital.[625] Nor is it common for EMTs to be the only medical personnel to see a patient for a month or months at a time.[626]

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[618] *Id.*; *see also* Oct. 9 Testimony of Mike Puisis at 155:3-8 ("[G]enerally people use registered nurses because they're higher level of training and can make independent assessments. And that's what most facilities use, most correctional programs.").
[619] Oct. 9 Testimony of Mike Puisis at 154:20-55:2.
[620] *See* JX 3-b at 00510 (discussing telemedicine in the context of "trying to cut down on costs and make fewer trips").
[621] PX 6 at 0020 (footnote omitted).
[622] *Id.* at 0021.
[623] Oct. 15 Testimony of Susi Vassallo at 144:1-10.
[624] Oct. 15 Testimony of Susi Vassallo at 142:17-25.
[625] *Id.* at 151:17-52:4, 160:13-25; *see also* Oct. 16 Testimony of Susi Vassallo at 13:19-14-2.
[626] Oct. 16 Testimony of Susi Vassallo at 5:22-6:17.

190. Because their role outside of LSP is limited to pre-hospital stabilization and transportation, EMTs' training is limited: they cannot independently manage patients; they cannot perform differential diagnosis; and they cannot provide a professional medical opinion.[627] Their practice is strictly limited to defined procedures under a Scope of Practice Matrix issued by the Louisiana Bureau of Medical Services.[628]

191. The evidence shows that Defendants employ EMTs far beyond this proper scope. As discussed *infra* ¶¶ 207213 and 223234, 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. As Dr. Vassallo explained, "EMTs are used as primary providers."[629] Even Dr. Moore testified that EMTs are used at Angola more than she had ever seen.[630]

192. As Dr. Vassallo testified, EMTs at Angola examine and assess patients and manage their care for extended periods of time without doctors ever examining the patient.[631] In emergencies, this results in hours or days of deterioration without examination by a physician; for chronic conditions, it results in patients being denied an opportunity at diagnosis for months or years.[632] On the whole, Dr. Vassallo credibly found, "the periods of

their symptoms, and so using EMTs as "gatekeepers" to care denies patients any diagnosis and is "highly inappropriate in terms of their scope of practice."[636] As Dr. Vassallo summarized, "Multiple times … patients did not … receive a diagnosis and did not receive the proper workup for serious medical complaints that resulted in their death or a delayed transfer to the hospital, which resulted in significant harm."[637]

195. Defendants' reliance on EMTs in the ATU for hours or days with little physician involvement is even more deficient. Due to the severe understaffing at the provider level, most patients are treated principally by EMTs

196. Moreover, 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."[644] Dr. Lavespere testified that he provides no formal training for EMTs and does not meet with them in any regular, formalized way.[645] While he testified that the EMS director, Major Cashio, trained EMTs on the use of protocols,[646] Major Cashio denied this.[647]

that would be "complicated even for emergency physicians with experience and critical care specialists"—"way out of scope for an EMT and even some doctors."[654]

199. 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 simply write "according to protocol" without identifying the protocol they chose, let alone how they chose it.[655] 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,[656]—even though Plaintiffs' medical experts found that "in the majority of cases … EMT medical examinations are completely inadequate"[657] and Defendants' own providers have acknowledged that EMTs sometimes do not perform a thorough exam.[658]

200. Defendants attempt to reconcile the sweeping scope of EMTs' practice at LSP with the lawful scope of EMTs as specified in the Scope of Practice Matrix by reference to "trauma triage" and "treat and release protocols."[659] As Dr. Vassallo explained, neither of these permissions remotely resembles how EMTs practice at LSP. "Trauma triage" is triage within an emergency situation such as a multi-victim car crash; it is not the routine triage of patients in a non-trauma setting, which is how EMTs perform at LSP.[660] Treat and release protocols are for situations where a patient does not want transport to a hospital—not for situations where a patient seeks medical attention and an EMT decides that they do not need to see a doctor.[661] Neither function justifies anything like EMTs' practice at LSP.

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[654] Oct. 15 Testimony of Susi Vassallo at 192:2-6; *see id.* at 180:7-93:8; Oct. 16 Testimony of Susi Vassallo at 8:3-11:6. For example, Defendants "abdominal pain protocol" requires EMTs to subjectively assess and diagnose symptoms of abdominal pain. JX 8-a at 8-00024. *See also* Oct. 23 Testimony of Jacqueline Moore at 154:12-155:5 (testifying that EMT protocols could be "enhanced" and that "Plaintiffs did a fairly good job of mentioning the protocols that they felt needed to be done").

[655] PX 6 at 0041; *see* Oct. 16 Testimony of Susi Vassallo at 11:6-24.

[656] Oct. 24 Testimony of Darren Cashio at 50:14-51:7 (testifying that it's been years since he was notified about anyone in EMS failing to follow a protocol); JX 4-dd, Cashio Depo. at 72:21-73:16; JX 4-gg, 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).

[657] 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.").

[658] JX 4-uu, 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.").

[659] DX 15.

[660] Oct. 15 Testimony of Susi Vassallo at 147:4-148:9.

[661] *Id.* at 148:17-49:9.

205. 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 beginning at 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.[667]

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

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

207. 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

> 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.[668]

208. The evidence at trial proved that this assessment was reliable and credible. EMTs do not commonly consult doctors during sick call visits. As Major Cashio admitted, "[m]ost of the time" patients who submit an HSR do not see a doctor (at least not "immediately").[669] Internal statistics show that fewer than half of all sick call visits from April to June 2016 were even referred for provider review.[670] As the sick call requests themselves show, provider review rarely consists of more than initials.[671]

this.[673] Plaintiffs' experts documented numerous instances in the medical records where "because that was happening, patients did not receive a diagnosis and did not receive the proper workup for serious medical complaints that resulted in their death or a delayed transfer to the hospital, which resulted in significant harm."[674] Even Dr. Moore agreed that sick call requests were "not followed up timely by the physicians."[675]

209. Thus, the principal—and often only—medical attention Class members receive in response to sick call is a cursory and inadequate EMT assessment. As Dr. Vassallo and Ms. LaMarre aptly put it, EMTs are serving as "gatekeepers" to care, a chokepoint that frequently ends patients' access to care.[676] This does not qualify as a professional medical judgment, and denies or delays access to diagnosis and treatment.[677] As explained *supra*

> 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 … .[678]

211. 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.[679]

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.[680]

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 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.[681]

d. Patient # 18 requested an HIV test but was not tested and discovered positive for over two months, until he became 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 the 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.[682]

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[678] PX 6 at 0032-33.
[679] *Id.* at 0193-99.
[680] *See id.* at 0216-27.
[681] *See id.* at 0256-57.
[682] *See id.* at 0200-08.

e. 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.[683]

f. 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 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.[684]

212. In some cases, EMTs do contact physicians to report assessments and request instruction. But there is significant evidence that physicians' participation often 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."[685] These orders "result in delay in care, lack of evaluation by a physician and in some cases death."

b.

216. Second, sick call occurs at unscheduled times, beginning as early as 4:30 in the morning in some housing units.[697] 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.

219. 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."[705] 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.[706] As Plaintiffs' medical experts explain, "[t]his is 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."[707] Dr. Puisis expanded on this at trial:

> [T]he most striking item in my mind was the practice of what we were told is aggravated malingering, which is … actually a punishment issued to the inmate. When the inmate complains of a certain condition and is evaluated for that condition but the staff member who evaluates the patient determines that the patient does not have the condition, then the patient is punished, can be issued a citation. And there's two problems that we had with it. Number one, the medical staff should not be participating in punishment. Their purpose is professionally medical and clinical care, and so it's not punishment. So that's one problem.
>
> But the second one is that similar to an patient who would go to an emergency room, patients don't know what they have when they make a complaint. If I have chest pain and go to an emergency room and they do an evaluation and discovery I do not have heart disease or an ulcer, I feel very happy but I wouldn't be punished for that. In this case, the inmates are punished. So it's perverse, and it's an aberration of professional responsibility.

[705] PX 53.

[706] JX 4-dd, D. Cashio Depo. at 83:17-84:10; *see also, e.g.*, JX 4-zz, S. Poret Depo. at 42:15-43:7 (Mr. Poret acknowledging that when he provided direct care, he used malingering charges "often"); JX 4-gg, A. Cowan Depo. at 43:21-25 (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-s, H. Varnado Depo. at 29:11-21, 30:23-31:2 (describing accusation of malingering); Oct. 15 Testimony of Danny Prince at 112:3-113:20 (explaining that an EMT at the ATU wrote him up for malingering after a security officer sent him there for treatment); JX 4-t, 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.").

[707] PX 6 at 0033.

a day in the ATU, according to Dr. Lavespere.[725] Wait times are often hours long, leading some patients to give up on seeking care and returning to their housing units.[726]

229. Examples of this practice are numerous and horrifying. Patient #1, for example, was managed by EMTs in the ATU for more than 24 hours in the middle of an episode of diabetic ketoacidosis and acute renal failure, leading to his death a day later.[735] Patient #15 was managed by EMTs in the ATU overnight despite acute coronary syndrome, and then discharged to his housing unit at 3:45 in the morning; he returned to the ATU later that morning and then died en route to the hospital.[736] Patient #20 was similarly managed by EMTs in the ATU overnight despite a physician's telephone order that he be admitted to the nursing unit, because there was no room in the nursing unit; the patient's symptoms suggested he was "internally bleeding and at risk of death," and indeed he died the following day.[737] Patient #38 and #42 were also managed for eight hours or more by EMTs, despite symptoms suggestive of stroke (and, in Patient #38's case, a history of stroke); Patient #38 died the following day, while Patient #42 was left with long-term deficits.[738]

230. 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

his 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, nor did he 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 "bagging" the patient. About 15 minutes later, Dr. Lavespere entered and restarted the bagging, 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.[754]

ii. Inappropriate procedures in emergency care

235. In addition to these critical failures to provide competent care in the ATU, Defendants employ several wholly inappropriate practices in the ATU. As Dr. Vassallo reliably testified, "the care is not standard of care in America today."[755]

First, Defendants presume that

patients in the emergency room is “a very juni

medical care with no basis in modern practice and delays transport to the hospital."[768]

c. 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."[769]

241. Second, Defendants inappropriately use restraints as a substitute for mental health treatment in the ATU for extended periods of time. One patient with a history of mental illness who presented to the ATU after cutting his forearms received no mental health treatment and instead was placed in four-point metal restraints with flex-cuff reinforcements—that is, strapped to a table by the arms and legs—as the sole form of care.[770] As Dr. Vassallo explained, physical restraint is only appropriate

biopsy.[775] They proceeded to provide minimal care and examinations without waiting for a decision, and even after the patient decided that he wanted to proceed with chemotherapy.[776] When the patient developed hypotension and altered mental status, an LSP physician again tried to convince him to sign an advance directive and held the patient in the ATU for five hours before sending him to a hospital, where he soon passed away.[777]

245. 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.[778]

c. *Inadequate Chronic Disease Management Program*

246. A chronic disease is "a condition that is present for at least six months or more and requires regular intermittent monitoring by a physician."[779] 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

[775] *Id.* at 0077.
[776] *Id.* at 0138-40.
[777] *Id.* at 0141-42; JX 10-iii at 60463.
[778] PX 6 at 0071 (footnote omitted).
[779] Oct. 9 Testimony of Mike Puisis at 124:15-17.

program is to decrease the frequency and seve

249. Chronic disease guidelines are a critical component of ensuring a competent, adequate standard of care. As Ms. LaMarre explained:

> Chronic disease guidelines are important in a correctional agency to give guidance to clinicians about what standard the department expects them to meet in terms of delivering chronic disease care to patients at the facility, and they should be … evidence-based and based on national guidelines that are being updated all the time to basically give guidance about who should be enrolled in the clinic, what's the baseline evaluation for each patient, how often should patients be seen, how often should they be seen if they're well-controlled, and how often should they be seen if they are poorly controlled.[787]

250. Angola's chronic disease guidelines, however, are "very skeletal."[788] Angola's Chronic Care Manual[789] 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."[790] 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."[791] They are, simply put, "completely inadequate."[792] Even Dr. Lavespere's prepared testimony about chronic diseases demonstrated a failure to understand or observe modern practices for treating chronic diseases.[793]

251. Many of these observations were corroborated by Dr. Moore. In her report, she found that the "chronic care guidelines could be enhanced"; that "some providers documented a focused exam, pertinent medical history[,] medication compliance and laboratory results better than others"; that a chronic care nurse should be added "so that offenders with chronic care disease can be scheduled and tracked in chronic care clinic and when the patient is seen by the provider, the laboratory work is in the chart"; and that the number of chronic care visits in the six months before her assessment seemed low for Angola's population.[794]

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[787] Oct. 16 Testimony of Madeleine LaMarre at 158:19-159:4.
[788] *Id.* at 159:5.
[789] JX 8-l (Chronic Care Manual).
[790] PX 6 at 0042-43.
[791] *Id.*; *compare, e.g.*, JX 8-l at 02708 (LSP hypertension guidelines) *with* Rec. Doc. 517-5 (Eighth Joint National Committee, 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults). *See* Sept. 25, 2018 Minute Order (taking judicial notice).
[792] PX 6 at 0043; *see also* Oct. 16 Testimony of Madeleine LaMarre at 159:7-8 ("[I]t just wasn't really adequate to ensure that clinicians knew what they should be doing.");
[793] *See* Oct. 25 Testimony of Susi Vassallo at 86:2-87:3.
[794] DX 13 at 02865-66.

disease is not being managed and it causes morbidity and mortality. And the morbidity includes direct harm, hospitalization, and deterioration of disease."[811]

254. Plaintiffs' experts reviewed at least 33 patients with chronic diseases, and found major, prolonged delays and errors in care in every one.[812] For example:

a. Defendants use Coumadin (also known as warfarin), an outdated blood thinner,[813] as their principal anticoagulant, but exhibit a dangerous unfamiliarity with its appropriate use. Patients #51 and #53 received "booster" doses of Coumadin in 2015 and 2016, but use of a single extra dose of Coumadin "is not recommended therapy and is below standard of care and harms the patient by ensuring lack of therapeutic anticoagulation."[814] Defendants prescribed Coumadin for Patient #30 for a presumptive deep vein thrombosis ("DVT"; a blood clot in the legs) without performing an ultrasound to confirm the suspicion; after 12 days, an ultrasound was performed and revealed that he did not have a DVT and instead had a hematoma, which are exacerbated by blood thinners.[815] Even if it had been a DVT, Coumadin would have been the wrong medication, as it takes several days to begin to work.[816] Doctors never asked Patient #52 whether he suffered any bleeding, even when his clotting ratio was twice the normal range in 2016, putting him at substantial risk.[817] Indeed, Defendants subjected him to treatment that exacerbated the risk of potentially life-threatening bleeding: medics provided him ibuprofen, which is contraindicated due to the risk of causing bleeding in patients on blood thinners; and Defendants shackled him in segregation, causing bleeding, then failed to check his clotting ratio.[818] And Defendants kept Patient #54 on warfarin for a year after an ablation procedure, placing him at heightened risk, until a cardiologist informed them that he should have been discontinued after two months.[819]

b. Patient #9 suffered from cirrhosis of the liver due to HCV and was transferred to Angola in February 2014.[820] Defendants failed to provide necessary diagnostic tests and maintained the patient on multiple hepatotoxins, drugs that are directly

[811] Oct. 9 Testimony of Mike Puisis at 127:12-15.
[812] PX 6 at 0043-47; *see, e.g.*, Oct. 9 Testimony of Mike Puisis at 133:6-152:16 (discussing Patients #11 and 13); *id.* at 181:8-195:12 (discussing Patient #3); Oct. 16 Testimony of Madeleine LaMarre at 199:14-201:24 (discussing Patient # 20); *id.* at 216:10-218:14 (discussing Patients # 25 and 26).
[813] *See* Oct. 25 Testimony of Susi Vassallo at 86:18-87:3.
[814] PX 410 at 3-4; *see also* Oct. 22 Testimony of Randy Lavespere at 113:16-19, 115:10 (stating that he gave Patient #21 a "booster dose of Coumadin").
[815] PX 6 at 0065-66; Oct. 16 Testimony of Susi Vassallo at 44:8-45:4.
[816] Oct. 16 Testimony of Susi Vassallo at 44:13.
[817] PX 410 at 5.
[818] *Id.*
[819] *Id.* at 1-2.
[820] PX 6 at 0131.

contraindicated for patients with compromised livers.[821] The patient died of a systemic infection possibly related to his weakened liver within two months.[822]

c. Defendants mismanaged Patient #11's severe Crohn's disease and ulcerative colitis from at least 2013 through 2016.[823] Among other problems, they provided him inadequate medication to prevent formation of fistulas,[824] failed to follow up on a test showing an abscess requiring immediate attention, failed to send him to a gastroenterologist for 15 months, and (as discussed in greater detail *infra* ¶ 283.d) showed no understanding of how to treat him in the infirmary after he returned from a partial colectomy.[825]

d. Patient #14 had out-of-control blood pressure and high blood lipids for more than two years between 2013 and 2015, during which providers saw him 13 times without addressing all of the patient's conditions, frequently leaving his blood pressure and blood lipids unaddressed, and only once performing a reasonably focused physical examination.[826] This likely contributed to a coronary event requiring a coronary artery stent.[827] Providers did not address the patient's chronic kidney disease, and on one occasion diagnosed him with chronic obstructive lung disease without any clinical evidence for the disease.[828] In 2015, an LSP physician took the patient off Lipitor (a high-dose statin) without explanation and despite the clear indication of a high-dose statin for his conditions, placing the patient and harm and possibly contributing to a hospitalization in February 2016.[829]

e. Patient #31 had hepatitis C, but did not receive direct acting antiviral medicine.[830] Despite being followed in the hepatitis C clinic, the patient presented with symptoms of liver failure for at least six months without meaningful treatment, even during an infirmary stay.[831] Defendants consistently failed to recognize signs of infection or

[821] *Id.* at 0135-36.
[822] *Id.*
[823] *See generally* Oct. 9 Testimony of Mike Puisis at 133:12-139:4; PX 6 at 0044-45.
[824] This was recognized not only by Plaintiffs' experts but by a gastroenterologist who the patient finally saw in January 2016. *See* JX 10-r at 16122; Oct. 9 Testimony of Mike Puisis at 136:17-138:15.
[825] Oct. 9 Testimony of Mike Puisis at 135:1-136:5; PX 6 at 0045.
[826] *Id.* at 0044; 175.
[827] *Id.* at 0044.
[828] *Id.*
[829] *Id.* at 0178, 181-82. Here again, outside doctors apparently shared Plaintiffs' experts' concern, restarting the statin when they next saw the patient. *Id.* at 0182; JX 10-ff at 30045.
[830] PX 6 at 0261; *see generally* JX 10-rr.
[831] PX 6 at 0067, 261-63.

acute decompensation and failed to transfer him to a hospital as his condition deteriorated, leading to his death.[832]

f. Patient #33 suffers from chronic kidney disease, heart failure, diabetes, and other serious chronic conditions.[833] Both before and after a hospital stay was necessitated by decompensated heart failure, acute respiratory failure, and acute renal failure,[834] physicians exhibited little effort to care for the patient, primarily leaving care to EMTs and seemingly writing off the patient because they "[d]oubt[ed] this zebra can change its stripes."[835]

255. In case after case, all of the elements of a chronic disease management program were missing.[836] Providers did not review each of the patient's diseases, perform a relevant examination, 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.

256. The substantial risk of serious harm stemming from these inadequacies in Angola's chronic care program was further corroborated by the testimony of Drs. Jones and Dhand, both of whom frequently treat Angola patients with a range of chronic diseases.[837] Dr. Jones credibly testified that her patients from Angola are generally experiencing acute exacerbations of their chronic illnesses—such as HIV, Hepatitis C, cancer, and sickle cell—which means that those illnesses have become "out of control" by the time they come to UMC.[838] According to Dr. Jones, her Angola patients with these acute exacerbations of chronic illness generally suffer symptoms with a "higher level of severity th

Angola patients with acute exacerbations of other chronic illnesses such as cancer and sickle cell disease.[842] Dr. Dhand likewise testified that her patients from Angola with chronic conditions present with severe symptoms[843] and that "almost all" of her Angola patients report delays in treatment before their arrival at UMC.[844]

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

258. 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 instructions, which must be incorporated into the patient's medical records and reviewed by the patient's primary care provider.[845]

259. 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.

i. Delays in obtaining specialty care

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

261. 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 "the lack of training of physician staff, physicians do not always appreciate when patients need referrals for care."[846]

which enters the referral into a computer database called Eceptionist.[848] Through Eceptionist, the Statewide Medical Director and other non-treating RNs review each referral

264. Additionally, Eceptionist does not track whether appointments are completed or rescheduled. This information often appears not to be transmitted back to facility providers, leading to 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.[855]

265. 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."[856] 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. The medical experts noted that they saw this type of miscommunication "multiple, multiple times."[857] For example, at least three patients had echocardiograms performed but not sent with the patient to the cardiologist, delaying treatment for serious cardiovascular conditions.[858]

266. 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.[859] Given that UMC, the primary location for specialty care, is approximately 150 miles away—a four- to five-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.[860]

267. All these problems combine to create "significant delays in obtaining specialty care."[861]

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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.").
[855] PX 6 at 0073; *see also* Oct. 17 Testimony of Stacye Falgout at 183:14-17 (Eceptionist is "a communication tool," not "a medical record"); Oct. 11 Testimony of Mike Puisis at 73:16-24.
[856] 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").
[857] Oct. 9 Testimony of Dr. Mike Puisis at 157:1-158:7; *see also, e.g.*, PX 6 (Patients # 6, 7, 11, 13, 17, 46); PX 28 (Patients # 51, 53, 54, 55).
[858] PX 6 at 0139-52 (Patient #13); *id.* at 0076, 117-26 (Patient #6); PX 410 at 0001 (Patient #51).
[859] *See* Oct. 15 Testimony of Danny Prince at 103:4-8.
[860] 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); *see also, e.g.*, JX 10-g at 07712 (Patient #41 refusing transport for medical care because Defendants could not or would not transport him with his oxygen supply).
[861] Oct. 9 Testimony of Mike Puisis at 158:24-25.

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

268. When specialty consultations, procedures at outside facilities, or hospitalizations occur, patients frequently return with recommendations for medication or particular treatment

consultation."[866] Patients' records at Angola seldom include the "[c]ompleted consultation

for pain.[875] Dr. Jones likewise testified that when she prescribes her Angola patients physical therapy upon discharge, those orders are also ignored.[876]

275. 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. Numerous patients exhibited an identical pattern of delayed cancer diagnosis due to the failure to consult specialists, follow specialists' recommendations, take adequate history, perform physical examinations, provide indicated diagnostic tests, or follow up on troubling test results, including:

i. Patient #5 complained for two years of weight loss and abdominal pain so severe he became unable to walk; only once he was hospitalized due to an emergent crisis was his colon cancer diagnosed.[877]

ii. Patient #7 showed two lung nodules on a June 2012 X-ray.[878] A follow-up CT scan was delayed for four months and showed a mass suspicious for cancer.[879] A delayed pulmonology consultation four months later recommended a biopsy, but Defendants failed to send the patient for a biopsy.[880] Another pulmonology consultation six months later again recommended an "[i]mmediate" biopsy.[881]uagai

initial X-ray[882]—his lung cancer had advanced to the point that doctors performed a lobectomy immediately instead of merely biopsying the lung.[883] Defendants then failed to follow up upon the patient's return until a specialist called in November 2013 to ensure he was referred to an oncologist; by the time the consultation was scheduled to occur, in January 2014—three months after the confirmation of a cancer so advanced he received an immediate lobectomy—the patient had died.[884]

iii. Patient #17, who had previously undergone chemotherapy for leukemia, showed a suspicious lung nodule on a CT scan in May 2012.[885] An oncologist and pulmonologist both recognized it as possibly malignant and recommended follow-up diagnostics on multiple occasions, but Defendant never performed these tests.[886] From October 2012 through November 2013, the patient complained repeatedly of chest pain and leg pain without receiving a physician evaluation, even though he deteriorated to the point that he needed a wheelchair for ambulation.[887] His metastasized cancer was not acknowledged until November 2013; he died two months later.[888]

iv. Named Plaintiffs Joe Lewis and Shannon Hurd experienced an indistinguishable delay in diagnosis, despite making numerous sick calls.[889] Mr. Lewis complained of cough, hoarseness, and losing his voice for 33 months beginning in April 2012, explicitly stating on a February 2014 sick call form that "I have a history in my family of cancer,"[890] but Defendants did not refer him to an ENT specialist until November 2014, and he did not see a specialist until January 2015.[891] Mr. Hurd, as discussed in detail elsewhere, made dozens of sick call requests for symptoms of renal cell carcinoma between September 2013 and September 2015, but did not receive a CT scan until December 2015—and even when that til ern eoms-6.02 Tw[(Decemb)-4.9(e)1.3eiI doze possibly malignant andP01¶¶ Januar1.4(ious lung n)5[(Decemb)-4.9(e)1.3eiI dozen.

with multiple lung nodules, physicians failed to follow up for nearly a month.[892]

b. An aortogram was requested for Patient #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." 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 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."[893]

c. 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.[894] 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

preventable, and it “was caused by lack of recognition of the need for anticoagulation over a two-year period an

concern for this patient and appeared to promote a terminal prognosis and delay care before the patient had an adequate chance at treatment."[899]

f. Patient #53, who had had a heart valve replacement and chronically sub-therapeutic levels of anticoagulants, was on Tegretol, an anticonvulsant medication for which he had no documented indication.[900] A cardiologist pointed out the lack of indication for Tegretol in 2016, but this was never reviewed by physicians, leading the patient to remain on Tegretol for at least three more months.[901]

g. Patient #51 suffers from, among other problems, COPD. While he has been followed by a pulmonologist, from July 2015 to July 2016 there is no evidence that his pulmonary consultation or the results of a diagnostic pulmonary function test were integrated into LSP providers' care, or even reviewed by an LSP provider.[902] His history, follow-up tests, and examinations lacked numerous indicated steps for monitoring and assessment of his COPD.[903]

j. Otto Barrera testified at trial regarding the significant delays in surgery that he experienced since arriving at Angola in 2013. Mr. Barrera had been told by surgeons before he was incarcerated that he needed

no documentation of the reports, and the coordi

adequate history and seldom perform physical examinations appropriate for the patient's 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."[923] Providers write only "episodic notes" that generally do not "identify all of the patient's problems," resulting

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.[957] It also poses a high risk of abuse, as Nurse Falgout acknowledged.[958] Indeed, Defendants' own nursing expert admitted that this use of inmate orderlies is "not always the best thing."[959]

287. 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.[960] 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.[961]

288. Plaintiff Farrell Sampier credibly testified about some of the consequences of this practice. He reported observing "aggressiveness" from orderlies and related that both he and at least one other patient were "almost dropped."[962] Because the orderlies are often "stressed" and overworked, patients often rely on other nursing unit patients for help.[963] He further testified that it is orderlies and not nurses who monitor patients on a day-to-day basis and respond to problems in the unit.[964] Former Class member Frances Brauner credibly testified that

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[955] PX 243 at 0064-65.
[956] Oct. 9 Testimony of Mike Puisis at 175:4-176:11.
[957] PX 6 at 0080-81.
[958] JX 4-ii, T. Falgout Depo. at 27:25-28:8; *see also, e.g., id.* 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.").
[959] Oct. 23 Testimony of Jacqueline Moore at 161:12-19.
[960] *Compare* JX 8-k at 02688 (Nursing Service Policy 20) *with* JX 4-ii, T. Falgout Depo. at 17:23-25 (Warden Falgout testifying that security deals with staffing and assigning orderlies).
[961] PX 6 at 0082; *see also, e.g.*, JX 4-ii, T. Falgout 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 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).
[962] Oct. 9 Testimony of Farrell Sampier at 65:3-11.
[963] *Id.* at 65:5-66:2.
[964] *Id.* at 65:14-20.

Defendants use orderlies even beyond activities of daily living, performing dressing changes on some patients.[965]

289. The overbroad nature of orderlies' use on the wards is confirmed by their training, which Ms. LaMarre explained is "essentially … training inmates to provide nursing care."[966] This training is an abridged certified nursing assistant ("CNA") training PowerPoint, which is not adapted to account for orderlies who have difficulty reading or other limitations understanding the presentation.[967] Along with the training, they have "hands-on" training that is principally provided by other orderlies, rather than nurses or other medical professionals.[968] Some orderlies start their duties even before they are trained, and they neither take a test after training nor undergo annual reviews.[969] 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.[970]

290. 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.[971] Some of these rooms are used for hospice patients or dialysis—but others are used to discipline patients in the nursing units.[972] 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.[973] For this reason, "a person with an infirmary-level illness should not be

[965] Oct. 12 Testimony of Frances Brauner at 98:5-9.
[966] Oct. 16 Testimony of Madeleine LaMarre at 161:9-12.
[967] Oct. 25 Testimony of Tracy Falgout at 40:5-10; JX 4-ii, T. Falgout Depo. at 21:25-22:3.
[968] JX 4-ii, T. Falgout Depo. at 31:1-16; At trial, Warden Falgout attempted to cabin the training to teaching tasks such as bed-making, but his Rule 30(b)(6) deposition testimony directly contradicts that characterization and is controlling here. *See* Oct. 25 Testimony of Tracy Falgout at 39:12-15.
[969] JX 4-ii, T. Falgout Depo. at 19:15-17, 30:13-17, 31:2-6, 33:6-9, 80:16-21.
[970] JX 6-eee at 6-00270 (annual training); JX 8-k at 02688 (24 hours of classroom training and 24 hours of clinical training); *compare* JX 4-ii, 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").
[971] JX 4-ll, 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); Oct. 12 Testimony of Francis Brauner at 88:1-11.
[972] *See, e.g.*, Oct. 12 Testimony of Otto Barrera at 215:8-17 (describing being locked up in an isolation room with no reason given); JX 10-ii-1 at 36661, 36666 (showing Patient # 39 placed in a "locked room" with the "hatch up" when admitted to the infirmary with a 103.6º fever and altered mental status).
[973] *See* Oct. 12 Testimony of Francis Brauner at 88:21-89:10 (explaining that he developed sepsis after 30 days in an isolation cell with no of accessing the nurses).

housed in a room that is not within sight or sound of a nurse."[974] 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.[975]

291. Third, as discussed above with emergency care, providers obtain DNR orders as a substitute for providing actual therapeutic care.[976] For example, when named Plaintiff Farrell Sampier arrived in the infirmary with transverse myelitis, an LSP doctor presented him with a DNR order to sign and told him "in pretty much graphic detail how I would have to have some ribs cracked and a lung punctured [to be resuscitated], and he was like, are you sure that's what you want to do?"[977] As Dr. Puisis explained, this is doubly inappropriate: it is inappropriate to discuss a DNR order with a patient who doesn't have a terminal condition, nor is it proper to "frighten a patient" by giving worst-case scenarios about resuscitation.[978]

292. Similarly, there is evidence that Defendants use DNR orders as a gateway to serious pain medication, essentially forcing patients to choose between salving their pain and continuing life-sustaining measures. With Patient #31, for example, Defendants began discussing a DNR with him as he entered a critical and painful state of decompensation, and did not begin meaningful pain medication until after he had signed the order.[979]

293. 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 have described it as "a dire situation" in which "some of the beds are grossly dirty."[980] Multiple class members testified at trial that patients lie in their beds covered in

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[974] PX 6 at 0082; *see also* PX 243 at 0130 (NCCHC standard: "Patients are always within sight or hearing of a qualified healthcare professional.").
[975] 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.
[976] *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.
[977] Oct. 9 Testimony of Farrell Sampier at 55:2-21.
[978] Oct. 9 Testimony of Mike Puisis at 179:5-180:16.
[979] *See, e.g.*, Oct. 16 Testimony of Susi Vassallo at 47:17-48:21, 106-07; *see also* Oct. 9 Testimony of Mike Puisis at 180:17-20 (not appropriate to make narcotic medication available only to patients who are on palliative or hospice care); Oct. 10 Testimony of Mike Puisis at 20:15-20 (same).
[980] PX 21 at 0001-02 (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

urine and feces, and that discarded, used sanitary materials and dirty diapers are left strewn about their rooms.[981] There are "fly traps hanging from the ceiling, over people's bed where you had to eat."[982] The bathrooms, outfitted with only "a shower curtain for a door," are also covered in feces, urine, and blood. Used bandages are left around the tub and sink, which are "black from … them bathing patients and never getting cleaned."[983] Given the heightened vulnerability of patients in the infirmaries, unsanitary conditions in the infirmaries place patients at a substantial risk of serious harm.

iii. Absence of care in the medical dormitories

294. 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 … any other general population units," and are crowded and disorganized.[984] 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.[985]

295. 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.[986] The reality is that the healthcare orderlies in the medical dorms are

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for many years at this point that the staffing levels were inadequate and created a risk for patients. *See* PX 67 (Dr. Singh noting the inadequacy of staffing and the risks that it created in 2010); PX 147 (nursing director describing understaffing in 2010). (nur3000300ai1o.00Jmany y e(nur3000300ai2o.00Jmany ytsTJ12

relied upon to perform medical duties far beyond their very limited training and capacity.[987] Dr. Lavespere admitted as much when he testified in reference to the medical dorms that "orderlies tend to those patient's medical needs."[988] In Ash 2, there are only two to five orderlies per shift to assist approximately 43 sick and disabled patients, some of whom are completely incapacitated.[989] In addition to the assistance the orderlies provide the patients within the dorm—including feeding, bathing, and transferring them between their beds and wheelchairs—they are also tasked with transporting patients outside of the dorm, which often leaves them unable to meet the needs of other patients as they arise.[990] Further, the orderlies are supervised by security, which directly undermines the care they are able to provide.[991]

296. In addition to being crowded and understaffed, the conditions in the medical dormitories are also unsanitary. Many of the patients are unable to clean up after themselves and the janitorial orderlies are only able to provide limited assistance.[992] The dormitories are also often dirty and moldy, particularly in the bathroom.[993] These "are not proper hygiene practices … to house very sick individuals."[994] In addition to the ADA violations discussed

f. *Inadequate Medication Administration and Pharmacy Services*

297. Angola's provision of medication is inadequate in both policy and practice. Defendants refuse to provide adequate pain medication; withhold treatment for hepatitis C; maintain a disorderly and unclean pharmacy 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.

i. Improper medication administration and medication administration records

298. 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.[996] LPNs or RNs should administer medication to ensure that "staff that administer medications have the adequate educational preparation and training to do what they are being asked to do."[997]

299. Medication is a "high-risk area" in any healthcare setting, but LSP in particular has an "extraordinarily high volume and extraordinarily high potential for medication error."[998] Yet Defendants' medication administration system violates all of the requirements laid out above. Correctional officers and even inmate orderlies administer medication, leading to improper 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.[999]

300. First, due to the shortage of nurses or other medical professional, LPNs administer medication only in the infirmary, the ATU, and some centralized pill call rooms.[1000] In the

[996] *Id.* at 0049, 51-52; Oct. 16 Trial Testimony of Madeleine LaMarre at 165; *see also* DX 3-a at 1910 (LSP medication training citing "6 Rights of Medication Administration," including the five above and "Right Documentation").
[997] Oct. 16 Trial Testimony of Madeleine LaMarre at 164:19-165:21; *see also* PX 243 at 0063 (NCCHC: healthcare staff should administer medication at facilities where healthcare staff are on site seven days a week for at least 16 hours a day).
[998] Oct. 16 Trial Testimony of Madeleine LaMarre at :163:13-164:11.
[999] PX 6 at 0049-51
[1000] PX 6 at 0049-50.

rest of the prison, correctional officers with no medical training deliver medication to the majority of patients, including in the so-called medical dormitories.[1001]

301. 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."[1002] Tammi Willis, who supervised pill call and pill call training, confirmed the meager nature of pill call training. In 2015, when the case was filed, officers received just two hours of training.[1003] Ms. Willis then expanded training to five hours, including breaks and a multiple choice test.[1004] Even this expanded training included just 15 minutes apiece on numerous critical topics, such as "medication handling/proper use of punch cards," "medication measurements/dosing schedules," and "medication compliance/DOT."[1005] Defendants then planned to make the training even simpler and convert medical terms into "layman's terms" because corrections officers found the actual medical terminology confusing.[1006] While Defendants considered making this a 20-hour program, Ms. Willis testified that they ultimately gave a "more simplified" version that was only five hours.[1007] While training is conducted by a registered nurse and a pharmacist, the actual day-to-day administration of medication by correctional officers is overseen by other correctional officers.[1008]

302. Moreover, even if Defendants provided significantly more training, "correctional officers simply do not have the training to know medications and what they are for and what their side effects are, and they don't have the capacity to recognize if the pharmacy has filled a prescription that shouldn't be filled."[1009] This "creates a risk of harm to patients because officers are performing a function … that they do not have adequate knowledge for."[1010]

303. Plaintiffs' experts' concerns about using correctional officers with no medical training to administer medication are "validated by actual practice, showing that officers do not follow correct procedure and have no supervision by qualified health care professionals. This

[1001] Oct. 24 Trial Testimony of Tammi Willis at 89:22-24 (confirming that LSP requires no medical

practice is dangerous and creates a systemic risk of harm to inmates at LSP."[1011] 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.[1012]

304. 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[1013] and "tend to those patients' medical needs."[1014] This prevents even correctional officers, even if properly trained, from ensuring that the five rights of medication administration are observed.[1015]

305. 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.[1016] "As LPNs may administer medications to more than 100 inmates, this renders MARs unreliable with respect

[1011] PX 6 at 0051; *see, e.g.*, Oct. 15 Testimony of Charles Butler at 65:20-67:9 (recounting an incident in which he was forced by pill officers to take all his medications for the day—15 to 18 different pills—before leaving Angola to work at DOC headquarters; lost consciousness and fell while hanging drywall eight feet off the ground; and was transported back to Angola in the back of a pick up truck, aggravating his fractured clavicle).
[1012]

to accuracy of medication administration."[1017] Defendants acknowledge that it is impossible to reliably record medication after distributing medication to dozens of patients.[1018]

306. Predictably, this system of administration results in inconsistent receipt of medication and wholly inadequate and unreliable documentation.[1019] MARs document patients receiving medication in their housing units at times they were in a hospital or in the infirmary.[1020] They record medications that can only be given in person by a medical professional, such as IV antibiotics and nebulized treatments, as "keep-on-person" medications that are distributed to patients to take on their own.[1021] In one case, officers indicated on a written MAR that a patient received medication all month, but entered into the electronic MAR that the patient did not medication at all.[1022]

307. In the most egregious example, Patient #18, medication administration records reported a patient who was acutely ill in the infirmary as simultaneously receiving medication in his housing unit and missing it in the infirmary.[1023] They then show the patient receiving an injectable controlled substance as a KOP medication in his housing unit while he was in an outside hospital.[1024] And they then show the patient receiving medication for several days after he dies in an outside hospital.[1025] While Defendants' counsel argued aggressively on cross-examination that the notation of daily administration was merely indicating the length of a KOP allotment,[1026] Ms. Willis directly refuted this assertion, explaining that KOP

[1017] PX 6 at 0050; *see also, e.g.*, JX 4-zz, S. Poret Depo. at 51:16-53:4 (acknowledging that correctional officers do not complete MAR contemporaneously in cell blocks).
[1018] Oct. 24 Trial Testimony of Tammi Willis at 97:12-17; JX 4-ddd, 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* Oct. 24 Trial Testimony of Tammi Willis at 96:9-12 (officers may see hundreds of patients for pill call).
[1019] *See* Oct. 16 Trial Testimony of Madeleine LaMarre at 162:12-177:23.
[1020] PX 6 at 0052-53.
[1021] *Id.*
[1022] Oct. 16 Trial Testimony of Madeleine LaMarre at 168:16-22.
[1023] *Id.* at 171:8-174:16; JX 10-jj at 39498, 39505.
[1024] Oct. 16 Trial Testimony of Madeleine LaMarre at 175:14-176:13; JX 10-jj at 39506.
[1025] Oct. 16 Trial Testimony of Madeleine LaMarre at 176-177:13; JX 10-jj at 39494.
[1026] Oct. 10 Trial Testimony of Mike Puisis at 159:9-160:4; Oct. 17 Trial Testimony of Madeleine LaMarre at 42:7-44:14.

prescriptions are marked only on the day that they

and other severe, debilitating symptoms.[1033] 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.[1034]

313. Instead of providing properly indicated pain management, Defendants "treat chronic pain with a combination of non-steroidal anti-inflammatory medications (NSAIDS), aspirin and acetaminophen.[1035] 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."[1036] Fully one of every ten Class members is prescribed Keppra, despite its *only* FDA indication being seizure treatment.[1037] As Plaintiffs' medical experts observe, "LSP's use of these medications appears to be excessive."[1038] 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.[1039]

314. While Defendants will presumably try to justify their restrictions as necessitated by security concerns, "[y]ou should be able to administer medication anywhere. If a person is in a maximum security unit, they should be able to receive a narcotic. If they're on a general medicine unit, they should be able to receive a narcotic. The fact that that's not done is inappropriate. They don't have access to required medication."[1040] Like in the civilian community, narcotic pain medication is kept "in a locked cabinet within a locked pharmacy room," with a "strict accounting of every pill."[1041]

315. Defendants also claimed that Dr. Puisis's textbook showed that "[n]arcotics being administered … to inmates in the housing units … is prohibited generally in prisons across

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[1033] *See id.* at 17:20-18:20 (discussing role of pain management in sickle cell disease); PX 28 at 0008-10 (discussing Mr. Cazenave's medical care).
[1034] PX 28 at 0008-10; *see also* Oct. 10 Testimony of Mike Puisis at 17:20-18:20 (describing role of narcotics in managing sickle cell); Oct. 11 Testimony of Anthony Mandigo at 80:18-81:10, 84:13-16, 101:1-9 (explaining that, before he was incarcerated, he used to get Demerol or morphine shots when was having a sickle cell crisis, but at Angola he only receives Tylenol, Ibuprofen, or Keppra).
[1035] Oct. 12 Testimony of John Tonubbee at 142:23-143:22 (testifying that he has made multiple requests for treatment for the excruciating pain in his knees, and that all he has received are cortisone shots and an anti-inflammatory drug).
[1036] PX 6 at 0049; *see also, e.g.*, JX 4-q, B. Prine Depo. at 26:6-23 (Class member testifying that Keppra provided no relief from orthopedic pain).
[1037] *See* PX 75 at 0001.
[1038] PX 6 at 0049; *see also* Oct. 10 Testimony of Mike Puisis at 19:25-20:14.
[1039] *Id.*
[1040] Oct. 10 Testimony of Mike Puisis at 17:14-19.
[1041] *Id.* at 18:21-19:8.

the country."[1042] The textbook says no such thing. The single sentence that Defendants cited is in a section on the ethics of "The Right to Die," and is part of a discussion about how physicians "must be honest with their patients regarding the extent to which palliative care is truly available" because "[i]n many correctional facilities, formularies either prohibit or severely limit the availability of narcotics and other pain medication."[1043] This passage has nothing at all to do with the availability of narcotic pain therapy; it solely concerns end-of-life palliative care. Moreover, it is discussing *formularies*, which determine which particular narcotics are available—not prison policies about who may access narcotic medication and how.[1044]

iii. Refusal to provide adequate HCV medication

316. Highly effective treatment is available for chronic HCV. There are several Food and Drug Administration ("FDA") approved medications

a. 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.[1058] He had to take two shots a day, five days a week, for a year.[1059] Three months after completing the treatment, the HCV was determined to still be present, yet he has received no further treatment.[1060] 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.[1061] He was further told he had to wait in line so that other prisoners who had not been treated yet could get treated first.[1062] Lawrence Jenkins has not received any treatment for his HCV since the failed round of earlier treatment methods approximately eight years ago.[1063]

b. Charles Butler is also incarcerated at Angola and diagnosed with HCV.[1064] Angola treated Mr. Butler with Interferon around 2005. His treatment was discontinued before it finished because, as he was told, it was ineffective.[1065] After his treatment was discontinued, he spoke with doctors at Angola about pursuing alternative treatments.[1066] He recalls being told by Dr. Lavespere approximately two or three years ago that Harvoni is the standard accepted treatment nowadays but that it costs too much.[1067] Charles Butler has never again been treated for his HCV since the initial failed round of Interferon over ten years ago.[1068]

323. Both Mr. Jenkins and Mr. Butler credibly testified that they received little to no education on HCV at LSP, despite the import on education expressed in the national standards.[1069] Mr. Jenkins testified that all of his knowledge of the disease came from his time working in

him that "hepatitis C could be transmitted to others."[1071] Mr. Butler received no education or courses on managing HCV or spreading HCV but did refer to being provided a pamphlet.[1072] Mr. Falgout spoke of the pamphlet in his testimony.[1073] A simple review of this pamphlet demonstrates clearly its deficiencies. While it is clear that all persons infected with chronic HCV should receive treatment,[1074] and that certain patients should receive treatment urgently,[1075] the pamphlet explicitly says no treatment will come until liver problems develop.[1076]

324. Patient #44 provides an equally troubling example of Defendants' failure to provide education and treatment for Class members who test positive for HCV. On May 23, 2016, Patient #44 tested positive for hepatitis-C antibodies.[1077]

12 months."[1085] In other words, LSP's policies flatly deny treatment to anybody who *might* be released in the next two years (even if there is no guarantee of release), and to anybody who tested positive for any illicit drug or was convicted of merely possessi

serious acute and chronic medical conditions."[1094] As discussed earlier, Defendants' failure to transport patients to outside providers who can perform indicated diagnostic services in

i. Inadequacies of Defendants' medical records system

332. 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.

333. Individual patients' records are "jumbled" and "not orderly."[1101] As a result, "different sections of the record were in different areas and sometimes mixed up. [The experts] would find consultant reports with MARs; … MARs with refusals; … MARs in progress notes; … consultant reports in progress notes."[1102] This was not limited to the photocopies prepared for trial; when Plaintiffs' experts reviewed original records on site, they were "very chaotic" and "misfiled sometimes"; as Dr. Vassallo put it, "sometimes we had a record of one date; 60 pages later, we were back to the same episode of care."[1103]

334. 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.[1104] Similarly, because LSP's electronic and paper records are not properly integrated, providers are unable to readily search the record to review current medications or medication adherence, or to verify appointment scheduling and completion.[1105]

335. Moreover, 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.[1106]

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.[1115]

ii. Inadequate confidentiality and access policies

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

342. 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.[1116] 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.[1117]

343. By contrast, patients themselves cannot see their own medical record.[1118] 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.[1119]

i. *Inadequate and Unsanitary Facilities*

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

345. 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.[1120] While Dr. Lavespere disputed the photographic

[1115] PX 6 at 0059.
[1116] JX 5-a at 00171 (§ 6(C)).
[1117] PX 6 at 0049-52, 60.
[1118] *Id.* at 60; *see, e.g.*, Oct. 9 Testimony of Farrell Sampier at 56:12-14; Oct. 15 Testimony of Otto Barrera at 20:7-9 ("I have never seen my medical records at Angola."); Oct. 12 Testimony of John Tonubbee at 165:18-21 (same); Oct. 15 Testimony of Charles Butler at 75:4-6 (same). Despite the fact that Defendants refuse to let their patients see their medical records, Defendants had no problem using those records—even those not in evidence—to cross-examine class member witnesses on specific numbers, names, and dates going back four or five years. *See, e.g.*, *id.* at 80:22-82:6; Oct. 12 Testimony of John Tonubbee at 156:1-157:25, 159:19-161:11, 165:22-166:11.
[1119] PX 6 at 0060.
[1120] *Id.* at 0028-29, 274-78.

evidence of the state of the examination rooms, this testimony was patently incredible, as

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

155 *Inadequate Leadership*

budget.[1136] 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.[1137] In all, "[h]e was unable to provide any specifics of how he spends his time in organizing or supervising the medical program."[1138]

354. Similarly, Dr. Lavespere provides no training to doctors who come to Angola.[1139] All parties agreed that correctional medicine has unique aspects.[1140] Dr. Thomas, for example, made sure that all physicians underwent a specific training program before seeing any patients in the Florida correctional system when he worked there.[1141] Yet even though all physicians came to Angola shortly after significant disciplinary actions and several had no prior primary care experience,[1142] Defendants provide no comparable preparation.[1143] Dr. Lavespere is not even familiar with the restrictions placed by the LSBME on the physicians he ostensibly supervises.[1144]

claimed that Major Cashio provided training on the EMT protocols, Major Cashio denied this.[1149]

357. 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."[1150] 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.[1151] If there is an absence of documentation in the medical records, the necessary assumption is that care did not take place. As Plaintiffs' experts explained, the standard in medical practice is "if you don't write all the details of it, you didn't do it."[1152] This is because "medical documentation is how we communicate our thoughts with the rest of the world, how we communicate our decision-making, and how we communicate with others subsequently."[1153] It is particularly important at LSP, where several different doctors, nurses, and EMTs, along with outside providers, may see a given patient. Defendants' practice of not creating appropriate medical records does not "adhere to standards of medical practice" and results directly in the serious harm documented above.[1154]

358. Equally disturbing, Dr. Lavespere, by his own admission, believes that his biggest challenge

as Dr. Puisis explained.[1164] The textbook was discussing administrative ways to route non-medical requests (e.g., requests for things like long underwear) and non-clinical medical requests (e.g., dental floss) to the proper channels without burdening the medical system.[1165] It has no resemblance to Dr. Lavespere's affirmed disbelief in his patients. Quite to the contrary, the chapter talks about the problems when staff "come to view inmates as abusing their access to health care," and notes that data show that "inmate use of ambulatory care is not different from that of people in the community."[1166]

362. 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."[1167] This fear is borne out by the pervasive appearance of Dr. Lavespere's inadequate clinical tendencies throughout all providers' records, as shown above.[1168]

363. 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, among other things, "personality disorder NOS [not otherwise specified] with antisocial, narcissistic and avoidant features."[1169] 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.[1170] 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.[1171]

364. The problems in attitude and leadership are not limited to Dr. Lavespere. The medical director before Dr. Lavespere, Dr. Collins, was the only physician at LSP in the past decade without a history of disciplinary violations (albeit a gynecologist, rather than a practitioner

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[1164] *See id.* at 100:18-101:12; PX 406 at 55.
[1165] PX 406 at 55.
[1166] *Id.* at 56.
[1167] PX 6 at 0014.
[1168] *See also, e.g.*, JX 4-f, K. Clomburg Depo. at 62:12-63:2 (describing EMTs accusing patients of "faking," or laughing at broken bones).
[1169] *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.
[1170] 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.
[1171] JX 4-rr, R. Lavespere Depo. at 82:19-22; *see* PX 63.

with relevant experience).[1172]

overtime worked."[1178] The minutes from April 2015 read "Topics discussed: Specific Offender surgeries such as joint replacement, cataract, and hernia repair and budgeting costs for these types of surgeries."[1179]

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

repeated warning that the cheapest regimen was inferior and posed the lowest chance of survival, Dr. Toce and Dr. Singh chose the cheapest one.[1186]

369. In the face of this explicit documentary evidence, Dr. Lavespere's testimony that budget considerations never influence treatment determinations[1187] is flatly incredible and demonstrable false.

370. The clear evidence of basing medical decisions on budget concerns goes hand-in-hand with Angola's leadership's disengagement from the budget. None of the medical leadership at Angola have any input into or knowledge of the content of the budget or the budgetary needs of the medical program.[1188] Dr. Puisis asked Assistant Warden Lamartiniere, Medical Director Lavespere, and Nursing Director Sherwood Poret about the budget, but "no one

Defendants' expert Dr. Moore testified that Defendants' budget is incomprehensible.[1196] This missing data is necessary to give administrators "an idea on [their] spending administratively and whether there might be a problem in a certain area or not a problem."[1197]

373. Despite Defendants' lack of knowledge about their own budget and their thoroughly inadequate recordkeeping, Plaintiffs' experts were able to determine the overall size of Angola's budget. They demonstrated that Angola's budget is "drastically less than an amount that would be expected for a facility of this size."[1198] 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.[1199] 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.[1200] 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.[1201]

374. 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

adequate medical care.[1202] Plaintiffs' medical experts explained that "[l]abor costs are typically 50% of a correctional medical program budget."[1203] The fact that these concrete and critical 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.[1204] Indeed, even Dr. Moore identified "manpower shortages, legislative cutbacks and other salient budgetary issues affecting the Department" and recommended that "a healthcare administrative structure also be added to assist the clinical director with an analysis of non-clinical issues affecting the budget."[1205]

375. Defendants' counsel suggested that Plaintiffs' experts failed to account for Medicaid 340B pharmaceutical pricing.[1206] But as Dr. Puisis explained, LSP's budget is "very low" even given 340B pricing, and "most correctional facilities get [340B pricing]."[1207]

376. 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.

(4) Inadequate Monitoring and Quality Assurance

377. The pervasive, systemic problems proven in this case persist in part because Defendants do not engage in appropriate monitoring or quality assurance.

378. 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.

a. *Inadequate Peer Review*

379. 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

[1202] PX 6 at 0027.
[1203] *Id.*
[1204] *See id.*
[1205] DX 13 at 02846.
[1206] Oct. 10 Testimony of Mike Puisis at 126:14-127:19. "340B" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations at reduced prices. *See generally* 42 U.S.C. § 256b.
[1207] Oct. 10 Testimony of Mike Puisis at 126:14-127:19.

typically occurs every year in correctional medical programs.[1208] 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."[1209]

380. *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.[1210]

383. Moreover the evidence at trial revealed that LSP has not been responsive to feedback during the peer review process. Dr. Lavespere testified that he made changes to the chronic care guidelines in late 2016 after a peer review suggested it (and after Plaintiffs' experts' site visit and Dr. Lavespere's depositions), but other documents raised on cross-examination revealed

changes to policies, procedures, or practices are warranted and to identify issues that require further study."[1230] It is usually performed by a group that "reviews the patient's problems, their medications, the course of treatment … as far back as is necessary to determine whether the presumed cause of death could actually have been modified by care that was provided."[1231] It is not performed by the treating providers, but rather an outside group that "interview[s] the clinicians, nurses, doctors, medics, mental health professionals who cared for the patient to determine what happened."[1232] "[I]t is not recommended to have the person who provided care perform the peer review because obviously they are less likely to identify problems with their own care."[1233] As Dr. Puisis testified, this is standard practice in correctional medicine and the subject of NCCHC standards.[1234]

390. Dr. Vassallo concisely summarized the purpose of mortality review: "[T]he idea is to get a root cause analysis, why did this happen to this patient? To look at the truth and the facts of what happened and say, where can we do better? … It's not an autopsy. It's to say, how could this have gone better? … It's a very organized matter."[1235]

391. Rather than perform mortality review, Defendants simply "perform a death summary" where "the physician who cared for the patient provides a paragraph or two summary of the circumstances surrounding the death, but it's not a critical review of the death."[1236] As Dr. Vassallo put it, "[t]hat's not a morbidity or a mortality review. That is a summary as the doctor who took care of the patient."[1237]

392. Unsurprisingly, mortality review at Angola invariably reports no problems with patients' care—despite the serious errors and delays found in virtually every recorded death that Plaintiffs' medical experts reviewed.[1238] "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."[1239]

[1230] PX 6 at 0084.
[1231] Oct. 10 Testimony of Mike Puisis at 30:5-9.
[1232] *Id.* at 30:2-5.
[1233] *Id.* at 30:15-18.
[1234] *Id.* at 35; *see also* PX 243 at 0039-0040 (NCCHC standards); Oct. 15 Trial Testimony of Susi Vassallo at 178-79 (testifying that she participates in morbidity and mortality review ("M&M") "almost every week").
[1235] Oct. 15 Trial Testimony of Susi Vassallo at 179:4-13.
[1236] Oct. 10 Trial Testimony of Mike Puisis at 35:21-24.
[1237] Oct. 15 Trial Testimony of Susi Vassallo at 179:20-21; *see also* Oct. 9 Testimony of Mike Puisis at 199:25 ("[T]here was no mortality review to speak of.").
[1238] *See supra* ¶¶ 34-34.
[1239] PX 6 at 0085; *see also* See PX 233 at 0339-0340.

393. This appears to be by design: there is evidence that Defendants consciously refrain from critically examining the medical care preceding inmates' deaths, knowing that they could be liable for fatal neglect and mistakes in care. When an inmate was found dead in his bed after mislabeled medication led to Defendants

anyone from the medical department, EMS department, pharmacy, laboratory, radiology, or medical records departments.[1256] Even the Assistant Warden for Healthcare Services, Ms. Lamartiniere, attended just two meetings in the five-year period.[1257] 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.[1258]

401. This fundamentally undermines the possibility of an effective CQI program. As Dr. Puisis explained:

> [I]t has to have the support of the leadership. The leadership has to not only buy in, but they have to promote it. And if the leadership doesn't promote the fact that we're going to have a quality improvement program and we're going to try to improve continuously, it won't happen. So that's fundamental.[1259]

402. 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.[1260] The only improvement activities that occurred were confined to nursing issues, due to the lack of participation by other departments.[1261] For the most part, these studies "were not really critical studies of identification of problems and trying to fix them, but were more observational ones such as looking at the data on death but not documenting any analysis of it."[1262] Even after urgent warnings, like the 2014 warning that patients with strokes were not being sent to the hospital in time, no CQI studies and improvement plans were added.[1263]

403. As a result, Defendants fail to address obvious problems—even when warned by their own staff. For example, in November of 2014, the nurse supervisor over the infirmary reported that the dirtiness of the infirmary had become a "dire situation," with medical waste bags

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[1256] *Id.*

[1257] *Id.*; PX 6 at 0007; JX 4-rr, R. Lavespere 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."); Oct. 10 Testimony of Mike Puisis at 36:22-38:4 (discussing lack of participation by Medical Director, Assistant Warden, EMTs, and pharmacy).

[1258] JX 4-uu, C. Park Depo. at 67:4-68:8.

[1259] Oct. 10 Testimony of Mike Puisis at 36:1-6.

[1260] PX 6 at 0088-89, DX 13 at 28-29.

[1261] PX 6 at 0088-89; JX 3-a; *see also, e.g.*, JX 4-zz, S. Poret Depo. at 101:13-102:14 (QA study on post-operative infections did not change behavior).

[1262] Oct. 10 Testimony of Mike Puisis at 37:11-15. Dr. Puisis also critiqued the studies for lacking a "fully dedicated position." *Id.* at 37:9-16. Indeed, given the myriad roles that Warden Tracy Falgout plays, the cursory nature of these reviews are perhaps inevitable. *See* Oct. 25 Testimony of Tracy Falgout at 33:5-37:2 (describing his many job responsibilities).

[1263] *Compare* PX 12 at 0001-02 *with* JX 4-bbb, R. Singh. Depo. at 61:20-62:2 (acknowledging that there had been no CQI study on stroke diagnosis).

"full" and "leaking," beds and floors not cleaned every day, and similar problems.[1264] At the same time, six post-operative infections were reported in the infirmary—three of which resulted in death.[1265] The next quarter the QA/QI committee began recording the number of infections, but made no recommendation for improvement even though it identified infections that originated at LSP.[1266] Defendants closed the study after a year without recommending or making any changes.[1267]

404. 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."[1268]

405. 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. As Dr. Puisis summarized:

> [I]t's pretty clear that they don't have a CQI program that's effective. It's a group of nurses who meet. They have a very limited perspective and agenda. There is no participation from medical; as a result, the serious problems that exist in medical care. … Why don't records, reports from the specialists come back to the providers? Why don't the providers review those reports? Why does it take 12 months or 15 months to get a biopsy of a probable lung cancer? Those problems don't get identified. And when they don't get identified, there is discussion on how to improve it; and as a result of that, the same problems reoccur over and over, and it's harmful. It causes morbidity and mortality.[1269]

C. Defendants' Counterarguments

406. Defendants did little to factually rebut Plaintiffs' evidence of a risk of serious harm or the connection between their poor practices and that risk. As discussed *supra* ¶¶131134, Defendants' experts did not controvert Plaintiffs' experts' record review in any significant way, and Defendants' attacks on cross-examination were insubstantial.

407. Defendants left much of the documentary and deposition evidence unrebutted altogether. They had no response to the documents contemporaneously showing problems in critical

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[1264] PX 11 at 0002-03; *see also* PX 21 at 0001-02 ("[I]t 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. … 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 clean as a hospital and I think it should be.").
[1265] PX 34.
[1266] JX 3-a at 00391-92, 397.
[1267] *Id.* at 441; JX 4-zz at 64:12-22.
[1268] DX 13 at 29; *see also* Oct. 23 Testimony of Jacqueline Moore at 149:7-13.
[1269] Oct. 10 Testimony of Mike Puisis at 38:24-39:11.

subjects like timely diagnosis and treatment of strokes and infections;[1270] they declined to acknowledge the testimony of their former Medical Director Dr. Collins and their former Assistant Warden for Health Care Kenneth Norris, who both acknowledged failures to provide basic services to patients; [1271] and they left unaddressed the numerous documents about backlogs and staff shortages that could harm patients.[1272]

408. Instead, Defendants' efforts to dispute Plaintiffs' showing involved four basic counterarguments: first, that some patients refused care; second, that some patients received multiple appointments with LSP providers or non-LSP specialists, multiple medications, and the like; third, that outside hospital services were inadequate for some or all of the time period; and fourth, that the facility was accredited by the ACA. None of these arguments does anything to rebut Plaintiffs' overwhelming showing that Class members are exposed to a substantial risk of serious harm.

(1) Refusals of Care

409. First and most emphatically, Defendants emphasized at trial that some Class members do, on occasion or on a repeated basis, refuse medical care. While this may be true, it does not diminish Plaintiffs' showing of a substantial risk of harm for at least three reasons: because the vast majority of deficient care evidenced in the records was unrelated to refusals; because most of the refusals Defendants identified were irrelevant or justified; and because Plaintiffs identified serious deficiencies in Defendants' handling of refusals.

410. *First*, while Defendants spent much time and energy at trial identifying specific instances in which patients in the Plaintiffs' experts' sample or named Plaintiffs had refused medical care, these refusals represented a tiny fraction of the encounters where Plaintiffs' experts identified problems. Even if all of the refusals Defendants identified were viewed as serious problems for Plaintiffs' experts' conclusions (which, as discussed below, they cannot be) most of the patients in the sample would still be entirely unaffected, as would the vast majority of relevant medical care for most if not all of the patients who did refuse care at one time or another.

411. *Second*, many of the refusals Defendants proffered had nothing at all to do with the deficiencies and harms that Plaintiffs' experts identified, or were readily explained by problems within Defendants' control, rather than the patient's.[1273]

[1270] *See supra* ¶¶ 230233.

[1271] *See* JX 4-tt, K. Norris Depo. at 37:13-38:5; JX 4-ee, J. Collins Depo. at 23:19-24:19, 123:12-125:15.

[1272] *See supra* ¶¶ 261264.

[1273] *See, e.g.*, Oct. 9 Testimony of Farrell Sampier at 81:22-82:7(explaining why he refused a wheelchair that was not designed for paraplegics); Oct. 12 Testimony of John Tonubbee at 144:9-146:22 (explaining how after waiting in a locked holding room for more than two hours to see the orthopedist, he was required to sign a refusal form in order to go back to his camp, even though

412. These problems were well illustrated in the case of Patient #1, Defendants' very first cross-examination of Plaintiffs' experts on the sampled patients.[1274] Dr. Puisis had identified three basic and serious sets of deficiencies that had exposed Patient #1 to a risk of harm: the

Plaintiffs' experts' finding of "significant departures from standard of care" over a ten-day period where the patient developed pneumonia and a systemic infection, leading to the patient's "preventable" death.[1289]

Similarly, Defendants identified two instances in which Patient #39 was not taking

419. *Third*, Plaintiffs established that Defendants' handling of refusals was deficient in numerous ways. Plaintiffs' experts testified at length about the standard practices that should be followed when a patient refuses medical care. The standard practice when a patient refuses medical care is that "a refusal form is signed for each refusal, and for certain items, when patients refuse repeatedly, nurses will notify a physician who will meet with the patient and document a discussion to try to determine why the patient is refusing."[1297] The patient should "put a reason for a refusal" so that "whoever looks at that refusal understands why the refusal exists."[1298] Medication administration records should similarly document refusals.[1299] As Ms. LaMarre summarized:

136.

> [W]hen patients refuse care for serious medical problems, you want to bring the patient to the clinic and sit down and discuss with them why they are refusing, … what their understanding of the disease is, what their understanding of the treatment options are, and be sure you thoroughly educate the patient, and then if they continue to refuse, you want to document that refusal.[1300]

420. While this sometimes occur at Angola, the evidence suggests it is infrequent. Most of the time when a refusal was noted, it was "based on provider notes about what was happening to the patient," rather than a signed and informed refusal.[1301] While Defendants identified "w7TT90 0scTw( )T1epntmnee[s]"(onad s)-55(m)0(aill hanfult of ocassios,")]TJ7.0066 0 0 7.02 68.438 417.1

care."[1316] There is no thus evidence to support Defendants' suggestion that Plaintiffs' standards are inappropriately high, and ample evidence for rejecting it.

(2) Examples of Care in the Record

426. Next, Defendants suggested that the fact that some patients received numerous appointments with specialists or other off-site medical care mitigated the risk of harm. As Defendants' counsel put it, "it's all about clinical care, and … they're getting clinical care. They're getting taken to outside providers, they're getting seen."[1317]

times between February and May 2016, without Mr. Cazenave once seeing a wound care specialist,[1330] as Dr. Thomas admitted on cross-examination.[1331]

431. Moreover, as Plaintiffs' experts explained and the records confirm, Mr. Cazenave had not seen a hematologist for at least 16 years as of February 2016.[1332] The omission of a critical specialty from testimony that patients were "frequently" and "regularly" seen highlights the core flaw in Defendants' argument that the existence of any non-LSP care mitigates the risk of harm: the occasional access to certain specialists cannot make up for inadequate or nonexistent access to indicated care that would reduce the risk of harm.

(3) The Availability of Outside Providers

432. Defendants also suggested that, to the extent there was any risk of harm to Class members, it was due to the lack of available outside providers, and was short-lived. Defendants focused in particular on the closure of Earl K. Long Hospital in April 2013, arguing that some backlogs developed and services were curtailed during the aftermath of the closure but the situation was returning to a safe level by the end of the discovery period. More generally, they noted that LSP is in a remote location far from hospital services.

433. As discussed *infra* n.1905, this is not a legally cognizable defense. Among other things, it is Defendants' choice to house Plaintiffs at LSP; nothing requires them to house the sickest patients in the DOC system at one of its most remote facilities. Indeed, nothing requires DOC to maintain a prison on a farm 60 miles from Baton Rouge. The government cannot choose to incarcerate individuals at an inaccessible location and then blame its inaccessibility for problems delivering medical care.

434. Even if this theory were legally cognizable, however, the facts do not bear it out. The evidence showed that the risk of harm was present before the closure of Earl K. Long and persisted long after it. As already noted, Plaintiffs' experts reliably identified numerous instances of deficient practices exposing patients to severe harm as far back as 2010, when they began reviewing records, and as far forward as mid-2016, the close of discovery.[1333]

Moreover, both the expert testimony and the record of the deficits in care rule out the

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.[1358]

446. These findings were supplemented by later annual 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 "Constitutional obligation to provide optimal health care to inmate populations."[1359] 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.[1360]

447. Nonetheless, LSP has fewer medical employees today, despite housing roughly 1000 more inmates.[1361]

448. 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' claims, the evidence irrefutably shows Defendants' awareness over the past several years.

449. 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

Department of Justice; from consultants that Defendants retained; from outside providers; and from DOC personnel themselves.

(1) Warnings from the DOJ

451. 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.[1362]

452. 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.[1363]

453. 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.[1364]

454. 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."[1365] 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 number 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.

455. 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.[1366]

456. 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.[1367]

[1362] PX 239. To be clear, the facts in this section are discussed only to establish Defendants' knowledge of the risks caused by the practices described in the 1990s litigation. Plaintiffs are not seeking to (and do not need to) establish that those practices in fact existed at that time.
[1363] Id. at 0001.
[1364] Id. at 0002.
[1365] Id. at 0002-04.
[1366] Id. at 0002-03.
[1367] See PX 17.

illnesses, particularly for older inmates," and concluded that Defendants were "dangerously deficient in the treatment of chronic illnesses."[1379]

462. The DOJ found the physician clinic was understaffed and consistently overcrowded,[1380] 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."[1381]

463. 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."[1382] The EMTs were "not adequately trained nor sufficiently experienced to recognize serious medical illness or triage sick call," and they could not di12 0e201 0163.

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."[1395]

472. Wexford similarly noted that Defendants' Quality Management Program (a forerunner to the current CQI program) "has little structure, thereby rendering it less functional than desired."[1396]

473. 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."[1397]

(3) Warnings from Outside Providers

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

475. In January 2014, for example, Defendants were notified that outside providers had to cancel

recognition and transport.[1401] Despite this warning, Defendants did not warn EMTs that they were failing to recognize signs of stroke.[1402]

477. 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 a lot of resources to fix something that could have been treated easily if diagnosed sooner."[1403] Despite this warning, Defendants did not warn EMTs that they were failing to recognize signs of infection.[1404]

department was “extremely understaffed,” 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.[1411]

482. 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.[1412]

483. In 2012, Secretary LeBlanc and Dr. Singh regarding recognized that funding and staffing shortages would result in “delay of critical care.”[1413]

484. Defendants also recognized the risks of having correctional officers administering medication at least as early as August 2010.

487. Defendants have even taken conscious steps to withhold information that could prove crucial to their patients' health. When educating patients about the dangers of dehydration, heat exhaustion, and heat stroke—serious risks for men required to work in the field in Louisiana summers, many of them with various medical vulnerabilities—Defendants chose to omit signs and symptoms to watch for, placing their desire to keep their patients working over their duty to ensure their patients' health.[1417]

488. 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."[1418] Mr. Norris testified that both Dr. Singh and Warden Cain knew about the delay.[1419]

489. 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.[1420]

490. Similarly, Defendants are aware of the extremely high and rapidly rising mortality rate discussed *supra* ¶ 148. Defendants have repeatedly cited BJS statistics as an authoritative source of information on the mortality rate in Louisiana's prisons.[1421]

491. 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.[1422]

C. Defendants Received Thousands of Complaints and Grievances from Class

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.[1425]

"misrepresented the facts of the patient's medical history" despite the provider's knowledge to the contrary.[1432]

497. 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 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."[1433]

498. 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.[1434] Others admitted to deleting medical emails.[1435] This furtiveness suggests a desire to avoid liability and consciousness of guilt.

499. 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 Dr. Collins

AMERICANS WITH DISABILITIES AC T AND REHABILITATION ACT CLAIM

I. THE DOC'S POLICIES AND PRACTICES DENY PROGRAMMATIC ACCESS TO AND DISCRIMINATE AGAINST INDIVIDUALS WITH DISABILITIES

500. The evidence overwhelmingly shows that patients with disabilities are routinely denied access to Angola's programs, services, and activities, and are otherwise subject to discrimination in the following ways: First, Angola's physical plant contains hundreds of architectural barriers that make it impossible for many patients with disabilities to access a broad array of services ranging from toilets and showers to the prison's law library. Second, the DOC and Angola have implemented certain policies that unlawfully discriminate against individuals with disabilities by denying them the opportunity to participate in programming for which they otherwise would be eligible. Third, Angola's policies, practices, and procedures regarding staff training and the identification, processing, and tracking of patients' disability-related grievances and requests for accommodations are inadequate and result in widespread failures to accommodate disabilities and to address acts of discrimination. Finally, patients with disabilities are often segregated from the able-bodied population when it comes to their housing assignments, yet they do not receive the types of medical services in those locations that would justify their segregation.[1437]

A. The Subclass Consists of Individuals with a Range of Disabilities.

501. 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."[1438]

502. There is no dispute that Subclass members have disabilities that affect their activities of daily living. Warden Donald Barr, who served as Angola's ADA Coordinator in the summer of 2016, testified that at Angola, "there's all sorts of disabilities [sic] . . . . You have prisoners who have hearing problems, prisoners who have limb problems, walking, hearing, and visual and things of those natures."[1439] Tracy Falgout, who assumed the role of ADA Coordinator after Warden Barr's retirement, similarly confirmed that Angola's population includes wheelchair-bound patients, including individuals who are paraplegic, as well as blind patients and patients suffering from dementia and other cognitive impairments.[1440] Aaron Brent, a former inmate health care orderly in one of Angola's so-called "medical dormitories," testified that his responsibilities involved caring for 29 or 30 patients in wheelchairs, as well

[1437] Plaintiffs' ADA and Rehabilitation Act claims are pleaded only against the DOC, not the individual Defendants.
[1438] Rec. Doc. 394 at 30.
[1439] JX 4-z, D. Barr Depo. at 12:13-17.
[1440] JX 4-jj, T. Falgout Depo. at 17:10-14; Oct. 24 Testimony of Tracy Falgout at 208:3-4, 8-14.

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

a. Plaintiffs' Evidence

505. Plaintiffs' architectural accessibility expert, Mark Mazz, has over 30 years of experience as a licensed architect and architectural accessibility consultant, including eight years with the federal government, three of which were spent in the Department of Justice's Disability Rights Section.[1448] Since his licensure in 1983, only two years of his career have been devoted to issues other than accessible design, and he has focused exclusively on accessibility issues for the last 18 years.[1449] In his practice, Mr. Mazz regularly assesses facilities' compliance with the "programmatic access" provisions of Title II of the ADA and Section 504 of the Rehabilitation Act, which require public entities to ensure that their programs, services, and activities are accessible to individuals with disabilities.[1450] His work for the government and as an independent consultant has included review of more than 30 correctional facilities in approximately ten states, as well as other Section 504 and ADA Title II barriers assessments and transition plans.[1451] Throughout his career, Mr. Mazz has served as a consultant or expert on behalf of the Department of Justice, local governments and private litigants in connection with approximately 100 projects.[1452]

506. Mr. Mazz testified credibly at trial regarding the accessibility of various programs, services, and activities to patients with disabilities who are housed on the ward, in two of the prison's medical dorms, in the Treatment Unit, and at Camp F. Defendant did not dispute Mr. Mazz's substantial qualifications,[1453] and Defendant's own expert corroborated each of the 190 violations of the 1991 ADA Standards for Accessible Design that were identified in Mr. Mazz's report.[1454] At no point did defense counsel question Mr. Mazz's veracity or the accuracy of his well-documented findings. Additionally, the report detailing Mr. Mazz's findings was admitted into evidence without objection.[1455]

507. Mr. Mazz conducted a site visit on July 20, 2016, in which he took measurements and photographs of specific areas within the prison.[1456] He 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

[1448] PX 7 at 0002; see also Oct. 12 Testimony of Mark Mazz at 7:6-25.
[1449] Oct. 12 Testimony of Mark Mazz at 6:24-7:1, 7:6-8:6.
[1450] PX 7 at 0002.
[1451] Id.; see also Oct. 12 Testimony of Mark Mazz at 6:7-11, 8:10-21.
[1452] Oct. 12 Testimony of Mark Mazz at 9:14-21.
[1453] See id. at 10:22-11:1.
[1454] PX 18 at 0002.
[1455] See PX 7.
[1456] Oct. 12 Testimony of Mark Mazz at 11:13-19.

encountered while displaying the corresponding photographs documenting each violation.[1478] As summarized in his report,[1479] Mr. 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.[1480]

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.[1481]

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.[1482]

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.[1483]

e. Sign-in desks and counters are out of reach for a person in a wheelchair.[1484]

f. The m a wheelchair.

j. Many ramps lack accessible handrails making it more difficult for an inmate with balance or stamina issues to use the ramps without falling.[1489]

k. Some ramps are too steep for many inmates in wheelchairs to use independently.[1490]

l. In some locations, mail slots are out of reach for many inmates in wheelchairs.[1491]

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.[1492]

n. In several locations, stools at the J-Pay stations blocked access for an inmate using a wheelchair.[1493]

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

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

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.[1499]

xi. Bathtubs are unusable for many inmates in wheelchairs because they lack any accessible features including seats, noncompliant grab bars, or controls not within reach.[1500]

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.[1501]

q. The Extended Lockdown shower is unusable for inmates in wheelchairs because it lacks any accessible features.[1502]

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.[1503]

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.[1504]

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.[1505]

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.[1506]

[1499] See also id. at 39:1-40:10.
[1500] See, e.g., PX 7 at 0030-3111 ll.37-41, 34 ll.169-73.
[1501] See also Oct. 12 Testimony of Mark Mazz at 41:23-42:10.
[1502] See also id. at 42:11-21.
[1503] See also id. at 42:22-43:12.
[1504] See also id. at 43:13-25. Consistent with the TU floor plan, see PX 14 at 00001, it was Mr. Mazz's understanding that each of the Time Out Cells is identical. Oct. 12 Testimony of Mark Mazz at 44:1-4.
[1505] See also Oct. 12 Testimony of Mark Mazz at 44:5-16.
[1506] See, e.g., PX 7 at 0030 l.130.

511. Viewing these areas in their totality, and based on his experience and understanding of the ADA and RA's programmatic access requirement

would shave and wash his hair in the sink.[1518]

completely ignored.[1545]

disabled patient who had defecated on himself.[1556] Mr. Sampier also alluded to his concerns regarding potential abuse during his trial testimony, explaining that relying on other inmates, especially for assistance with toileting and personal hygiene, was "not a position you want to be in in prison."[1557]

525. Additionally, several witnesses testified that orderlies are simply unwilling to perform their duties. For example, Subclass member Bryan Perine testified that he struggles to convince most of the orderlies in his medical dormitory to push him to his call-outs unless

part because he is not necessarily informed by security when this occurs,[1566] but he acknowledged that he is "continually training" new orderlies because "we do have that percentage of guys who don't play by the rules."[1567] Warden Falgout acknowledged that at least one orderly has been accused by a patient of sexual assault,[1568] while admitting that such complaints generally would go to security, such that he might not be aware of other allegations.[1569]

527. Additionally, the evidence shows that the inaccessibility of the facilities puts patients at risk of injury, regardless of the availability of nearby orderlies. Subclass 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.[1570] One wheelchair-bound patient reported falling out of his chair on the ramp to the West Yard kitchen at Main Prison.[1571] Mr. 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.[1572] Mr. Brent even drew up plans for a guard rail, but his suggestion was ignored.[1573] 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. Mr. Prince described one such incident, in which a patient fell on top of him while he was assisting the patient in the shower.[1574] Numerous patients with disabilities have filed ARPs reporting injuries sustained in showers lacking accessible features throughout the prison, expressing concerns about the potential for injury.[1575]

528. 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 highly personal functions. 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

[1566] Oct. 25 Testimony of Tracy Falgout at 43:5-14. See also id. at 43:15-19 (explaining that he only becomes aware that orderlies have left the program when security gives him a new list of candidates to train).
[1567] JX 4-ii, T. Falgout Depo. at 34:2-4.
[1568] Id. at 41:4-14.
[1569] Id. at 33:12-18; 34:16-24; 42:1-13.
[1570] JX 4-q, B. Prine Depo. at 64:12-65:2.
[1571] PX 231 at 2263-2265 (ARP of J.W.).
[1572] JX 4–c, A. Brent Depo. at 78:4-80:21.
[1573] Id.
[1574] Oct. 15 Testimony of Danny Prince at 104:10-19.
[1575] See, e.g., PX 231 at 2358-64, 2437-39 (ARP of J.W.); PX 231 at 1794-1809 (ARP of C.H.); PX 231 at 1609-13 (ARP of S.G.); PX 231 at 1846-55 (ARP of E.J.); PX 231 at 1887 (ARP of T.K.).

to other inmates within their security classification.[1576] But this goal simply is not attainable given the existing architectural barriers. In fact, the evidence clearly shows that the inmate health care orderly program has failed to make Angola's programs and services accessible to the patients housed on the medical wards and in Ash 2 and Cypress 2.

iii. The DOJ's Survey and Proposed Agreement

529. As Mr. Mazz noted in his report and at trial, a letter and proposed settlement agreement produced by Defendants in discovery indicate that the Department of Justice conducted its own survey of Angola's facilities in 2010.[1577] The DOJ surveyed a broader array of facilities at the prison, including Camps C, D, and J; the prison museum; Death Row; the visitor's center at the main gate; and additional areas within Main Prison, such as the chapel, courtroom, hobby shop facilities, and other dormitories.[1578]

530. Plaintiffs relied on the letter not as evidence of liability, but to demonstrate that Mr. Mazz's methodology in identifying architectural barriers to programmatic access was consistent with the DOJ's methodology, and that Defendant has been aware of the issues identified by the DOJ since its investigation in 2010.[1579] Defendant, on the other hand, argues that the DOJ's survey and proposed settlement effectively render Mr. Mazz's findings moot, and that requiring Defendant to remediate both lists of violations could subject Defendant to inconsistent obligations.[1580]

531. These arguments are without merit. First, because Angola did not execute an agreement with the DOJ before the close of discovery in September 2016, Defendant merely argued—but did not present admissible evidence—that the lack of programmatic access "is being addressed" as a result of a final agreement.[1581] Consistent with the Court's order limiting the parties' presentation of evidence to the discovery period, evidence of any post-discovery remedial measures, including measures taken as a result of an agreement with the DOJ, will be addressed during the remedial phase of this matter.[1582] In any event, Defendant's own architectural expert indicated that there is very little overlap between the two lists of

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[1576] JX 7-b (LSP Directive 07.004 – Housing for the Disabled) 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.").

[1577] See PX 7 at 0008.

[1578] See id.

[1579] See id.; JX 4-aaa, 0. Ratcliff Depo. at 27:6-28:9.

[1580] See, Oct. 17 Defendants' Rule 52(c) Argument at 114:9-115:13; Oct. 12 Testimony of Mark Mazz at 76:8-11 ("If all of the areas that were noted in Attachment A to the Department of Justice Report were remedied, would that take care of all the things that you found to be needing to be remedied?").

[1581] Oct. 17 Defendants' Rule 52(c) Argument at 114:9-115:13.

[1582] See Rec. Doc. 419 at 3 ("If Plaintiffs prevail on their constitutional and ADA claims, evidence of subsequent conditions may be relevant at the remedy stage.").

violations,[1583] and Defendant presented no evidence that Angola has remediated any of the violations identified in Mr. Mazz's report (and substantiated by Mr. Nolan).

532. Second, there is no risk whatsoever that Defendant will incur inconsistent obligations if required to remove the barriers identified in Mr. Mazz's report. To the extent his findings overlap with the DOJ's list, the Title II regulations indicate that the remedial alterations must comply with the 2010 Standards.[1584] Where they do not overlap, nothing in the draft DOJ settlement agreement suggests that the steps that would remedy Mr. Mazz's findings would interfere with their remedy. In other words, remediation of Mr. Mazz's findings would be satisfied by the same measures where the findings overlap and additional measures where the findings do not overlap—but in no case would require conflicting remedies.

iv. Consideration of Other Areas at Angola

533. During the cross examination of Mr. Mazz, defense counsel repeatedly implied that "programmatic access was being provided in all of the prison that [Mr. Mazz] did not review," by asking if Mr. Mazz would have any basis to dispute that assertion.[1585] Defendant then criticized Mr. Mazz in its Rule 52(c) motion for failing to survey the entire prison.[1586] Counsel's hypotheticals to Mr. Mazz are perplexing, for as he observed, it would be "highly unusual" to house patients with the most severe disabilities on the ward and in the medical dorms if there were more accessible facilities elsewhere on the prison grounds.[1587] And indeed, Defendant presented no evidence of other, more accessible housing areas at the prison. As discussed above,[1588] Mr. Mazz did not survey a third medical dormitory known as Hickory 4, but he expressed no opinion regarding that building. Further, the accessibility or inaccessibility of Hickory 4 (or any other part of the prison, for that matter) has no bearing on whether Angola's programs and services are accessible to the many patients with

[1583] As Mr. Mazz noted in his testimony, Defendant's expert, Mr. Nolan, conducted a review of both the DOJ's and Mr. Mazz's findings to identify areas of overlap. Of the 190 violations identified by Mr. Mazz, Mr. Nolan noted only 11 that also were cited in the DOJ's proposal. Oct. 12 Testimony of Mark Mazz at 80:15-81:5.

[1584] 28 C.F.R. § 35.151(c)(3); see also PX 7 at 0009 ("'Citation for Remediation' provides the 2010 ADA Standards citation for the alteration requirements, since remediation will occur after the effective date of March 15, 2012."), and 0018-39 (the applicable 2010 Standards in Attachment 2).

[1585] Oct. 12 Testimony of Mark Mazz at 63:5-21; see also at 65:1-3 ("If Louisiana State Penitentiary implemented program access in other areas of the prison that you didn't review, would you be able to dispute that?").

[1586] Oct. 17 Defendants' Rule 52(c) Argument at 113:21-114:2.

[1587] Oct. 12 Testimony of Mark Mazz at 63:18-64:9; see also at 65:7-15.

[1588] See supra at 1461.

unsupported assertions of counsel during examination, of course, are not evidence and cannot support Defendant's argument.[1594]

(2) Enforcement of Exclusionary Policies

536. Angola also enforces certain policies that discriminate against individuals with disabilities by excluding them from programming available to their able-bodied counterparts. For example, Angola maintains a hobby shop where men can participate in hobby craft such as leather work, woodwork, and painting. The participants sell their crafts at the Angola Rodeo, and they are permitted to keep a portion of the proceeds for personal items such as toiletries and food from the canteen or phone calls to family members.[1595] However, if an individual has a disability that necessitates a restricted duty status, Angola's policies automatically bar him from participating in all hobby craft, including low-risk activities such as painting, regardless of whether participation in the activity would present a risk of harm to himself or others.[1596] Francis Brauner, a former patient at Angola, testified that he had prior experience with leather work and wanted to participate in hobby craft during his time at Angola. When he requested permission, he was told that because he had a restricted duty status, he could not participate.[1597] Another patient filed an ARP challenging his exclusion from the hobby shop, explaining that even with his restricted duty status, he received work assignments that required sweeping, mopping, scrubbing, and walking for eight hours; yet he was not permitted to sit in front of a canvas and do simple woodwork.[1598] His ARP was denied because "according to LSP Directive #09.036, when an offender under medical care and/or treatment, requiring a duty status [sic], an offender utilizing the hobbyshop is interrupted until the offender is returned to regular duty without restrictions."[1599] In his appeal, the patient explained that his duty status was permanent and argued that Angola's policy discriminated against patients with disabilities by requiring them either give up their duty status or forgo

[1594] *See* United States v. Kahn, 887 F.2d 568, 572 (5th Cir. 1989) ("[S]tatements by counsel are not evidence at trial . . . .").

[1595] Oct. 12 Testimony of John Tonubbee at 165:3-17.

[1596] JX 7-c (LSP Directive 09.036 – Hobbyshop Operations) at 00016 (prohibiting use of the hobby shop "until such time as the inmate is returned to regular duty without restrictions"); JX 7-d (LSP Posted Policy G-17 – Hobbyshop Operations) at 00016 (stating

hobby shop privileges.[1600] The DOC denied his appeal, taking the position that "[t]his restriction is not discrimination and is in accordance with policy."[1601]

537. Similarly, Angola does not offer work assignments to individuals with certain disabilities. For example, all blind inmates are placed on "no duty."[1602] Farrell Sampier, a former chef who was paralyzed from the waist down, testified that he "would love" to get back in the kitchen but was not permitted to have a job due to his condition.[1603] Inmates on "no duty" are not permitted to work and are unable to earn incentive wages;[1604] they receive no discounts for phone calls or at the canteen.[1605] Additionally, if an individual has a duty status restriction, he is not permitted to participate in Angola's work release program, which enables individuals with less than two years left on their sentence to work outside the prison as part of their integration back into the community.[1606] Dr. Singh also issued a blanket prohibition on approving HIV-positive individuals for work release.[1607]

538. Angola also discriminates against disabled inmates by denying them the opportunity to participate in educational, therapeutic, religious, and recreational programming. At trial, Mr. Sampier testified that when he was living on medical wards, he was not allowed to attend any of the classes offered at the prison, including programs such as anger management, victim awareness, and substance abuse classes.[1608] Similarly, Mr. Brauner testified that he and other patients living on the ward were not permitted to attend church services or recreational sporting events that were available to other inmates.[1609] According to Mr. Brauner, this left him and other patients with essentially nothing to do all day.[1610] Named Plaintiff Otto Barrera, who was housed on Ward II until December 2015, also testified that he was not permitted to leave the ward to attend classes or church services. Mr. Barrera explained that he was required to take anger management and substance abuse courses in order to be eligible for release. When he asked if someone could come to the ward to teach the classes on location, he was told that there were not enough patients on the ward who needed the courses to warrant the accommodation. Mr. Barrera recalled at least five patients on Ward II who needed at least one of the courses.[1611]

[1600] Id. at 1513.
[1601] Id. at 1514.
[1602] JX 4-z, D. Barr Depo. at 44:6-13; JX 4-kk, R. Peabody Depo. at 53:22-54:7.
[1603] Oct. 9 Testimony of Farrell Sampier at 62:25-63:10.
[1604] JX 4-z, D. Barr Depo. at 44:6-13.
[1605] Id. at 47:3-6.
[1606] JX 4-jj, T. Falgout Depo. at 59:11-25.
[1607] PX 99 at 0001 (June 8, 2010 email from Sonya Bufalo to Amanda Amman).
[1608] Oct. 9 Testimony of Farrell Sampier at 48:13-16; see also id. at 62:13-24.
[1609]

C. Poor Training and Practices Result in Discrimination Against Patients with Disabilities.

539. Both the DOC and Angola have adopted written policies and procedures addressing the prison's obligation to provide appropriate accommodations to patients with disabilities. However, the evidence shows that prison administrators, medical personnel, and security staff fail to comply with these policies, resulting in discrimination. The lack of appropriate training provided to both the prison's ADA Coordinator and its staff more generally has resulted in a chaotic system in which staff fail to recognize, document, and track patients' disabilities and needed accommodations; requests for accommodations are misrouted, mishandled or arbitrarily denied; and accommodations that are granted are misapplied by staff. The result is a system in which patients with both physical and mental disabilities are regularly denied even the most basic accommodations in almost every area of daily life, including personal mobility, transportation, communication, security procedures, work assignments, and even discipline.

Failure to maintain a qualified ADA Coordinator

544. Assistant Warden Tracy Falgout, Angola's current ADA Coordinator, was appointed to the position in September 2016, sometime after Warden Barr's retirement and just before the close of discovery.[1633] He received no training or manual when he took office and did not discuss the role with his Warden Barr.[1634] He was not familiar with the ADA Amendments Act or the Rehabilitation Act,[1635] the individualized response plans he was required to create for disabled patients pursuant to LSP Directive 01.016,[1636] or the concept of an ADA transition plan as defined in 28 C.F.R. § 35.150(d).[1637]

545. Additionally, the laundry list of responsibilities assigned to Warden Falgout during the relevant period calls into question his ability to effectively oversee facility-wide ADA compliance. At the time of his appointment, his duties included supervising a mental health nurse; overseeing Angola's Quality Improvement program, which involved formulating studies, collecting data for as many as six studies at a time, preparing reports, and leading quarterly meetings; preparing and maintaining files to demonstrate compliance with the ACA's medical standards, both for annual internal audits and the triennial ACA audit; making level of care determinations for individuals being transferred from Angola to other facilities, which required thousands of record reviews every year; providing nursing staff training and continuing education; running the health care orderly and hospice volunteer training programs; leading re-entry classes; and performing patient histories and assessments as

handout is almost entirely devoid of instruction as to the specific accommodations a patient with a disability might require and exhibits a troubling preoccupation with the possibility of patients faking symptoms or selling their prescribed medication. For example, the handout instructs security officers that "maximum security offenders often fake seizures just to get out of their cells and go to the infirmary," and emphasizes that the medication prescribed to epileptic patients must be "carefully monitored" to prevent the patients from bartering with it due to the "high" it purportedly produces.[1651] It further warns that "offenders can hide contraband in casts and prosthesis [sic] and may also use these items and the crutches as weapons."[1652] Additionally, this course was designed for security officers, and it is clear from Warden Falgout—who is a nurse in addition to Assistant Warden—that medical staff are offered no additional training beyond the one-hour course.

550. Perhaps even more troubling is the fact that Warden Falgout was unable to recall the existence of this training prior to his preparation for trial. At his August 2016 deposition, he 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."[1653] Similarly the Director of Nursing, Sherwood Poret, stated that nursing staff do not receive training on the ADA.[1654] Assistant Facilities Maintenance Manager Odis Ratcliff, who testified as the DOC's 30(b)(6) witness regarding the accessibility of Angola's facilities, admitted that no one in his department receives training on the ADA's architectural accessibility requirements.[1655] To the extent the DOC's orientation materials address the ADA, they focus exclusively on issues relating to hearing-impaired patients,[1656] which appears to have been prompted by a resolution agreement with the Department of Justice concerning that population.[1657]

551. The inadequacy of Angola's training program is especially concerning as it relates to staff who are charged with responsibilities that require a more detailed understanding of the ADA, such as the security officials who are responsible for selecting work assignments for patients with duty status restrictions, or the administrative officer who is tasked with processing ARPs and determining whether the particular complaint implicates the ADA such that it should be routed to the ADA Coordinator's office. These issues are discussed at greater length below.

(4) Failure to inform patients of rights and procedures

552. LSP Directive 01.016 states that the nurse assigned to the Initial Classification Board must provide each new patient with a Request for Accommodation form to review and sign

[1651] Id. at 029476.
[1652] Id. at 029483.
[1653] JX 4-ii, T. Falgout Depo. at 93:16-22.
[1654] JX 4-zz, S. Poret Depo. at 13:17-14:3.
[1655] JX 4-aaa, O. Ratcliff Depo. at 9:4-11.
[1656] JX 12-f.
[1657] JX 4-ww R. Peabody Depo. at 12:23-13:15.

during the intake process.[1658] If an accommodation is needed, the policy calls for the request to be evaluated by the Medical Director and a final decision to be rendered by the ADA Coordinator within 7 days.[1659] The patient's disability must be documented in his medical record,[1660] and the ADA Coordinator is responsible for developing an individualized response plan to address the patient's needs, which also must be included in the medical record.[1661] Additionally, during Offender Orientation, the classification officer is responsible for informing new patients of prison's obligations to them under the ADA.[1662] Finally, the policy states that information regarding the ADA and the services provided to patients with disabilities must be included in the informational materials provided to new patients.[1663] In practice, patients are provided with little to no information regarding their rights under the ADA or the process for requesting accommodations during the intake and orientation process.

553. Warden Richard Peabody, who served as Angola's ADA Coordinator until late 2015 or early 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.[1664] He simply "assume[d]" that a disabled patient could ask around, and "someone is going to tell him what he needs to do."[1665] His successor, Warden Donald Barr, did not know how individuals are made aware of their right to request an accommodation.[1666] He suggested that individuals with disabilities should make sick call to find out what accommodations are available to them.[1667]

554. Warden Tracy Falgout, who replaced Warden Barr as ADA Coordinator in late 2016, testified that the nurse performing intake should ask each individual if he has any physical limitations or requires any assistive or adaptive devices.[1668] But Plaintiffs' medical experts did not find "clear documentation of disability accommodations" or "evaluations or assessments of needs in that respect" in a single chart they reviewed,[1669] notwithstanding the DOC's policies requiring that disabilities identified at intake be documented in the medical

[1658] JX 7-a at 5.
[1659] Id.
[1660] JX 12-f at 00312-13.
[1661] JX 7-a at 3-4.
[1662] Id. at 5.
[1663] Id.
[1664] JX 4-ww, R. Peabody Depo. at 14:20-15:2.
[1665] Id. at 104:4-25.
[1666] JX 4-z, D. Barr Depo. at 14:19-24.
[1667] Id. at 48:9-15.
[1668] JX 4-ii, T. Falgout Depo. at 94:20-95:10; 24:1-24; Testimony of Tracy Falgout at 163:16-25.
[1669] PX 6 at 0059 n.74.

record,[1670]

Correctional Center and lost the ability to walk just prior to his transfer to Angola.[1678] At intake, rather than being informed of the procedures for requesting accommodations, he was told that if he was not truly paralyzed, his wheelchair would be taken away and he would be locked up.[1679]

559. Warden Falgout testified that new arrivals to Angola are provided with a Health Information Pamphlet and another informational pamphlet titled "AU Board Handout."[1680] Neither pamphlet includes information regarding services available to patients with disabilities or the procedure for requesting accommodations,[1681] despite the fact that Angola's own policies require the inclusion of this information.[1682] Additionally, Angola "does not provide braille versions" of the request for accommodation or ARP forms.[1683]

560. Finally, 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 defining the term "auxiliary aid"),[1684] and list outdated contact information for a former ADA Coordinator.[1685] Mr. Brauner testified that he was not aware of an ADA Coordinator at the prison.[1686] Similarly, Mr. Barrera testified that during the period of time at issue, he did not know the identity of the ADA Coordinator, had never seen any signage explaining how to request an accommodation, and did not know the procedure for making a request.[1687]

(5) Inadequate procedures for processing accommodation requests and grievances

561. The evidence shows that Angola's procedures for processing and evaluating requests for accommodations and other disability-related grievances are inadequate, and staff involved in

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[1678] Oct. 9 Testimony of Farrell Sampier at 51:16; 44:3-10.

[1679] Id. at 44:11-15. Mr. Sampier's experience stands in contrast to Warden Falgout's professed practice of seeking to put each individual at ease during the intake process. See Oct. 24 Testimony of Tracy Falgout at 163:25-164:13, and suggests that, at minimum, not all staff take the same approach.

[1680] JX 8-j; see also Oct. 24 Testimony of Tracy Falgout at 165:16-166:2; JX 4-ii, T. Falgout Depo. at 30:16-31:4.

[1681] JX 4-ii, T. Falgout Depo. at 30:16-22; 31:5-9; 32:10-33:6.

[1682] JX 7-a at 5 (LSP Directive 01.016). Moreover, no pamphlet is available in Braille. JX 4-ii, T. Falgout Depo. at 57:22-58:8.

[1683] UF ¶ 17.

[1684] 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-ii, T. Falgout Depo. at 57:22-58:8.

[1685] JX 12-h (ADA Signage); JX 4-ii, T. Falgout Depo. at 30:13-15.

[1686] Oct. 12 Testimony of Francis Brauner at 106:22-24.

[1687] Oct. 12 Testimony of Otto Barrera at 215:18-216:8.

the process often fail to recognize when an inmate's request relates to a disability and implicates the ADA. As a result, these requests and grievances are often routed to the wrong department or summarily denied without addressing the basis for the complaint.

562. Per the DOC's own policies, a request for accommodation can take any form. An individual may—but need not—complete the DOC's official Request for Accommodation form,[1688] or he may file an ARP, write a letter, make sick call, or even make the request orally.[1689] In any case, the DOC is charged with knowledge of the request.[1690]

563. According to LSP Directive 01.016, the initiation of a request for accommodation should trigger a process whereby (1) the formal RFA form is completed; (2) the ADA Coordinator forwards the request to the Assistant Warden for Health Services; (3) the requestor is scheduled for a clinic appointment to verify the impairment within two days; (4) the Medical Director or his designee conducts an evaluation and provides the ADA Coordinator with a written recommendation as to whether the requested accommodation is medically indicated; (5) either the physician or the ADA Coordinator completes a form titled "Inquiry in Response to an Offender Accommodation Request" (Form B-08-010-A), documenting the evaluation and recommendation; and (6) the ADA Coordinator initiates a dialogue with the requestor and ultimately communicates his decision to the requestor through the ARP First Step Process.[1691]

564. In practice, many requests for accommodation never make it through this process. Despite the existence of the RFA form, the DOC regulations indicate that requests for accommodation should be made using the standard ARP process.[1692] It does not reference the RFA form. Likewise, the DOC's training materials instruct LSP staff to direct inmates to the ARP process if they wish to request an accommodation.[1693] When Francis Brauner, a former patient at Angola, was asked whether he knew how to request an accommodation, he appeared to be unaware of the specialized RFA form and procedures, indicating that a patient would need to use the ARP system.[1694] Former ADA Coordinator Peabody acknowledged that "a lot" of requests for accommodations are filed as ARPs.[1695] Additionally, the ARP process is the only mechanism for filing ADA-related grievances, such as a claim of discrimination.

[1688] See JX 12-a at 1 (Form A-02-017-A).

[1689] JX 5-d at 3; JX 4-vv, R. Peabody Depo. at 11:4-8; JX 4-ww, R. Peabody Depo. at 32:1-14; JX 4-jj, T. Falgout Depo. at 19:18-24, 29:12-18; Oct. Testimony of Tracy Falgout at 174:18-175:1

[1690] JX 5-d at 0321.

[1691] See JX 7-a at 7; JX 12-a at 2-5 (Form B-08-010-A); JX 4-ii, Falgout Depo. at 88:9-90:7; Oct. 24 Testimony of Tracy Falgout at 172:17-173:15 (describing his role in processing RFAs relating to hearing impairment).

[1692] JX 5-d at 0321-22.

[1693] JX 12-f at 0313.

[1694] Oct. 12 Testimony of Francis Brauner at 106:12-19; 106:25-107:3.

[1695] JX 4-vv, R. Peabody Depo. at 12:21-24.

disabled, requested a bottom bunk assignment in light of his permanent duty status indicating no use of his left arm, only to have his request denied by both Angola and the DOC on the grounds that he suffered from “nerve problems” rather than a “disability.”[1707]

567. These responses are unsurprising, as even ADA Coordinators fail to recognize when medical issues implicate the ADA. For example, Warden Peabody testified that he does not consider it “a true ADA issue” when an inmate cannot walk over a certain distance.[1708] He admitted that “we’re so used to inmates making medical requests for duty status based upon a medical condition that we don’t necessarily see it as an ADA issue.”[1709] He did not think requests for restri5* 09 5G8c sognwimsHe admioulda mmeeft aif hrpristhough0 Tw

accommodation in the DOC's ADA database using Form B-08-010-B.[1722] In practice, there appears to be no Angola-specific tracking system, and the DOC's database is woefully inadequate to effectively track individuals with disabilities, their requests for accommodation, the disposition of those requests, or the individual's duty status. The "database" shows the total number of each type of accommodation (such as wheelchairs, walkers, et cetera) granted to all patients at a given facility (including Angola), and separately, it lists the name of each individual who has received an accommodation.[1723] 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.[1724] Even after assuming the role of ADA Coordinator, Tracy Falgout did not recognize the first part of the list,[1725] as for the second half, he described it as "an alphabetized master list of everybody who has requested ADA for one reason or another."[1726] He admitted that the list would not give the viewer a full picture of each individual's disability and was not really a tracking database for individuals.[1727] He also acknowledged that the viewer would have no way of knowing whether an individual's needs were being met by looking at the list.[1728] Further, staff at DOC headquarters appeared to either be unaware of the database's existence, or unable to utilize it to determine the number of patients with various disabilities and accommodations at a given facility.[1729]

573. Additionally, a large percentage of requests never make their way into the tracking database in any form. In 2014, DOC audits of LSP indicated that the ADA database was "not being used for offender request [sic]."[1730] During his tenure, Warden Peabody indicated that the database would not include any ARPs whatsoever.[1731] Warden Barr admitted that he was not

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[1722] JX 5-d at 0323-24; 0329.
[1723] JX 12-b.
[1724] Id.
[1725] JX 4-jj, T. Falgout Depo. at 37:17-38:4.
[1726] Id. at 40:8-17.
[1727] Id. at 41:8-42:6.
[1728] Id. at 44:15-23.
[1729] PX 306 at 2 (June 27, 2014 email from S. Fadgstaff to staff at LSP and other facilities, asking if those facilities "keep up with the number of offenders that are blind, handicapped, in a wheelchair," and if they could provide those numbers).
[1730] JX 33 at 1. This March 25, 2014 report indicated that the failure to utilize the ADA database had been referenced in previous reports, and corrective action was still pending.
[1731] JX 4-ww, R. Peabody Depo. at 65:10-66:15. This is likely because Warden Peabody did not follow the established procedures for processing accommodation requests even when ARPs flagged as ADA issues and routed to him. For example, when patient L.L. filed an ARP complaining of his inability to access the law library without his wheelchair pusher, the request was flagged ADA (likely because he specifically cited the statute), reviewed by Dr. Lavespere, and ultimately denied by Warden Peabody. However, it appears Dr. Lavespere merely reviewed the patient's records without completing the RFA evaluation form, and there is no evidence that the ARP tracking form B-08-010-B was ever completed. Notably, the DOC did not issue a second step response denying the

involved at all in recording information in the database and did not know who was.[1732] He did not know if oral requests or ARPs would be included in the database.[1733] Similarly, Warden 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.[1734]

(7) Charging copays for evaluation of accommodation requests

574. LSP Directive 01.016, which establishes guidelines for requesting accommodations, requires a medical evaluation for all accommodation requests, regardless of the nature of the request.[1735] It further states that "medical co-pays may be assessed for medical services, and that "[o]ffenders may be assessed restitution to hold them responsible for the financial consequences of their actions . . . ."[1736] Warden 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.[1737]

D. Angola Fails to Accommodate the Needs of its Disabled Patients

575. The DOC 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."[1738] Warden Falgout, testifying on behalf of the DOC, acknowledged that this obligation extends to accommodations such as "amplification for hearing impairment, canes, walkers, [and] wheelchairs for physical disabilities."[1739] As explained above, however, inadequate staffing, coupled with the prison's practices regarding the identification, evaluation, and tracking of disability-related requests and grievances, have resulted in a system in which patients' legitimate accommodation requests are routinely and arbitrarily denied, often without the involvement of the ADA Coordinator. Several examples of those denials are discussed below. Additionally, the evidence shows that prison officials have given no consideration to the needs of patients with disabilities when establishing procedures for operations and services ranging from pill call to discipline to the prevention and reporting of prison rape.

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patient's ARP until some three years after his request, by which time the patient had passed away. See PX231.1936-231.1944.

[1732] JX 4-z, D. Barr Depo. at 23:20-24:12.
[1733] Id. at 24:13-17.
[1734] JX 4-jj, T. Falgout Depo. at 65:8-14.
[1735] JX 7-a at 7.
[1736] Id.
[1737] JX 4-vv, R. Peabody Depo. at 28:10-29:4; 30:1-4, 17-20.
[1738] JX 5-d at pp. 0319-20; accord JX 7-a at 2.
[1739] JX 4-jj, T. Falgout Depo. at 12:10-14.

(1) Denial of Assistive Devices and Auxiliary Aids

576. Subclass members' credible testimony illustrated Angola's routine failure to provide patients with the assistive devices, auxiliary aids, and adaptive training they require for mobility, effective communication, and self-care. For example:

a. Farrell Sampier testified at trial that prison officials refused to provide him with a wheelchair designed for paraplegic patients such as himself. As a result, he relied on a chair left for him by a paraplegic patient who was granted parole.[1740] Mr. Sampier also testified that when his wheelchair broke, he would rely on fellow inmates with access to the hobby shop to repair it.[1741]

b. Similarly, another paraplegic patient, Fred Brauner, testified that prison officials refused to provide him with a wheelchair, leaving him confined to his bed until he asked a U.S. Senator to intervene.[1742] After finally providing a chair, prison officials replaced the pneumatic tires, which facilitated independent movement, with tires that required less maintenance but made the chair difficult to maneuver.[1743]

c. Mr. Sampier also testified that he requested

experiencing severe pain. Whether Tonubbee should be permitted to purchase orthopedic shoes with his own money is left to the discretion of the warden who is supervising him at the time, which has resulted in needed periods of time in which he was unable to obtain the proper footwear.[1749] During cross-examination, defense counsel pressed Mr. Tonubbee to concede that a prison doctor, Dr. Polecki, had denied his request for custom-fit shoes, based on a note that counsel represented to be written by Dr. Polecki.[1750] Dr. Lavespere later admitted during his own cross-examination that he himself had written the note.[1751]

e. Derrick Woodberry, who suffered from severe hemorrhoids, testified that he had

Act.[1758] Indeed, the DOC has admitted that it “does not provide braille versions of forms such as sick call requests, Administra

such as navigating their dormitory limits their mobility and leaves them vulnerable to neglect or abuse.[1768] Indeed, the use of untrained inmates violates Angola's own policies.[1769]

(2) Failure to Accommodate Disabilities in Work Assignments

578. Individuals with disabilities may request a restricted "duty status," which establishes limitations on the types of work they may be required to perform.[1770] In practice, many individuals with disabilities face arbitrary denials or revocations of their duty status. For example, Adrian 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.[1771] 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.[1772] Jason Hacker was denied a restricted duty status and forced to work in the field despite medical determinations that he was blind.[1773] Testifying on behalf of the DOC, 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.[1774] 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.[1775]

579. Even when a patient is granted a restricted duty status, security officials, who determine job assignments, often misapply or fail to credit those restrictions. For example, Hymel 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.[1776] At trial, Anthony Mandigo testified

[1768] For example, one blind patient had $600 stolen off his account after being moved inside. See Ash 2. PX 85 at 2-3.

[1769] JX 7-b at 2 (LSP Directive 07.004 Housing for Disabled) ("Only appropriately trained staff and inmates will be assigned to assist a disabled inmate who cannot otherwise perform basic life functions").

[1770] JX 5-a at 0281-83 (HC-15 – Duty Status Classification System); JX 6-oo (LSP Directive 13.063 – Duty Status Classification System).

[1771] JX 4-h, A. Dunn Depo. at 27:10-23; 28:18-29:25.

[1772] JX 4-f, K. Clomburg Depo. at 26:14-30:7. Ashly, DOC Medical Director Dr. Raman Singh directed Dr. Lavespere not to refer patients to specialists when evaluating the need for a duty status restriction. See PX 161 at 0001 (Sept. 23, 2015 Email from Tonya Young to Ashli Oliveaux and Stacye Falgout).

[1773] JX 4-i, J. Hacker Depo. at 55:7-58:11.

[1774] JX 4-ww, R. Peabody Depo. at 87:14-21.

[1775] JX 4-j, M. Johnson Depo. at 10:5-21.

[1776] JX 4-t, H. Varnado Depo. at 21:8-23:23.

to accommodate the needs of inmates with disabilities interferes with medical care. Multiple patients were unable to travel for medical care—but treated as having "refused" care—because they could not travel with the oxygen supplies they needed to breathe.[1797]

(5) Lack of Accommodations in Prison Procedures

583. The testimony of Defendant'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.[1798] He further testified that no special consideration is given to individuals with disabilities in the prison's procedures for preventing and enabling the reporting of prison rape, and he did not believe inmates with disabilities would be at special risk of abuse.[1799] Testifying on behalf of the DOC, Tracy Falgout could not identify any accommodations made for blind individuals during pill call,[1800] and he did not know how a blind person would file an ARP.[1801] Subclass member Adrian Dunn testified that he was forced to administer

with a paraplegic, blind, or deaf individual, and he was not aware of any disciplinary measures that could not be imposed on individuals with disabilities.[1805] 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."[1806] Similarly, Warden Barr 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.[1807] Nurse Practitioner Cynthia Park likewise indicated that it is [her] situation to be able to intervene" in disciplinary decisions,[1808] and because she is not a member of the security staff, it is not up to her whether a patient gets placed in a locked room, regardless of his medical condition.[1809] This lack of oversight places individuals with disabilities at risk of harm. For example, internal emails show that one patient suffering from schizophrenia and total blindness due to glaucoma was "gassed" for refusing to shave.[1810] 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.[1811] Similarly, Francis Brauner, another paraplegic patient, testified at trial that he was placed in a locked cell with an iron door on Ward II, out of the line of sight of the nurses and without any way to communicate with them. As a result, he developed a bedsore and eventually sepsis.[1812] 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.[1813]

E. Patients with Disabilities Are Segregated Without Adequate Justification.

586. At Angola, patients with disabilities are often segregated from the able-bodied population when it comes to their housing assignments. As previously stated, individuals with long-term physical disabilities are typically housed in the medical dormitories or on Ward II.[1814] And as discussed above, patients on the nursing wards are excluded from participation in classes, church services, and recreational activities attended by able-bodied inmates.[1815] Similarly,

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[1805] JX 4-jj, T. Falgout Depo. at 123:12-19.
[1806] JX 4-ii, T. Falgout Depo. at 14:20-15:13.
[1807] JX 4-z, D. Barr Depo. at 40:13-25, 41:15-24.
[1808] JX 4-uu, C. Park Depo. at 13:14-21.
[1809] Id. at 14:4-19.
[1810] PX 85 at 0002-03.
[1811] PX 6 at 0081.
[1812] Oct. 12 Testimony of Francis Brauner at 87:23-89:10.
[1813] JX 4-ll, K. Hart Depo. at 40:8-41:2.
[1814] JX 7-b at 2 (LSP Directive 07.004 – Housing for the Disabled); JX 6-eee at 0269-70 (LSP Directive 13.088 – Offender Assistance Dorm);

patients living in the medical dormitories do not receive the types of services in those locations that purportedly justify their segregation. First, the dormitories were designed for the general population and lack most of the features that would make them accessible to patients with disabilities.[1816] Second, despite their name, Angola provides no actual medical services on site in the medical dorms. For example, Angola's policies indicate that routine medical services such as wound care are to be rendered in the medical dorms.[1817] In practice, orderlies transport patients to the ATU for these services.[1818] Neither doctors nor nurses make rounds in the medical dorms,[1819] and health care orderlies in the dorms receive no supervision from medical staff.[1820]

587. Finally, 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.[1821]

CONCLUSIONS OF LAW

I. EIGHTH AMENDMENT CLAIM

A. Legal Standard

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."[1822] Accordingly, "[t]he Eighth Amendment's

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[1816] See supra ¶ 512 & n.1513.
[1817] JX 6-eee at 0270.
[1818] JX 4-c, A. Brent Depo. at 75:14-76:4; see also Sect. 22 Testimony of Rudy Lavespere at 205:17-20, 208:17-21.
[1819] Id. at 73:25-76:4; see also Sect. 15 Testimony of Danny Price at 98:20-24 (explaining that no doctors or nurses come to Ash 2 dormitory "unless there's like a tour or something coming through"). EMTs only visit the dormitories to conduct

prohibition against cruel and unusual punishment requires prison officials to provide 'humane conditions of confinement,' ensuring that inmates receive adequate . . . medical care."[1823]

"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."[1824] This inquiry consists of both an objective and a subjective test.[1825] The objective test requires showing that the prisoner has "serious medical needs," and "either has already been harmed or been 'incarcerated under conditions posing a substantial risk of serious harm.'"[1826] The subjective test requires a showing that prison officials had requisite knowledge of the risk of harm and either (1) disregarded it or (2) failed to act reasonably to abate it.[1827] In assessing whether prison officials' actions are sufficiently reasonable to avoid liability, "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, because such efforts are not reasonable measures to abate the identified substantial risk of serious harm."[1828]

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."[1829] Thus, in order to prevail on their Eighth Amendment challenge, Plaintiffs must establish (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.[1830]

(1) 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."[1831] Courts have recognized a wide range of conditions as constituting "serious medical

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[1823] Palmer v. Johnson, 193 F.3d 346, 351-52 (5th Cir. 1999) (quoting Farmer v. Brennan, 511 U.S. 825, 832 (1994)).
[1824] Domino v. Tex. Dep't of Criminal Justice, 239 F.3d 752, 754 (5th Cir. 2001).
[1825] Estelle, 429 U.S. at 104.
[1826] Braggs v. Dunn, 257 F. Supp.3d 1171, 1189 (M.D. Ala. 2017) (quoting Farmer, 511 U.S. at 834).
[1827] Farmer, 511 U.S. at 844-45; see also Braggs, 257 F. Supp. 3d at 1250 ("To establish deliberate indifference, plaintiffs must show that defendants had subjective knowledge of the harm or risk of harm, and disregarded it or failed to act reasonably to alleviate it.").
[1828] Braggs, 257 F. Supp. 3d at 1252 (internal citations and quotation marks omitted).
[1829] Brown v. Plata, 563 U.S. 493, 505 n.3 (2011).
[1830] See, e.g., Carlucci v. Chapa, 884 F.3d 534, 538 (5th Cir. 2018); Lawson v. Dall. Cty., 286 F.3d 257, 262 (5th Cir. 2002); Braggs, 257 F. Supp. 3d at 1189.
[1831] Gobert v. Caldwell, 463 F.3d 339, 345 n.12 (5th Cir. 2006).

needs" under the Eighth Amendment, including but not limited to broken bones,[1832] "injuries" that cause "severe pain,"[1833] ulcers,[1834] open wounds and infections,[1835] severe chest pain,[1836] HIV,[1837] Hepatitis C,[1838] cancer,[1839] tuberculosis,[1840] asthma,[1841] diabetes and its complications,[1842] arthritis,[1843] Crohn's disease,[1844] osteomyelitis,[1845] neurological disorders,[1846] serious back pain,[1847] a dislocated shoulder,[1848] serious ear infection,[1849] the need for post-surgical care,[1850] serious hemorrhoids,[1851] seizure disorders,[1852] and broken teeth.[1853]

Moreover, because this is a Rule 23(b)(2) class action challenging Defendants' actions "on a ground[ ] generally applicable to the class," Id. Defendants' provision of inadequate medical

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[1832] Harris v. Hegmann, 198 F.3d 153, 159-60 (5th Cir. 1999).
[1833] See, e.g., Thomas v. Baxter, 593 F. App'x 338, 342-43 (5th Cir. 2014).
[1834] Lawson, 286 F.3d at 262-63.
[1835] Gobert, 463 F.3d at 346 n.17, 349.
[1836] Mata v. Saiz, 427 F.3d 745, 754 (10th Cir. 2005).
[1837] Brown v. Johnson, 387 F.3d 1344, 1351 (11th Cir. 2004).
[1838] See Bender v. Regier, 385 F.3d 1133, 1137 (8th Cir. 2004) (classifying hepatitis C as "unquestionably a serious medical problem"); Lineberger v. Anderson, 487 F. Appx. 548, 549 (11th Cir. 2012) ("That Hepatitis C presents a serious medical need is undisputed."); Pietrzykowski v. Missouri Dep't of Corrs., No. 16-cv-04219, 2017 WL 1968317, at *4 (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[.]").
[1839] Rice v. Walker, No. 06-3214, 2010 WL 1050227, at *7 (C.D. Ill. Mar. 16, 2010).
[1840] Maldonado v. Terhune, 28 F. Supp.2d 284, 290 (D.N.J. 1998).
[1841] Board v. Farnham, 394 F.3d 469, 484 (7th Cir. 2005).
[1842] See Natale v. Camden Cty. Corr. Facility, 318 F.3d 575, 582 (3d Cir. 2003); Garrison v. Wilkinson, 309 F. Supp. 2d 1007, 1014 (N.D. Ohio 2004).
[1843] Christy v. Robinson, 216 F. Supp. 2d 398, 413 (D.N.J. 2002).
[1844] Woulard v. Food Service, 224 F. Supp. 2d 596, 603-604 (D. Del. 2003).
[1845] Gil v. Vogiland, 131 F. Supp. 2d 486, 490-92 (S.D.N.Y. 2001).
[1846] Kenney v. Parker, 217 F. Supp. 2d 1095, 1099 (D. Haw. 2002).
[1847] Palermo v. Corr. Med. Servs., 133 F. Supp. 2d 1348, 1353 (S.D. Fla. 2001).
[1848] See, e.g., Higgins v. Corr. Med. Servs. of Ill., 178 F.3d 508, 511 (7th Cir. 1999).
[1849] See, e.g., Zentmyer v. Kendall Cty., 220 F.3d 805, 810 (7th Cir. 2000).
[1850] Morales Feliciano v. Calderon Serra, 308 F. Supp. 2d 321, 341 (D.P.R. 2004); Brooks v. Wisconsin, 930 F.2d 1150, 1151-52, 1155 (6th Cir. 1991).
[1851] Jones v. Natesha, 151 F. Supp. 2d 938, 944 (N.D. Ill. 2001).
[1852] Hudson v. McHugh, 148 F.3d 859, 864 (7th Cir. 1998).
[1853] Carlucci, 884 F.3d at 538-39.

care at Angola—Plaintiffs must show that serious medical needs exist on a widespread basis, rather than on an individual basis.[1854]

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."[1855] "That the Eighth Amendment protects against future harm to inmates is not a novel proposition."[1856] 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.[1857] Nor must Plaintiffs show that the "likely harm [will] occur immediately."[1858] Rather, for purposes of the Eighth Amendment, Plaintiffs need only show that there is a 'substantial risk of serious harm."[1859]

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[.]"[1860] "[M]ultiple 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."[1861] In Fifth Circuit 01sl Am Circ1.125 TD -bilitycombine to deprive

(2) The Subjective Test

In order to prove an Eighth Amendment violation, Plaintiffs must also show that Defendants have a "sufficiently culpable state of mind."[1864] In prison-conditions cases that state of mind is one of deliberate indifference to inmate health or safety."[1865]

factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious."[1874] 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."[1875] Deliberate indifference may also be established "by proving that there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care."[1876] Willful blindness to the risk posed to inmates is not a valid defense to a deliberate indifference claims.[1877]

"In challenges to a correctional institution's provision of medical care, evidence of systemic deficiencies can also establish the 'disregard' element of deliberate indifference."[1878] 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.'"[1879] "[A]lthough one-off negligent treatment is not actionable, . . . frequent neglect, just like a single instance of truly egregious recklessness, may allow the court to infer subjective deliberate indifference."[1880] Deliberate indifference may also be "demonstrated straightforwardly, through direct evidence that an administrator was aware of serious systemic deficiencies and failed to correct them."[1881]

The "long duration" of unconstitutional conditions can also demonstrate correctional officials' knowledge of the deficiencies that cause a substantial risk of harm.[1882] In other words, if plaintiffs show that a substantial risk of unreasonable harm was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past" and that "the circumstances suggest that the [prison officials] . . . had been exposed to information concerning the risk . . . , then such

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[1874] Gates v. Cook, 376 F.3d at 333 (citing Farmer, 511 U.S. at 842).

[1875] Rouse v. Plantier, 182 F.3d 192, 197 (3d Cir. 1999); see also, e.g., Cabrera, 884 F.3d at 538 (noting that "delay" or "denial of recommended medical treatment" supports a finding of deliberate indifference);

evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk.[1883][1884]

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.

(1) 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.'"[1885] The Third Circuit has stated "[t]he inexorable nonattention and delays in receiving treatment attributable to personnel shortages, the ill-conceived system for referrals of inmates…from other facilities, and the maladroitly operated 'emergency' referral system all present grave constitutional problems."[1886]

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."[1887] Where prison officials' "manifest inability to adequately train, supervise or retain health care personnel which results in rampant understaffing and the consequent impossibility to adequately meet the needs of the inmate population," deliberate indifference is inherent.[1888] Further, "difficulties in recruiting do not negate the fact that understaffing has caused [a] serious systemic deficiency,"[1889] even if a prison's remote location makes recruitment difficult.[1890]

[1883] Farmer, 511 U.S. at 842-43; see also Williams, 545 F.2d at 1216 (concluding that the Eighth Amendment may be violated on a showing of "evidence of rampant and not isolated deficiencies").
[1884] Farmer, 511 U.S. at 842-43; see also Williams, 545 F.2d at 1216 (concluding that the Eighth Amendment may be violated on a showing of "evidence of rampant and not isolated deficiencies").
[1885] Harris v. Thigpen, 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. Granger, 887 F.2d 1552, 1556 (11th Cir. 1989); Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977)("[w]hen systematic deficiencies in staffing, facilities or procedures make unnecessary suffering inevitable, a court will not hesitate to use its injunctive powers").
[1886] Newman v. Alabama, 503 F.2d 1320, 1331 (5th Cir. 1974).
[1887] Inmates of Allegheny Cty. Jail v. Pierce

(2) Inadequate Access to Care

Courts have also repeatedly recognized 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."[1891] Moreover, deliberate indifference may be established by a showing of a decision to take an easier but less efficacious course of treatment.[1892] This is true whether the care is provided internally or at external facilities; where lack of personnel or transportation endangers the health of inmates, the lack of access to care violates both professional standards and the Constitution.[1893] Prison officials "may not allow security or transportation concerns to override a medical determination that a particular inmate is in need of prompt treatment."[1894]

(3) Inadequate Chronic Disease Program

The failure to provide "comprehensive and coordinated care," including "centralized treatment protocols," for "complex, chronic illnesses" may also help support a finding of an Eighth Amendment violation.[1895] A failure to provide follow up treatments or months-long waits for chronic care visits also may support a violation.[1896]

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partly because the authorized salary was "woe

substantial risk of serious harm to prisoners at Angola.[1915] The evidence and testimony compellingly demonstrates the following interrelated areas of inadequacy: (1) inadequate and inappropriate staffing; (2) failures to provide timely access to medical care; (3) inadequate chronic disease management; (4) failures to provide timely access to specialty care; (5) inadequate inpatient care; (6) inadequate medication administration; (7) inadequate diagnostic services; (8) failure to create, maintain and use adequate and reliable medical records; (9) inadequate facilities; (10) inadequate medical leadership; (11) inadequate funding and inappropriate budget management and (12) inadequate monitoring and quality assurance.[1916] 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.

i. Inadequate and Inappropriate Staffing

Plaintiffs 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.[1917] In addition to Dr. Lavespere, Angola has provider-level medical professionals: four physicians and one nurse practitioner, who manage caseloads of up to 1280 patients per provider.[1918] The Angola providers' caseloads increase the risk that patients will receive poor quality care.[1919] The failure of Angola physicians to timely and adequately examine patients, review diagnostic results, and implement specialists' recommendations further elevates the risk of harm to the Class. Defendants' corresponding failure to provide a sufficient number of nurses compounds the risk of

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.[1920] This violates Defendants' Eighth Amendment obligation to ensure that prisoners receive timely, professional medical judgment from qualified medical professionals, 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,[1921] as does Defendants' reliance on LPNs, EMTs, and correctional officers for medical functions outside the scope of their qualifications.[1922] That risk is compounded by Defendants' demonstrated failure to provide adequate supervision.[1923]

ii. 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.[1924] 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.[1925] The documentary evidence, credible witness testimony, and reliable expert testimony demonstrate that this routine and consistent denial of access to professional medical judgment and the treatment it would recommend contributes substantially to the risk of harm to Class members, with often catastrophic results.[1926]

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.[1927] Whether or not these practices on their own would suffice to cause a substa

barriers (along with the other inadequacies described herein) unquestionably increases the likelihood that Class members will not receive crucial medical care and treatment.[1928]

iii.

specialists' recommendations, and generally allow treatable conditions to deteriorate until they become intractable or precipitate crises (at which point Plaintiffs suffer from the deficits in emergency care).[1936]

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.[1950]

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, suffering, and exacerbation of their chronic illnesses.[1951] Similarly, Defendants' policy of prohibiting 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;[1952] 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."[1953] Defendants' failure to create appropriate medication administration records further harms Class members, by failing to ensure that medication is consistently received and preventing providers and specialists from making informed treatment decisions.[1954]

viii. Inadequate Diagnostic Services

Defendants' systemic failure to provide adequate diagnostic testing contributes to the substantial risk of serious harm for Class members. As countless examples in the record and the experts' findings reveal, indicated diagnostic tests such as biopsies and CT scans are frequently delayed by months or years.[1955] Similarly, in emergency situations, Defendants forgo critical testing to determine the appropriate response, and delay in the decline to transport patients to facilities capable of performing needed tests.[1956] Moreover, the evidence shows that Defendants fail to provide sufficient testing, such as glucose tests for diabetics and colonoscopies of at-risk

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[1950] See supra ¶¶ 300304; PX 6 at 0050-51; see also, e.g., PX 4-n, M. Murray Depo. at 56:19-24 (describing errors in medication administration); PX 4-l, 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); Litscher, No. 17-CV-1275-JPS, 2017 WL 6017683, *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").

[1951] See supra ¶¶ 311-314; 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 narcotics violates constitutional rights.").

[1952] See supra ¶¶ 316326; see, e.g., Rec. Doc. 517-4 at 30-31.

[1953] Hoffer, 290 F. Supp. 3d at 1304.

[1954] See supra ¶¶ 298310.

[1955] See supra ¶¶ 230234, 328331.

[1956] See supra ¶¶ 235245.

[1957] PX 6 at 0055.

patients.[1958]

to records. Combined with the other inadequacies described herein, Defendants' failure to maintain an adequate and readily accessible medical records system increases the likelihood of a substantial risk of harm.[1966]

x. Inadequate Facilities

inference may be further buttressed by evidence that unconstitutional conditions have persisted for a "long duration."[1981]

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 under their care.[1982] Indeed, defendants have been made aware of their significant deficiencies due to the DOJ's lawsuit, outside consultants, and the thousands of annual healthcare complaints made by patients for thirty years.[1983] The unmistakable severity of the recurring harms that result should (and often did) give Defendants notice that their medical system was deeply flawed, from a patient living without a bottom jaw and half a tongue for at least three years before receiving surgery,[1984] to a patient developing a bone-deep ulcer the width of a liter bottle of soda,[1985] to a patient showing up in the ATU three days in a row with obvious stroke symptoms before providers recognized his condition,[1986] to a patient necrotizing from the waist down.[1987] These diverse and pervasive problems, and hundreds more like them, have caused Louisiana's mortality rate to skyrocket at a time when mortality in America's prisons is flat elsewhere.[1988]

In cases involving similarly severe risks to prisoner safety, courts have found officials to be deliberately indifferent even where plaintiffs did not present any additional evidence showing officials had actual knowledge of the risks to prisoner safety beyond the deplorable conditions themselves.[1989] 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, credible documentary and testimonial evidence demonstrating that Defendants had actual knowledge of the risk of harm.[1990] For decades, warnings of deficient care from a variety of different sources—the Department of Justice, outside consultants, and outside providers—put Defendants on notice of the same overarching concern: deficiencies in the provision

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[1981] Wilson, 501 U.S. at 300.
[1982] Farmer, 511 U.S. at 842.
[1983] See supra ¶¶ 450468.
[1984] Oct. 12 Testimony of Dr. Barrera at 206:14-20.
[1985] Oct. 12 Testimony of Francis Brauner at 130:2-7
[1986] See supra ¶ 141.
[1987] Oct. 9 Testimony of Mike Puisis at 192:23-194:2.
[1988] See supra ¶ 148.
[1989] See, e.g., Gates v. Cook, 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 correctional officer staffing).
[1990] See supra ¶¶ 138139, 469477.

of medical care at Angola place prisoners at a substantial risk of serious harm.[1991] 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.[1992] And yet, as the evidence unquestiona

remaining analysis to establish deliberate indifference asks whether the Defendant disregarded the risk of serious harm to inmate health more than mere negligence.[2000]

When prison officials are aware of: (1) the availability and efficacy of DAA drugs for treating

II. THE DOC'S PRACTICES VIOLATE THE AMERICANS WITH DISABILITIES ACT AND REHABILITATION ACT

"The ADA is a broad mandate of comprehensive character and sweeping purpose intended to eliminate discrimination against disabled individuals, and to integrate them into the economic and social mainstream of American life." [2007] Title II of the ADA focuses on disability discrimination in the provision of public services. Specifically, Title II, 42 U.S.C. § 12132, 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." [2008] A "public entity" includes "any department, agency, special purpose district, or other instrumentality of a State or States or local government." [2009] State prisons

The record clearly reflects—and indeed, Defendant does not dispute—that the Subclass consists of individuals with qualifying disabilities. Angola's current and former ADA Coordinators described a patient population living with an array of conditions including blindness, hearing impairments, paraplegia, and dementia, as well as numerous other conditions limiting patient mobility and, in many cases, requiring the use of a wheelchair. Indeed, the stated purpose of Angola's inmate health care orderly program is to address the needs of the numerous patients who require assistance with activities of daily living such as eating, bathing, and toileting. Two former orderlies, Aaron Brent and Danny Prince, confirmed that their responsibilities included caring for dozens of patients using wheelchairs and walkers, as well as stroke and cancer patients, patients with tracheostomy tubes and colostomy bags, patients who suffer from seizures, and patients with mental illnesses and cognitive impairments. This evidence, coupled with the credible testimony of several current and former patients regarding their own disabilities, clearly demonstrates that Angola has a sizable population of patients living with qualifying disabilities.

B. Angola Denies Programmatic Access to and Discriminates Against

In Pennsylvania Department of Corrections v. Yeskey, the Supreme Court held that Title II applied to correctional facilities, recognizing that "[m]odern prisons provide inmates with many recreational 'activities,' medical 'services,' and educational and vocational 'programs,' all of which at least theoretically 'benefit' the prisoners (and any of which disabled prisoners could be 'excluded from participation in')."[2033] Since Yeskey, courts across the country have recognized that,

> [b]ecause of the unique nature of correctional facilities, in which jail staff control nearly all aspects of inmates' lives, most everything provided to inmates is a public service, program or 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.[2034]

Title II's implementing regulations similarly acknowledge 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 related 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; 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

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Title II brings within its scope 'anything a public entity does.'" (quoting Lee v. City of Los Angeles, 250

must “implement reasonable policies, including

dormitories themselves.[2057] Defendant's accessibility expert corroborated each and every violation,[2058] and Defendant has not otherwise disputed the existence of these architectural barriers.

Defendant has criticized Mr. Mazz for relying on the 1991 Standards while evaluating the facilities under the more flexible "program access" standard. But Defendant presented no evidence—in the form of expert testimony or otherwise—to refute Mr. Mazz's credible testimony that he followed the industry-standard methodology for evaluating programmatic access.[2059] As even Defendant acknowledges that courts rely on the 1991 Standards for guidance in determining whether a facility's programs are accessible.[2060] For example, in Falls v. Board of Commissioners of the New Orleans Regional Transit Authority, the court concluded that evidence of widespread noncompliance with the architectural standards, coupled with the plaintiffs' anecdotal evidence of difficulties accessing the bus stops at issue, was sufficient to prove that plaintiffs had been denied programmatic access.[2061] And in Pierce v. County of Orange, the plaintiffs' architectural accessibility expert also relied on the federal accessibility standards, while limiting his survey to the areas in which patients with disabilities were housed.[2062] The plaintiffs also presented evidence that patients with disabilities were forced to rely on fellow inmates for assistance when faced with inaccessible bathroom facilities.[2063] The court held that relief for the plaintiffs was proper.[2064]

Here, as in Falls and Pierce, Plaintiffs' evidence of noncompliance with the architectural standards is supported by Defendant's own admissions of accessibility problems throughout Main Prison, as well as the testimony of numerous witnesses who recounted difficulties navigating the prison's facilities or who personally witnessed other patients encountering such problems.[2065]

[2057] Id.

[2058] See supra ¶ 512.

[2059] See supra ¶¶ 512520.

[2060] Rec. Doc. 497 (Defs.' Proposed Findings of Fact (As of September 30, 2016)) at 40 (citing 472 F. App'x at 292 n.3); see also, e.g., Pascuiti v. N.Y., 87 F. Supp. 2d 221, 226 (S.D.N.Y. 1999) ("[E]ven though only new construction and alter

Plaintiffs also presented ample evidence that Amgs failed to make its programs, services, and activities accessible to individuals with disabilities through alternative methods. Because Mr. Mazz limited his survey to areas specifically designated for individuals with disabilities—in other words, the prison's most accessible areas—his methodology foreclosed the possibility that the DOC reassigns services for patients with disabilities to more accessible buildings, or delivers those services at alternative accessible sites. As discussed above, Defendant presented no evidence that would suggest otherwise.[2066] Nor can the programs, services, and activities identified in his survey be brought to the disabled individual. For example, the outdoor recreation areas cannot be moved to where the sidewalks end, and the JPay stations, which are mounted to the wall,[2067] cannot be moved to accessible areas for use by individuals in wheelchairs. And Mr. Mazz credibly testified that he excluded from his findings those violations that could be resolved through alternative

Defendants have not produced any evidence that these changes have resulted in the accommodation of some or all inmates with disabilities; that any funding has been provided for these changes; that staff have been trained on the changes; that Defendants are monitoring staffs compliance with the changes or that the changes are permanent. A more fundamental problem

(2) Enforcement of Exclusionary Policies

Angola also denies patients with disabilities access to its services, programs, and activities

society;

on a particular individual with a disability . cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with

qualified and adequately trained ADA Coordinator;[2110] (2) fails to maintain an ADA advisory committee as required by its own policies;[2111] (3) inadequately trains its staff regarding the ADA;[2112] (4) fails to inform patients of their rights and the procedures for requesting accommodations;[2113] (5) fails to appropriately process accommodation requests and disability-related grievances;[2114] (6) fails to

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aspects of prison life. A series of decisions by the district court and Ninth Circuit ordered injunctive relief after establishing that the defendants' policies and procedures with regard to disabled prisoners and parolees were inadequate and violated the ADA and RA. Among other things, the defendants were ordered to create and implement an adequate disability grievance system, as well as a computerized system for tracking prisoners' and parolees' disabilities and accommodations; to provide accessible housing and necessary assistive devices and auxiliary aids; and to train staff regarding the ADA, effective communication with patients with disabilities, and the provision of accommodations. *See Armstrong v. Brown*, 857 F. Supp. 2d 919 (N.D. Cal. 2012), for a summary of the litigation.

[2110] *See supra* ¶ 540546; *cf., e.g., Armstrong v. Davis*, 275 F.3d 849, 858 (9th Cir. 2001) (affirming injunction requiring defendant to hire a "full-time ADA coordinator"); *Armstrong v. Schwarzenegger*, No. 94-2307, Rec. Doc. 1045 at 5 (N.D. Cal. Jan. 18, 2007) (noting that full-time ADA Coordinator at each facility should work only on ADA compliance matters, with a supervising correctional counselor as an assistant).

[2111] *See supra* ¶ 547.

[2112] *See supra* ¶ 548551; *cf., e.g., Armstrong v. Davis*, No. 94-2307, Rec. Doc. 523 at 74-76 (N.D. Cal. 1999) (finding violation where some staff received one-hour training that many employees could not recall, while others received "virtually no training pertaining to the identification and accommodation of disabled prisoners and parolees," because "[w]ithout training, even when staff have sufficient information before them to identify and accommodate disabilities, they do not do so because they lack the necessary skills"); *Armstrong v. Davis*, 275 F.3d at 859 (affirming in relevant part the district court's order requiring all personnel in relevant roles to undergo training "in the general requirements of the ADA, disability awareness, the appropriate method of determining whether a prisoner adequately understands written and verbal communications, and other relevant policies and procedures").

[2113] *See supra* ¶ 552560; *cf., e.g., Armstrong v. Davis*, 275 F.3d at 858 (affirming district court's conclusion that notice was "insufficient to apprise prisoners and parolees of the ADA's 'applicability to the services, programs, or activities' of the DRP or to 'apprise such persons of the protections against discrimination assured them by' the ADA"); *id.* at 859 (affirming order requiring defendant to provide alternative formats for all forms used by prisoners and parolees); *id.* at 862 (noting that defendant did not "train its officials or employees to communicate with disabled individuals" regarding the accommodation forms "and does not evaluate their ability to do so").

[2114] *See supra* ¶ 561568; *cf., e.g., Armstrong v. Brown*, 857 F. Supp. 2d at 933 (holding that class members' ADA rights were violated where they had no access to "functional and timely grievance procedures at county jails to request and obtain disability accommodations"); *Armstrong v. Davis*, 275 F.3d at 863 (holding that accommodations process violated ADA where practice was "to rely primarily on Department employees untrained in issues of disability to determine whether an

identify and track patients' disabilities and accommodation requests,[2115] and (7) charges patients to evaluate their accommodation requests.[2116]

Additionally, Plaintiffs clearly demonstrated that these policies and practices have resulted in discrimination against patients with disabilities.

Here, as in the *Armstrong* litigation, Defendant's failure to implement appropriate policies and procedures to identify, track, and accommodate the needs of patients with disabilities has resulted in systemic, persistent discrimination against members of the Subclass. Plaintiffs provided numerous examples of Defendant's failure or refusal to (1) provide assistive devices and auxiliary aids ranging from wheelchairs and wheelchair gloves to tapping canes and informational materials in Braille;[2130] (2) accommodate disabilities in work assignments;[2131] (3) accommodate patients' dietary needs relating to their disabilities;[2132] (4) accommodate disabilities when transporting patients;[2133] (5) accommodate disabilities in prison procedures ranging from medication administration to evacuation plans to the filing of ARPs;[2134] and (6) accommodate patients' disabilities when imposing discipline.[2135]

(5) Failure to Integrate Individuals with Disabilities

Title II's implementing regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"[2136] In the correctional setting, facilities must "ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals."[2137] Specifically, prisons must not "place inmates or detainees with disabilities in designated medical areas unless they are actually receiving medical care or treatment."[2138] The goal is to "enable[] individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[2139]

Plaintiffs take no position as to whether any specific patient should be housed on the ward or in the medical dorms. Nor do they challenge the prison's general policy of housing most patients with disabilities in those spaces. However, Plaintiffs take issue with the prison's policy of excluding patients on the ward—particularly Ward II, which operates not as an infirmary but as a long-term nursing care unit—from participation in programming available to the general population.[2140] This policy not only deprives those patients of programmatic access, but also prevents them from being

able to learn, worship, work, and interact with members of the prison's general, nondisabled population.

Plaintiffs also challenge Defendant's decision to warehouse patients with disabilities in the medical dorms without providing any actual medical services in those areas and without making those dormitories accessible. They presented evidence that neither doctors nor nurses visit the medical dorms, and patients have to visit the ATU for routine care such as dressing changes.[2141] The placement of patients with disabilities in designated medical dormitories without providing medical care on site violates § 35.152(b)(2). Similarly, Angola's practice of placing healthy patients with disabilities in isolation cells on the medical ward due to the lack of accessible cells elsewhere in the prison[2142] also violates § 35.152(b)(2).

C. The Discrimination Against Plaintiffs is By Reason of Their Disabilities

In order to establish entitlement to relief under Title II, Plaintiffs must show that the discrimination they have experienced is "by reason of" their disabilities.[2143] This is not a difficult standard to meet. In *Hale*, the plaintiff alleged "that the Appellees prevented him from using community work centers, accessing satellite and regional prison facilities, working in the prison kitchen, and attending school because he has Hepatitis C, chronic back problems, and psychiatric conditions (including post-traumatic stress disorder)."[2144] The Fifth Circuit held that these allegations, if true, were sufficient establish that the discrimination against Hale was "by reason of" the conditions from which he claimed to suffer.[2145] Similarly, in *Falls*, the court concluded that the discrimination against the plaintiffs—namely, "the denial of safe use of or accessible bus stops—was caused solely by the fact that the Plaintiffs [were]

impairments requiring the use of wheelchairs and other assistive devices.[2147] The evidence clearly showed that Defendant enforces blanket policies excluding patients with disabilities from programs and activities such as hobby craft and work release based on the fact that they are disabled.[2148] As for Angola's failure to integrate patients with disabilities, the evidence shows that Subclass members are warehoused in the medical dorms without receiving medical services, or on the ward without access to classes and other programming, precisely because it is Angola's policy to house patients with disabilities in those spaces.[2149] Were it not for their disabilities, Plaintiffs would be housed elsewhere. The evidence also clearly shows that Defendant's methods of administration relating to the identification, tracking, and accommodation of disabilities have resulted in discrimination against numerous patients who would not have been affected by Defendant's policies and practices but for their disabilities and legitimate need for accommodations.[2150]

III. PERMANENT INJUNCTION FACTORS

"To obtain permanent injunctive relief, a plaintiff must demonstrate: (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction."[2151] The decision to grant or deny permanent injunctive relief is an act of equitable discretion by the district court, reviewable on appeal for abuse of discretion.[2152]

Consistent with the Court's prior order[2153] and the agreement of the parties,[2154] no final injunction shall issue until the parties proceed to the remedial phase of this matter. However, the evidence presented by the parties during the liability phase proves that Plaintiffs will be entitled to an injunction, with the only question remaining being the terms of that relief.

First, as explained above, Defendants have violated Plaintiffs' constitutional and statutory rights. "When an alleged deprivation of a constitutional right is involved, … most courts hold that no further showing of irreparable injury is necessary."[2155] The evidence conclusively demonstrates

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[2147] *See supra* ¶¶ 510, 513, 522.
[2148] *See supra* ¶¶ 536-538.
[2149] *See supra* ¶¶ 586-587.
[2150] *See supra* ¶¶ 539585.
[2151] *ITT Educ. Servs. v. Arce*, 533 F.3d 342, 347 (5th Cir. 2008) (quotation marks omitted) (quoting *eBay Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006)).
[2152] *eBay Inc.*, 547 U.S. at 391 (citing *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 320 (1982)).
[2153] *See* Rec. Doc. 419 (Order on Pls.' Mot. to Exclude Evidence of Post-Discovery Conditions) at 3 (bifurcating trial into liability and remedy phases).
[2154] JPTO at 15 ("The parties agree that all liability issues should be tried in a single trial. The parties agree that injunctive relief, if any, should be determined in post-trial proceedings.")
[2155] 11A Wright & Miller, Fed. Prac. & Proc., § 2948.1 (3d ed. 1998); *accord, e.g., Cole v. Collier*, No. 14-cv-1698, 2017 U.S. Dist. LEXIS 112095, at *140-41 (S.D. Tex. July 19, 2017) (Eighth Amendment violation is irreparable injury).

that Plaintiffs have suffered—and, more importantly, face an ongoing risk of suffering—irreparable injury. Specifically, all Class members face a risk of being irreparably 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.

Second, remedies available at law, such as monetary damages, are inadequate to compensate for these injuries. Class members' past injuries have included preventable death, unremitting pain, and the progression of treatable medical conditions, and their ongoing injuries include a substantial risk of those harms. 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 violations would not be committed in the future.[2156]

Third, the balance of hardships weighs decisively in favor of Plaintiffs. Defendants expose all Class members to 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' financial interests do not outweigh Class members' rights under the Eighth Amendment and the ADA and RA,[2157] and the relief that Class members request does not entrench upon Defendants' cognizable interests in any way.

Finally, the evidence suggests that 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.[2158] 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.

REMEDY

[2156] *Cf., e.g., Ball v. LeBlanc*, 988 F. Supp. 2d 639, 688 (M.D. La. 2013) (finding that monetary damages "undoubtedly" were inadequate to compensate plaintiffs for ongoing violation of Eighth Amendment rights), *aff'd in rel. part*, 792 F.3d 584 (5th Cir. 2015).

[2157] *Cf., e.g., Ball*, 988 F. Supp. 2d at 688 (explaining that defendant's purported financial hardships "can never be an adequate justification for depriving any person of his constitutional rights") (quoting *Udey v. Kastner*, 805 F.2d 1218, 1220 (5th Cir. 1986)).

[2158] *See, e.g., Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 n.9 (5th Cir. 2014) (citing *Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th Cir. 2012) ("[I]t is always in the public interest to prevent [illegible]

Plaintih cy4have proven that the pervasive, sy stemic deficiencies in the provision of medical

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 conducted by appropriately trained medical personnel and evaluating performance of clinical duties, including appropriate measures to address unsatisfactory evaluations;
- a plan for training applicable health care and custodial staff on all portions of the plan relevant to their job duties;
- a plan to require all EMS Personnel to report through the medical chain of command rather than the security chain of command, except to provide security during medical transport;
- a plan to require all inmate health care orderlies to report through the medical chain of command rather than the security chain of command in the performance of their job duties;
- a plan to ensure that medical staff play no role in the enforcement of security measures, except where ensuring that Class members' medical needs or disabilities are respected in disciplinary proceedings; and

<u>Clinical Provisions</u>

- 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 have all inmate health care removed from nursing units unless there to provide Hospice support;
- a plan to ensure that all patients in the nursing wards are within sight and/or sound of a provider or nurse at all times;
- a plan 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 cease the use of gastrointestinal lavage ("stomach pumping") and forced catheterization in emergency medical situations, unless indicated by specific evidence of drug overdose beyond the patient's symptoms, which must be documented in writing;
- a plan to eliminate the use of malingering as a security charge;
- 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; and
- 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 plan to cease all discrimination against inmates with disabilities in the provision of programs, services, and activities, which shall include:
- a job description for an ADA Coordinator and a plan to ensure that the individual has the necessary qualifications, training and time to meet the job requirements;
- a plan for the creation of an effective and comprehensive system for identifying and tracking individuals with disabilities and ensuring that they are accommodated appropriately in all aspects of their incarceration, including, but not limited to, their dietary needs, work assignments, mobility, communication, housing, and discipline;
- a plan to ensure that all patients are informed of their rights under the ADA, the identity of and contact information for the ADA Coordinator, and the various methods of and procedures for requesting accommodations and filing disability-related grievances;

- a plan to remove all barriers to requesting accommodations, including the policy of charging copays for the evaluation of accommodation requests;

- a plan to ensure that all requests for accommodation, including letters, ARPs, RFAs, and verbal requests, are referred to and evaluated by the ADA Coordinator or by appropriately trained and qualified designees acting under his or her direct supervision, with all final determinations made by the ADA Coordinator;

- a plan for the creation of a comprehensive database that reliably 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 health care orderlies about the ADA and compliance therewith by a qualified outside vendor;

- a plan to eliminate the architectural barriers to LSP's programs, services, and activities as 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 revise all other policies that result in the exclusion of patients with disabilities from LSP's services, programs, and activities, including, but not limited to, hobby craft, educational and therapeutic programming, religious services, and recreational activities;

- a plan to ensure that patients with disabilities are able to access and benefit from LSP's services, programs, and activities in the most integrated setting appropriate to their needs;

- a plan to ensure that patients with disabilities are provided with on-site medical services to the extent they are placed in designated medical areas such as the nursing wards and medical dormitories;

- a plan to ensure individuals with disabilities are transported safely in vehicles that adequately accommodate their disabilities both within and outside the facility; and

- 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 within two weeks of the issuance of this order, the Defendants will produce a report detailing all relevant material changes that have occurred at LSP and/or the DOC since the close of discovery. The report must be supported with documentation of such changes. Plaintiffs will be provided with an opportunity to conduct limited and speedy

discovery regarding any alleged changes. The Court will schedule a hearing regarding those changes shortly thereafter.

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 three times per year, to conduct thorough reviews of the facility and of records selected by the monitors. The monitors shall have unfettered 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 two weeks and the Court will select the monitors. After the entry of the Court's remedial order, 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 mTw[r rA sucsih ud.0011ing9 Tw[T.yeccess tties cana5 -1.1259 to hingm 6ather 0 TD3 TD-

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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 April 17, 2019, 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.

/s/ Mercedes Montagnes

Mercedes Montagnes