UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

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

Plaintiffs,

v.

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

Defendants.

CIVIL ACTION NO. 3:15-cv-00318

CHIEF JUDGE: Hon. Shelly D. Dick

MAGISTRATE JUDGE: Richard L. Bourgeois, Jr.

PLAINTIFFS' FINDINGS OF FACT AND CONCLUSIONS OF LAW

TABLE OF CONTENTS

FINDINGS OF FACT

BACKGROUND

I. CLASS MEMBERS

1.

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

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

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

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

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

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

III. OVERVIEW OF MEDICAL CARE PROVIDED BY DEFENDANTS

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

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

a. The main prison, which houses Class member

a. Medical providers:[16] Angola's table of organization allows Angola to have four

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

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

c.

evaluating compliance with the program access requirements of Title II of the ADA and Section 504 of the Rehabilitation Act by identifying architectural barriers to access. His work

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

EIGHTH AMENDMENT CLAIM

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

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

28. The medical care that Defendants provide is gr

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Plaintiffs' medical experts conclude that Patient #16 "did not receive timely and

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

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

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

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

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

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

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

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

49. This evidence paints the same picture as Plaintiffs' medical experts' sample: a picture of

carcinoma] for an extended period before he was diagnosed. LSP physicians failed to review abnormal laboratory results, failed to identify longstanding weight loss, and

recording telltale signs of a stroke—including facial droop, weakness in his left arm,

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

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

54. These include:

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

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

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

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

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

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

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

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

c. Dr. Singh and Secretary LeBlanc, who informed the Louisiana Secretary of Health and Governor's Office that they were concer

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

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

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

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

B. Specific Practices Contributing to Substantial Risk of Serious Harm

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

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

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

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

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

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

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

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

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

a. Inadequate Funding and Inappropriate Budget Management

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

65. Moreover, the budget's allocation compounds these shortfalls. 74% of the budget is spent on salaried and contracted professionals—meaning that just 26% of the budget goes to

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

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

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

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

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

    b.

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

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

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

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

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

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

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

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

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

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

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

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

[116] *Id.* at 0024-25; *see* Rec. Doc. 349 (granting Plaintiffs' Motion Request of Judicial Notice of the licensure of Angola physicians);, the oa.f c. 247-2 (Angola physician.21 TDhat 7tarts(f4.7,lified)]T76jA Tc004

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

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

ii. Nurses

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

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

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

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

94. Third, a single LPN serves as the presenter for nearly all telemedicine appointments. In a telemedicine appointment, a distant provider conducts a videoconference with a patient and a presenter, with the presenter performing tests and otherwise assisting the provider with tasm9ishat couant qu6r

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

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

iii. EMTs

96. With a severe shortage of providers and nurses, Defendants rely on EMTs for duties related

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

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

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

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

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

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[133] JX 8a.

[134] PX 6 at 0041;

[135] JX 4, Cashio 30(b)(6) Depo. at 72:21-73:16; *see also* JX 4, A. Cowan Depo. at 98:22-99:4 (EMT testifying that she had never heard a doctor or nurse tell an EMT that he or she had made a mistake in 14-year career).

[136] PX 6 at 0032; *see also id.* at 0061 ("EMTs [are] typically managing medical emergencies that are

iv. Correctional officers

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

c. Inadequate Leadership

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

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

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

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

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

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

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

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

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

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

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

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

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

d. *Sick Call and Access to Care*

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

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

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

[152] DX 14 at 20-21.

[153] PX 6 at 0031-32; JX 5-a at 0019-21 (HC-01, DOC Access to Care and Clinical Services Policy); *see also, e.g.*, JX 4, D. Cashio Depo. at 29:15-30:22, 44:20-45:8, 54:8-55:8, 60:4-6 (describing sick call process); JX 4, R. Lavespere Ind. Depo. at 26:22-30:14 (describing EMT decisions about whether to bring to ATU); *id.* at 38:1-12 ("if the EMS didn't think the person needed to be transported or didn't

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

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

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

> The EMT does not have the health record available to review the patient's past medical history or determine if the patient's complaint is a new or recurring complaint, and what if any previous treatment was provided to the patient. EMTs do not conduct assessments in examination rooms that are adequately equipped and supplied, afford privacy and confidentiality, or have access to handwashing. Moreover, the medical equipment and supplies that EMTs bring with them is not standardized. One EMT in Camp J had only a stethoscope, whereas another in the Transitional Unit brought a small bag with more equipment. Given the circumstances in which assessments take place, it is not surprising that in the majority of cases we reviewed, EMT medical examinations are completely inadequate. In addition, documentation reflected that EMTs usually do not directly communicate or consult with a physician regarding assessment findings at the time the patient assessment is performed. Therefore, the EMTs make independent assessments on a daily basis, which is beyond their scope of practice.
>
> After EMTs perform sick call, they place the patient's HSR in a physician's box. For the majority of HSRs we reviewed, physicians did not document any information regarding the assessment performed by the EMT oe5 TD.0.(39)T

professional medical judgment, and denies or delays access to diagnosis and treatment. As explained *supra*

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

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

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

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

158

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

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

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

vi. Policies and practices that impede access to care

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

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

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

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

128. Second, sick call occurs at unscheduled times, beginning as early as 4:30 in the morning in some housing units. Many Class members are sleeping at this time, and may not wake up for sick call. Patients who miss sick call must wait until the next sick call, or declare an emergency; they are not permitted to have another Class member submit an HSR for them. This is an unreasonable barrier to care that lacks a clinical or operational justificationu 9[-1.21 T0002 Tw0

135. At the same time that Defendants provide substandard care in the ATU, they frequently decline to send patients to outside hospitals when indicated by urgent, life-threatening vital signs and symptoms. The ATU is not an emergency room; it lacks numerous forms of diagnostic testing (or lacks qualified operators much of the time), including ultrasound, stress testing, and echocardiograms, which are necessary to diagnose emergency conditions and determine a proper course of treatment. Similarly, laboratory testing is not available after hours or on the weekend, making it impossible to perform critical diagnostic tests. It is

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

viii. Inappropriate procedures in emergency care

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

139. First, Defendants presume that any patient with altered mental status is using drugs, and thus routinely perform a urine toxicology test—often by forced catheterization, a painful and invasive process that may introduce infection—whether or not a patient has symptoms of a serious condition that might explain his mental status. Notably, this routine application of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. Inadequate Inpatient Care

xi. Inadequate provider care in infirmary.

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

165. Given the acuity of patients in the Nursing Units, regular provider and nursing rounds is crucial, as is the presence of a qualified health care professional who can see or hear patients at all times. But as with the rest of Angola's medical system, the Nursing Units are understaffed: Nursing Unit 2 is managed by a nurse practitioner w Tw; x6o ver TJ a nurse practitionerf15 00

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

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

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

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

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

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

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

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

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

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

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

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

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

[253]

xiii. Absence of care in the medical dormitories

173.

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

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

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

xv. Refusal to provide adequate HCV medication

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

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

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

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

administration; pill call times are inconsistent and at improper times such as 3 a.m.; and

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

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

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

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

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

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

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

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

xviii. Inadequacies of Defendants' medical records system

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

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

b. Second, as documented above, records from specialty consultations and hospitalizations are often missing, leaving follow-up recommally4Tw(1-3.8(Tf i5 -1.215 TD-.0401 Tc

m. Inadequate Peer Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Defendants Received Repeated Warnings About Deficiencies

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

(1) Warnings from the DOJ

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Warnings from Consultants

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

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

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

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

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[348] *Id.*

259. Secretary LeBlanc and Ms. Falgout, along with then-Warden Cain and then–Statewide Medical Director Singh, all received and reviewed the Wexford report. Their follow-up discussions with other DOC personnel included various acknowledgments of the "salient points" in the report and of problems with their practices—such as the fact that even certified Medical Assistants, who have state cer

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

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

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

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

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

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

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

287. Plaintiffs' ADA expert, Mark Mazz, has over 30 years of experience as an architect and architectural accessibility consultant, including three years in the Department of Justice's Disability Rights Section.[391] In his practice, he regularly assesses facilities' compliance with the requirement under ADA Title II and Section 504 of the Rehabilitation Act to ensure that their programs, services, and activities are a

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

288. Mazz was not told which parts of Angola's facilities were constructed or altered after the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Urinals were too high to use from a wheelchair.

Mirrors are too high for inmates in wheelchairs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Failure to Integrate Individuals with Disabilities

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

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[437] *Id.*

[438] *See, e.g.*, PX 231 at 2358-2364, 2437-2439 (ARP of James Weber); PX 231 at 1794-1809 (ARP of Cedric Howard); PX 231 at 1609-1613 (ARP of Shaundrick Gould); PX 231 at 1846-1855 (ARP of Ernest Jenkins); PX 231 at 1887 (ARP of Terry Kelly);

[439] PX 7.

[440] JX 7-b at 1 ("Equipment and facilities and the support necessary for inmates with disabilities to perform self-care and personal hygiene in a reasonably private environment will be provided as allowed by security.").

[441] PX 7 at 0016.

[442] JX 4–c, A. Brent Depo. at 73:25-74:7.

[443] JX 7b at 0001, JX 6-eee, at 0001-02. *See also* JX4, D. Barr Depo. at 49:10-18 (deaf inmates housed in medical dorms); JX 4, T. Falgout Aug. Depo. at 119:3-7 (blind inmates housed in medical dorms).

[444] LSP Directive 13.088 at 2.

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

(3) Failure to Provide Reasonable Accommodations or Modifications

300. The Department has acknowledged its obligation to provide assistive equipment and devices and make other reasonable accommodations. Regulation B-08-010 provides that "[a]ccess to

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

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

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

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

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

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

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

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

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

b. Denial of Assistance with Insulin Administration

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

c. Failure to Accommodate Disabilities in Work Assignments

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

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

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

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

d. Failure to Accommodate Dietary Needs

306. Numerous Class members testified that they either were denied necessary accommodations

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

f. Lack of Accommodations in Prison Procedures

308. The testimony of the Department's own employees reveals that Angola regularly fails to accommodate individuals with disabilities when establishing and enforcing prison procedures. Former ADA Coordinator Donald Barr could not identify any accommodations made for deaf prisoners during pill call, sick call, or head count.[489] He further testified that no special consideration is given to individuals with disabilities in the prison's procedures for preventing and enabling reporting of prison rape, and he did not believe inmates with

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

(4) Discriminatory Methods of Administration

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

a. Failure to inform individuals of rights and procedures

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

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

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

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

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

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

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

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

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

c. Failure to identify and track disabilities

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

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

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

326. Additionally, because many requests for accommodation are not properly routed to the ADA Coordinator, a large percentage of requests do not make their way into the tracking database. Peabody indicated that the database would not include any ARPs whatsoever.[553] Barr admitted that he was not involved at all in recording information in the database and2 50 T the

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

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

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

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

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

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

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

g. Failure to maintain an advisory committee

334. LSP Directive 01.016 requires Angola to maintain an ADA Advisory Committee.[582] Neither the prison's ADA Coordinators[583] nor its past or present wardens[584]

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

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

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

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[600] *See, e.g., Thomas v. Carter*, 593 F. App'x 338, 342 (5th Cir. 2014).

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b. Substantial Risk of Serious Harm

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

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

(3) The Subjective Test

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

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

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

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

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

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[636] *Id*.. at 835.
[637] *Gates*, 376 F.3d at 333 (citing *Farmer*, 511 U.S. at 842).
[638] *Rouse v. Plantier*, 182 F.3d 192, 197 (3d Cir. 1999); *see also, e.g., Carlucci*, 884 F.3d at 538 (noting that "delay" or "denial of recommended medical treatment" supports a finding of deliberate indifference); *Lawson*, 286 F.3d at 263-64 (affirming finding of deliberate indifference where prison staff knew of and disregarded instructions for follow-up care).
[639] *See Farmer*, 511 U.S. at 843 n.8 ("a prison official "would not escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist").
[640] *Braggs*, 257 F. Supp. 3d at 1251 (citing *Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991).
[641] *Braggs*, 257 F. Supp. at 1251-52 (quoting *Rogers v. Evans*

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

B. Individual Practices That Can Violate the Eighth Amendment

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

c. Inadequate and Inappropriate Staffing

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

d. Inadequate Access to Care

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

e. Inadequate Chronic Disease Program

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

f. Failure to Provide Specialty Care

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[647] *Farmer*, 511 U.S. at 842-43; *see also Williams*, 547 F.2d at 1216 (concluding that the Eighth Amendment may be violated on a showing of "evidence of rampant and not isolated deficiencies").
[648] *Harris*, 941 F.2d at 1505 (quoting *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980),

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

g. Denial of Necessary Medical Care Exclusively for Budgetary Reasons

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

h. Inadequate Maintenance of Medical Records

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

i. Inadequate Monitoring and Quality Control System

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

j. Inadequate Access to Emergency Care

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

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

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

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

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

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

b. Inadequate and Inappropriate Staffing

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

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

c. Inadequate Medical Leadership

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

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

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

d. Restrictions on and Inadequacies in Accessing Medical Care

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

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

e. Inadequate Chronic Disease Management

Although "[o]ne does not need to be an expe

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

h. Inadequate Pharmacy Services and Medication Administration

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

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

i. Inadequate Diagnostic Services

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

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

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

As explained in the Proposed Findings of Fact,

of harm to Class members.[723]

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

Plaintiffs have established that Defendants routinely and systemically failed to properly assess, diagnose and treat

The Court concludes that the nearly 200 undisputed architectural barriers identified by Plaintiffs' expert, Mark Mazz, deprive individuals with disabilities of meaningful access to Angola's programs and services. Both the physical characteristics of the surveyed areas and the testimony of Class members show that individuals with mobility impairments lack ready access to many of the prison's basic programs, services, and activities, including toilets, showers, medical care, communication devices, drinking fountains, and most programs outside the dormitories themselves. Here, as in *Chaffin*, the individual barriers combine to impede Class members' access to programs and services throughout the prison. From bathrooms to recreational areas to medical facilities, Defendants have failed to make programs and services "readily accessible."[760]

The Court further concludes that Angola has failed to make its programs, services, and activities accessible to individuals with disabilities through alternative methods. Because Mazz limited his survey to areas designated for use by individuals with disabilities—in other words, the prison's *most* accessible areas—the Department cannot reassign the services offered in those areas to accessible buildings, or deliver the services at alternative accessible sites. Nor can the programs, services, and activities identified in his survey be brought to the disabled individual. For example, the prison cannot bring the recreation yards, showers, or JPay stations to a patient. Finally, for the reasons stated in the findings of fact, the Court concludes that the assignment of inmate health care orderlies to the ward and medical dormitories is insufficient to render Angola's programs "readily accessible."[761]

2. Failure to Integrate Individuals with Disabilities

Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"[762] In the correctional setting, facilities must "ensure that inmates or detainees with disabilities are housed

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rendered inaccessible if it is held in an inaccessible facility"); *Gathright-Dietrich v. Atlanta Landmarks, Inc., 435 F. Supp. 2d 1217, 1226 (N.D. Ga. 2005)* (concluding that in existing constructions, the existence of architectural barriers should be determined using the standards as a guide, although the Defendant may have more flexibility in determining how to address the barrier); *Brown v. Cty. of Nassau*, 736 F. Supp. 2d 602, 616-18 (E.D.N.Y. 2010) (using the standards, in conjunction with other evidence, to determine the existence of barriers that violate the "program access" standard).

[760] 28 C.F.R. § 35.150(a).

[761] *Cf. Armstrong v. Brown*, 857 F. Supp. 2d 919, 933 (N.D. Cal. 2012) ("Reliance on other prisoners for access to basic services, such as food, mail, showers and toilets by prisoners with disabilities leaves them vulnerable to exploitation and is a dangerous correctional practice."); *Wright v. N.Y. State Dep't of Corr. & Cmty. Supervision*, 831 F.3d 64, 73-75 (2d Cir. 2016) (noting that mobility assistance program was ineffective because it required disabled individuals to "seek out and rely upon the cooperation of other inmates," exposed disabled inmates to a risk of neglect, and was "fundamentally in tension with the ADA and RA's emphasis on independent living and self-sufficiency," even in the prison setting); *Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1269 (D.C. Cir. 2008) (noting that the ADA and RA emphasize that for disabled individuals the "enjoyment of a public benefit is not contingent upon the cooperation of third persons"); *Flynn v. Doyle*, 672 F. Supp. 2d 858, 878-79 (E.D. Wis. 2009) (plaintiff could state ADA claim even if she availed herself of the assistance of wheelchair pushers to traverse treacherous paths on prison grounds).

[762] 28 CFR 35.130(d).

Additionally, Title II requires public entities employing 50 or more people to "adopt and publish grievance procedures providing for prompt and equitable resolution of complaints alleging any action that would be prohibited by this part."[773] The entity must "designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities" under the Title II regulations, "including any investigation of any complaint communicated to it alleging its noncompliance" with the regulations.[774] The entity must "make available to all interested individuals the name, office address, and telephone number of the [designated] employee or employees."[775]

reasonable accommodations or modifications; discriminatory methods of administration; and overt discrimination. Accordingly, Defendants are enjoined to remedy the substantial risk of serious harm to Class members and the violation of Subclass members' rights under the ADA and the RA.

IT IS HEREBY ORDERED that Defendants shall create a plan to correct the violations of the Eighth Amendment, ADA, and RA as identified herein. Given that the violations involve a substantial risk of serious of harm and loss of life, and that Defendants have been aware that their policies and practices were constitutionally deficient for more than 20 years,[778] it is essential that the parties move swiftly to begin to correct the systematic deficiencies. Defendants shall submit their proposed plan to the Court within 30 days of the issuance of this Order, along with a timeline for completing each item listed in the plan. The proposed relief must be both immediate and long-term. Plaintiffs shall comment on, propose alternatives to, or oppose any part of Defendants' proposal within 30 days. The Court shall thereafter evaluate and order any remedy it deems appropriate and

a plan for training applicable health care and custodial staff on all portions of the plan relevant to their job duties.

Clinical Provisions

a plan for all medical complaints and conditions to be reviewed by an appropriate and qualified medical professional;

a plan for every patient presenting to the ATU to receive a physical examination, review of recent medical records, and thorough medical assessment by a provider;

a plan to have registered nurses (RNs) with access to Plaintiffs' complete medical records perform all sick call other than reques byr2Tlely

a plan to have nursing staff provide sick call and pill call on site for Plaintiffs in the assisted living dormitories, and to conduct daily rounds to examine patients and provide supervision, instruction, and assistance to the inmate health care orderlies;

a plan to have all inmate health care orderlies on the infirmary and nursing wards be supervised by licensed nursing staff, and for qualified medical personnel, rather than orderlies, to perform activities of daily living on the infirmary and Nursing Units;

a plan to ensure to ensure Do Not Resuscitate orders are properly discussed with patients and not proposed to patients with altered mental status in the midst of life-threatening emergencies;

a plan to revise policies to ensure timely and adequate mortality reviews by an unaffiliated physician with sufficient detail as to the cause of death and the relevant medical and treatment history;

a plan to implement an electronic medical records system that includes adequate documentation of all medical encounters, including records from outside providers and medication administration records, and that makes medical records readily accessible to Class members upon request;

a plan to reform LSP's Continuous Quality Improvement ("CQI") program to include participation by the Medical Director, Assistant Warden for Health Services, and all medical departments, and to empower the CQI program to develop, implement, and monitor the effectiveness of quality improvement plans.

ADA Provisions

a job description for an ADA Coordinator and a plan to provide that individual the necessary training and time to meet the job requirements;

a plan for the creation of an effective and comprehensive system for tracking individuals with disabilities and ensuring that they are accommodated appropriately in all aspects of their incarceration;

a plan for the creation of a comprehensive database which captures all requests for accommodations (including letters, ARPs, RFAs, and verbal requests), as well as their status, disposition and any reasons therefor, and supporting documentation;

a plan to provide training for all staff and healthcare orderlies about the ADA and compliance therewith by a qualified outside vendor;

a plan to remove all access barriers to programs, services, and activities by eliminating the architectural barriers identified by Plaintiffs' ADA expert or the ADA monitor (discussed below);

a plan for revising the duty status policy to provide for individually-tailored restrictions, a more robust classification system, and a process by which inmates can request a new or modified duty status without relying on the sick call system;

a plan to train security personnel on the proper application of and compliance with duty status restrictions;

resumes to the Court within a week and the Court will select the monitors. Any disputes between the parties regarding the adequacy of any current or revised policies, procedures, protocols, training programs, staffing plans, or other items required by this Order will be submitted to the appropriate monitor for resolution, if the parties cannot reach agreement. In the event that either party is dissatisfied with the monitor's written resolution of any such dispute, that party may move the Court for relief. All costs incurred by the Parties in the enforcement of the Court's order will be paid by Defendants.

IT IS FURTHER ORDERED that Plaintiffs are the prevailing party in this case, and have leave to submit an initial Motion for Attorneys' Fees within 30 days of this order.

Respectfully submitted by:

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CERTIFICATE OF SERVICE

I hereby certify that on October 3, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send a notice of electronic filing to all CM/ECF participants.

Dated : October 3, 2018

/s/ *Mercedes Montagnes*
Mercedes Montagnes