**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF ILLINOIS**
**EASTERN DIVISION**

| | | |
|---|---|---|
| DON LIPPERT, LEWIS RICE, MILAM MARTIN, DEBRA PATTISON, JOHN RUFFIN and EZELL THOMAS<br><br>Plaintiffs,<br><br>v.<br><br>JOHN BALDWIN, LOUIS SHICKER, and BRUCE RAUNER,<br><br>Defendants. | ) | No. 10-CV-4603<br><br>Judge Jorge L. Alonso<br>Magistrate Judge Daniel Martin |

**FOURTH AMENDED COMPLAINT (REDACTED)**

## INTRODUCTION

This is a class action on behalf of class of all prisoners in the custody of the Illinois Department of Corrections with serious medical and dental needs. It seeks declaratory and injunctive relief to force Defendants to fix a healthcare system which daily puts the Plaintiffs and class members at risk of pain, injury, and death. The Eighth Amendment to the Constitution of the United States prohibits cruel and unusual punishment. Failure to treat, and unreasonable delay in treating, prisoners with serious health conditions inflicts unnecessary pain and suffering. The United States Supreme Court long ago held that prison officials have a constitutional obligation to provide adequate medical care. As the Supreme Court recently stated, "Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives inmates of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in a civilized society."[1]

[1] *Brown v. Plata*, 563 U.S. 493, 131 S.Ct.1910 (2011).

The Illinois prison system is plagued by persistent unremedied failures to provide constitutionally adequate medical and dental care to the persons imprisoned in its facilities. These failures are well known to Defendants. They cause untold human pain and sometimes death. In December 2014, a team of medical and dental care experts led by Dr. Ronald Shansky, a court-appointed expert, issued their report on the healthcare provided to prisoners in the Illinois Department of Corrections ("IDOC"). The Expert Team's conclusion was unequivocal. **"[T]he State of Illinois has been unable to meet minimal constitutional standards with regards to the adequacy of its health care program for the population it serves."** Dkt. 339 p. 45 (emphasis added).

## JURISDICTION AND VENUE

1. Jurisdiction is conferred upon this Court pursuant to 28 U.S.C. § 1331 and 28 U.S.C. § 1343 because the matters in controversy arise under the Constitution and laws of the United States. This civil action seeks declaratory and injunctive relief under 28 U.S.C. §§1343, 2201, and 2202 and 42 U.S.C. § 1983.

2. Venue is proper in this Court under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in the Northern District of Illinois.

3. One or more of the named Plaintiffs have exhausted administrative remedies reasonably available to them prior to bringing their 42 U.S.C. § 1983 civil rights claims in accordance with the Prison Litigation Reform Act, 42 U.S.C. § 1997(e)(a).

## PARTIES

### Named Plaintiffs

4. Plaintiffs Don Lippert, Milam Martin, Lewis Rice, Debra Pattison, John Ruffin, and Ezell Thomas are currently incarcerated in IDOC facilities and, like all prisoners in the class

defined below, have suffered or are substantial risk of suffering serious harm as a result of Defendants' deliberate indifference to their serious medical and dental needs.

**Defendants**

5. Defendant Bruce Rauner ("Rauner") is the Governor of the State of Illinois. He is sued in his official capacity. The Governor is the Chief Executive Officer of the State of Illinois. He is responsible for ensuring the provision of constitutionally adequate medical and dental care for all prisoners in the custody of IDOC, and is also responsible for establishing monitoring and other procedures to ensure that IDOC's healthcare vendor, Wexford Health Sources, Inc. ("Wexford") in fact provides the contracted services in a manner which complies with Illinois' Constitutional obligation to provide medical and dental care to Illinois state prisoners. In all his actions described in this complaint, Rauner is acting under color of state law and in the course of his employment.

6. Defendant John Baldwin ("Baldwin") is the Director of IDOC and is sued in his official capacity. As Director of IDOC, Baldwin is responsible for establishing, monitoring, and enforcing overall operations, policies, and practices of the Illinois state prison system, which includes the provision of constitutionally adequate medical and dental care for all prisoners in the custody of IDOC. Baldwin is also responsible for working with Rauner to submit budgets to the Illinois Legislature that request sufficient resources to comply with IDOC's obligations under the U.S. Constitution. In all his actions described in this complaint, Baldwin is acting under color of state law and in the course of his employment.

7. Defendant Louis Shicker ("Shicker") is the Medical Director for IDOC and is sued in his official capacity. As Medical Director, Shicker is responsible for ensuring that IDOC healthcare policies, directives, and protocols are properly implemented at all facilities; for the oversight of IDOC's "continuous quality improvement" ("CQI") and other healthcare self-

monitoring and correction processes; for ensuring that healthcare staff, including vendor staff, are appropriately qualified; for assisting with contract monitoring; and for updating and creating administrative directives, clinic, and health care guidelines. Shicker is also responsible for oversight of the independent contractor, Wexford, hired to provide healthcare personnel and treatment throughout the IDOC system. In all his actions described in this complaint, Shicker is acting under color of state law and in the course of his employment.

## NATURE OF THE CASE AND FACTUAL ALLEGATIONS

### Background to the Expert Report and Prior Allegations

8. This suit was originally filed in 2010, on behalf of Plaintiff Don Lippert only. In October 2011, it was expanded to include class allegations. Dkt. 39.

9. In December 2013, the Court appointed Dr. Shansky, by agreement of the parties, as an expert pursuant to Rule 706 of the Federal Rules of Evidence. The Agreed Order Appointing Expert charged Dr. Shansky with "assist[ing] the Court in determining whether the Illinois Department of Corrections ("IDOC") is providing health care services to the offenders in its custody that meet the minimum constitutional standards of adequacy." Dkt. 244 ¶ 1a. Dr. Shansky selected several additional experts in medicine, nursing, and dentistry to assist in his investigation (the "Expert Team"). *Id.* at 3.

10. The Order further provided that if, after investigation, "systemic deficiencies in IDOC health care are identified by the Expert, he will propose solutions . . .." Dkt. 244 ¶ 1a.

11. The prior complaints in this case had alleged a variety of systemic failures of medical and dental care in IDOC, including insufficient doctors, nurses, specialists and other medical providers to provide constitutionally required medical care; lengthy and dangerous delays in receiving appropriate treatment; failures to refer inmates to necessary and appropriate

specialists; failures to provide timely emergency treatment; the failure to identify and correct incompetent medical treatment; and failures to properly create and maintain medical records. Dkt. 39, 146.

**Systemic Failures Identified by the Expert Team**

12. In December 2014, the Expert Team issued their 405-page report (the "Expert Report"). Dkt. 339. The Expert Team found all the failures detailed in Plaintiffs' complaints, and more. The Report details a host of intertwined systemic deficiencies, including:

- Chronic breakdowns in staffing and leadership;
- Weak central office oversight of the system and of vendor performance;
- Lack of properly qualified doctors and inadequate and conflict-ridden processes to monitor those doctors who are in place;
- A non-functional continuous quality improvement program;
- Dysfunction at every step of the healthcare process, including:
    - intake programs crippled by long delays, and often unable to identify even routine medical or dental problems;
    - breakdowns in intrasystem transfer processes;
    - a sick call system unable to provide reliable access to healthcare services;
    - out of date, thoughtless, risky management of chronic diseases;
    - mismanagement and dangerous delays in scheduled offsite services;
    - mismanagement of emergency onsite and offsite services;
    - poorly equipped prison infirmaries housing patients who should have been sent to hospitals;
    - complete absence of any steps needed to provide routine dental care;
    - staggering delays in access to dental care.

- These failures are compounded by:
    - disorganized, illegible, gap-riddled medical records;
    - broken-down equipment, inadequate examination spaces, and widespread lapses in sanitation;
    - no reliable system for infection control oversight;
    - a mortality review process so flawed that there were serious deviations from the standard of care in 60% of inmate deaths reviewed by the Expert Team; and
    - no hospice or end-of-life palliative care.

Dkt. 339, *passim.*

13. The proposed solutions, for the system as a whole and for each of the eight facilities discussed in depth by the Expert Team, occupy approximately 35 pages in the Final Report.[2]

**The Failures Described in the Expert Report Are Ongoing, Cause Needless Pain and Suffering, and Endanger Lives Each Day**

***The Illinois prison population is overcrowded and ailing*:**

14. The state prisons of Illinois are dangerously overcrowded. Currently some 47,000 prisoners are held in facilities whose "design capacity" was for 32,000. In recent years, overflow populations have been housed in gymnasiums at Stateville and Logan Correctional Centers, and in unused rooms in the (non-operational) infirmary at Northern Reception Center.

15. As the state's prison population has soared, with a corresponding jump in the number of prisoners who are aging or elderly, the number of inmates suffering from serious

[2] *See* Dkt. 339 at 9-10, 12, 14-18, 23-24, 28, 31-32, 34-35, 37-38, 40-43, 79-86, 113-23, 159-65, 167-70, 197-202, 204-05, 237-46, 275-79, 283-84, 311-17, 323-24, 359-64, 369-71.

medical conditions and needing consistent medical treatment has soared as well. By 2011, Illinois was among the top ten states with inmates over 55 years old.[3]

16. Prisoners also need more healthcare than the general population. As of 2011-12, almost half of state and federal prisoners had been afflicted with a chronic medical condition, compared to 31% of the general population. Laura M. Maruschak et al., *Medical Problems of State and Federal Prisoners and Jail Inmates*, 2011-12, Bureau of Justice Statistics, Feb. 2015, at 3 (Table 1). Over 30% of prisoners had high blood pressure/hypertension; almost 10% had heart-related problems; and almost 15% had asthma. *Id.* While 4.8% of the general population reported having had an infectious disease, a staggering 21% of prisoners reported having had one, with incidences of tuberculosis or hepatitis B or C respectively some 10 and 15 times higher than in the general population. *Id.*

17. Faced with these challenges, Defendants have responded with indifference and neglect – knowing indifference and deadly neglect. The systemic problems identified by the Expert Team are not new, and they cannot be fixed without wholesale change.

***Chronic breakdowns in staffing and leadership*:**

18. Understaffing of nurses, physicians, and other medical personnel is a chronic problem in Illinois prisons. "IDOC [must] develop and implement a plan," wrote the Expert Team, "which addresses facility-specific critical staffing needs by number and key positions and a process to expedite hiring of staff when the critical level is breached." Dkt. 339 at 10.

19. What the Expert Team found was nothing new. Year after year, the John Howard Association of Illinois ("JHA"), an independent prison monitoring organization, has reported on the lack of medical staff in nearly all the Illinois prisons. In May 2011, JHA visited Hill

[3] The Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, *State Prison Health Care Spending* (July 2014), attached hereto as Exhibit 1, pp. 4, 12.

Correctional Center and reported "a 13-month backlog for dental care and a one year backlog for eye care. . . [several inmates] reported not receiving their medications, and others [reported] being denied medical care for an ongoing condition."[4] In a 2011 visit to Vienna Correctional Center, JHA documented a "great need for more nurses" and a lack of dental providers.[5] JHA's 2010 visit to Stateville Correctional Center revealed "significant understaffing problems" in both medical and correctional staff, problems which "have been the norm at Stateville for at least four years."[6]

20. More generally, in a special 2012 report on healthcare in Illinois prisons, JHA concluded that "healthcare resources and staffing are inadequate to meet minimum standards of care throughout IDOC. In particular, systemic nursing shortages prevent inmates from timely accessing sick call and necessary healthcare services. However, lack of adequate medical staffing and resources in all areas – medical, mental health, dental, vision – threaten serious harm by delaying diagnosis and treatment and inviting medical error. Inadequate medical staffing levels also contribute to staff burnout and turnover, which, in turn, help perpetuate chronic understaffing throughout IDOC."[7]

21. Defendants have known for years that understaffing was a problem, creating risks of serious harm for the class, and they know it is a problem that has not been fixed. [redacted]

[redacted]

[4] John Howard Association of Illinois, Monitoring Visit to Hill Correctional Center 5/31/2011, attached as Exhibit 2, at 5.
[5] John Howard Association of Illinois, Monitoring Visit to Vienna Correctional Center 9/27/2011, attached as Exhibit 3, at 13-15.
[6] John Howard Association of Illinois, Monitoring Tour of Stateville Correctional Center Sept. 14, 2010, attached as Exhibit 4, at 3.
[7] John Howard Association of Illinois, Unasked Questions, Unintended Consequences: Fifteen Findings and Recommendations on Illinois' Prison Healthcare System, attached as Exhibit 5, at 13.

[redacted] But Defendants, in spite of a $1.36 billion, five-year contract with Wexford, are unable to get their vendor to do its job.

22. As recently as September 2015, a series of emails among IDOC personnel including Defendant Shicker complained, initially, [redacted]. The discussion then expanded [redacted].

[redacted]

(IDOC Update 1034) attached as Exhibit 6.

24. [redacted] (IDOC Update 1034), Exh. 6.

As the correspondence continued, on September 16, 2015, Defendant Shicker wrote: [redacted]

[redacted]

(IDOC Update 1050), Exh. 7.

26. Year after year, Defendants have countenanced ongoing, long-term vacancies not just in healthcare staff generally, but in leadership positions – facility Medical Directors, Health Care Unit Administrators, Directors of Nursing, and staff physicians (at the handful of facilities which have more than one doctor). These vacancies in leadership positions were the most disturbing to the Expert Team. These empty positions include the most critical medical positions throughout the prison system, and they often remain open for months or years.

27. "The leadership vacuums at Dixon, Stateville, and NRC," the Expert Team wrote, "have resulted in process and care breakdowns *on a daily basis.*" Dkt. 339 at 6. Only one of the eight critical facilities reviewed by the Expert Team had complete staffing at the top: "as indicated through this review of eight institutions, very few if any with the exception of Pontiac have a complete team with all positions filled by capable individuals." *Id.*

28. Defendants are incapable of creating and keeping complete leadership teams in place at their most critical facilities. By the time JHA visited Pontiac Correctional Center – which houses over 2000 prisoners – in 2015, the Health Care Unit Administrator who was part of

the "complete team" reported in the Expert Report was gone, with no replacement in sight.[8] At Dixon Correctional Center, which houses some of IDOC's sickest and most vulnerable patients, [redacted]. And the Director of Nursing position at Logan – the women's facility and thus responsible for all aspects of women prisoners' healthcare – was vacant when the Expert Team visited, [redacted]. These are just a few examples of an endemic problem.

***Weak central office oversight*:**

29. Much of Illinois' prison healthcare spending is dispensed through the $1.36 billion contract with Wexford to provide health care services in the state's prisons. Since 2011, Wexford has been the sole IDOC healthcare vendor, [redacted].

30. Defendants barely oversee Wexford's work. In spite of Wexford's outsize presence among healthcare workers, [redacted].

31. "It is critical," the Expert Team wrote, "for the Office of Health Services to establish the specifications for the health care contracts as well as to monitor and oversee the performance of those contracts . . .." Dkt. 339 at 8. But as illustrated by the (recent) emails above, Defendants do not control their vendor or force it to perform.

32. In theory, the Wexford contract establishes performance standards that must be met by Wexford including,

[8] John Howard Association of Illinois, 2015 Monitoring Report Pontiac Correctional Center, attached as Exhibit 8, at 23.

[redacted].[9] In reality, there is no effective contract quality control: "This investigative team," wrote the Experts, "has been extremely disappointed in the performance of the vendor and the facility programs with regard to both professional performance review, mortality reviews and the entire quality improvement program." Dkt. 339 at 9. The same lack of oversight bedevils the provision of dental care. *Id.* at 39.

33. Defendants exercise only the most minimal oversight of how Wexford discharges its duties under the contract. Exhibit IV to the contract sets [redacted]. Exh. 9, Exhibit IV. [redacted].

34. [redacted] (IDOC Update 1683-84) attached as Exhibit 11. [redacted].

[9] May 2011 Contract, attached as Exhibit 9; *see, e.g.*, §§ 2.2.2 – 2.2.7; Exhibit I (Schedule Es), and Exhibit IV (Performance Targets); and August 2013 Contract Amendment, attached as Exhibit 10, § 2.4 and attachment (New Schedule Es).

***Lack of properly qualified doctors coupled with inadequate and conflict-ridden peer review processes*:**

35. Lack of adequate oversight at both the facility and central office level is even more problematic because the practitioners are often incompetent. The Expert Report states bluntly: "clinician quality is highly variable across the institutions we visited and across medical records we reviewed. . . .For example, none of the three physicians at one institution we visited had any formal training in a primary care field, [and] we came across several examples of avoidable harm to patients resulting from inappropriate management of common primary care conditions." Dkt. 339 at 6. "When asked, Dr. Brown indicated that she does not routinely take blood pressures on patients with a history of hypertension." *Id.* at 120. "Universally we were informed by both State employed staff as well as some vendor employed staff that there were significant problems with the vendor employed regional medical directors." *Id.* at 9.

36. The Expert Report is filled with examples of physician incompetence leading to harm.

37. In one case, a 56-year-old man at Centralia Correctional Center had reported blood in his urine in July 2012. Dkt. 339 at 393. The doctor "diagnosed a [urinary tract infection] and treated him with an antibiotic. . . . His weight at this visit was 173#, down from 185# four months earlier. The weight loss was not commented upon. . . . One week later, the urine still showed blood and the doctor continued the antibiotic. . . .*These are Type 1 lapses in care; a 56-year-old man with painless hematuria and weight loss has urological cancer until proven otherwise*." *Id.* at 393-94 (emphasis added). The prisoner, who had repeatedly come to sick call from October 2012 to February 2013 complaining of testicular pain, was finally diagnosed with metastatic renal cancer in March, when the cancer was no longer "amenable to treatment." He died three weeks later. *Id.* at 394.

38. In another case, a 54-year-old man at Stateville Correctional Center complained of chest pain in hypertension clinic in May 2013; the physician referred him to the facility medical director, who in June referred the patient to cardiology – but the appointment was not scheduled until *December*. Dkt. 339 at 59-60. In the interim, the patient was seen for other health care issues and in chronic care clinic, where "[the doctor] also ordered naproxen 500 mg twice a day routinely for six months, which is [] contraindicated in patients with coronary artery disease." *Id.* at 60. When he finally had his cardiology appointment in December, he was admitted to the hospital and had triple bypass surgery. *Id.* In summary, the Expert Team wrote: "This patient presented with chest pain that seemed clearly anginal in nature . . .. The first doctor did nothing to work this up aside from refer the patient to her colleague, who is no more adept than she is. The Medical Director also took a very casual approach to the problem, evidently tolerating a six-month delay in specialty care for this potentially life-threatening problem." *Id.*

39. The problem of provider incompetence is compounded by a provider performance review process which ranges from weak and conflicted to, for dental, non-existent.

40. [redacted] For the doctors, Wexford is left to monitor itself: the physician peer review process consists of Wexford doctors reviewing other Wexford doctors. There is a "conflict of interest," as the Expert Report states, "inherent in corporate employed physicians reviewing the work of corporate employed physicians. A decision of termination becomes an expense for the corporation." Dkt. 339 at 9. For the dentists, there is no performance review process at all: "There is no peer review process in place within the IDOC dental program." *Id.* at 40.

41. [redacted]

[redacted] (Excerpts from Louis Shicker deposition transcript, at 126:12-127:19), attached as Exhibit 12.

***A non-functional continuous quality improvement program:***

42. The continuous quality improvement program "is the program that is the basis by which health organizations, whether they be in the community or in correctional facilities, measure and identify [] quality, process and professional performance . . .." Dkt. 339 at 43. "[T]he quality improvement program of any and all health care organizations" is "central." *Id.* at 9.

43. Even where significant deficiencies relating to the provision of healthcare have been identified, Defendants fail to act in response to these identified systemic failures in the medical care delivery. "A well-run quality improvement program looks at or reviews every major service provided at least annually," the Expert Team wrote. "We were unable to find, in *any* of the eight institutions we reviewed, documentation of such measurement." "In *none* of the eight sets of minutes that we reviewed did we find *anything remotely related to efforts to improve the quality* of the program." "Most dental programs had no studies, assessments or subsequent improvements in place." Dkt. 339 at 39, 43-44 (emphasis added). In short, there is no "improvement" in "continuous quality improvement."

[redacted] What the Expert Team reported is confirmed by [redacted] (Excerpts from the Amber Allen deposition transcript, at 24:12-26:13), attached as Exhibit 13. [redacted]

(Excerpts from the Nicolette Duffield deposition transcript, at 116:4-117:8), attached as Exhibit 14 (emphasis added).

***Intake programs crippled by long delays, and unable to identify even routine medical or dental problems*:**

45. The problems with IDOC medical and dental care begin at the front door, at the intake centers, where delays in processing prisoners, shoddy record-keeping, and inadequate screening endanger prisoners with healthcare needs. At the major male intake center, Northern Reception Center (NRC), "there are substantial delays," the Expert Team found, "in medically processing patients through the reception process. In some instances, these delays extend for *more than a month.*" "[M]edical records are dysfunctional," and "the forms being used do not

elicit questions regarding current symptoms *as is standard in most systems.*" Dkt. 339 at 13 (emphasis added).

46. Chronic care is neglected: "We looked at a random sample of 10 charts of patients who were detained at [NRC] for *more than 60 days*. Five of the 10 patients had chronic health issues, yet *none had been enrolled in the chronic care program or had his chronic disease intake evaluation* . . .." Dkt. 339 at 99 (emphasis added).

47. Dental screening fails as well: "[E]gregious deficiencies were observed at the NRC during the [dental] screening exam. . . ." Dkt. 339 at 38 (emphasis added).

48. There is still no dedicated Health Care Unit Administrator at Northern Reception Center, despite the Expert Team's urging that a site as important as NRC – through which some 85-90% of prisoners entering IDOC are processed – requires its own dedicated leadership team. (The Stateville Correctional Center HCUA also covers NRC – which requires her getting into her car and driving over there when she needs to be on site.)

49. These recurring failures increase the likelihood of, among other things, missed diagnoses and deteriorating disease control. The Expert Report details the case of a 23-year-old type 1 diabetic who arrived at NRC in August 2012 with an A1c of 5.2%, which steadily rose to 11.4% by August of 2013. However, "[h]is insulin orders have remained almost unchanged for the entire length of his stay despite the dramatic decline in his disease control." Dkt. 339 at 104. At Logan Correctional Center, a woman arrived "with asthma. There was no adequate history. This patient was referred to the chronic clinic but the chronic clinic has never occurred." *Id.* at 215.

***Breakdowns in intrasystem transfer processes*:**

50. After intake at NRC, prisoners are transferred (though sometimes not for months) to permanent facilities, and Defendants frequently transfer prisoners between facilities thereafter. Defendants' intrasystem transfer processes also endanger prisoners with healthcare needs.

51. The Expert Report points to widespread lack of compliance with procedures which (theoretically) are designed to ensure continuity of healthcare services when prisoners are transferred. The problems were worst at the "special medical mission" facility, Dixon Correctional Center, where "the process [was] broken": "virtually every intrasystem transfer record we reviewed was significantly flawed." Dkt. 339 at 15.

52. Examples of problems abound in the Report. A 51-year-old man with end stage renal disease, who arrived at Stateville Correctional Center on October 9, 2013, had not yet been seen by a facility doctor when the Expert Team visited in February 2014. Dkt. 339 at 65. "He was seen by ID telemedicine on 12/18," the Report notes, "and the provider requested labs, but it does not appear that these were ordered. In fact, there were no labs in the chart since the patient arrived at Stateville." *Id.* At Pontiac Correctional Center, a 43-year-old arrived in February 2014 with hepatitis C and thrombocytopenia, but his transfer summary did not include hepatitis C. *Id.* at 181.

53. [redacted]

[redacted]

***A sick call system unable to provide reliable access to healthcare services*:**

54. Sick call is the point of access to routine medical care in IDOC, and it is broken system-wide. Unless a prisoner has a chronic condition and is enrolled in a "chronic clinic," access to a physician, a physician assistant, a test or an outside specialist, ordinarily occurs through sick call. Nonetheless, prisoners are required to make a $5 "copay" to access sick call. In some facilities, a practice persists of only permitting one issue, or only the "top three" issues, to be addressed at one sick call visit, no matter how many problems the prisoner has.

55. As with virtually every other element of IDOC healthcare they reviewed, the Expert Team found that sick call was systemically dysfunctional: "Nursing sick call ranges from problematic to significantly broken throughout the system." Of particular concern was the universal practice of permitting LPNs or "Correctional Medical Technicians" to conduct sick call: "At every facility, a sick call process has been established which allows for non-registered nurses to conduct sick call . . . . [T]here is no efficient way for RNs to supervise this process," which meant that there was no way to ensure that an appropriate diagnostic assessment had been performed. Dkt. 339 at 16-17. This practice is also, in the Expert Team's view, a violation of the Illinois Nurse Practice Act, 225 ILCS 65/50-1 *et seq*. *Id.* at 17.

56. Sick call requests are required to be reviewed by health care staff within 24 hours of receipt. A nursing evaluation is required to take place within 3 days. When an inmate is referred to a physician, the physician's evaluation is required to occur within 72 hours.

57. Historically, these time frames have been widely disregarded. [redacted]

58. Sick call for the thousands of prisoners throughout IDOC who are confined in segregation units was particularly problematic, in the Expert Team's view. "[A]t many of the facilities," they wrote, "particularly in the segregation unit, legitimate sick call is not being conducted but in its place a 'face-to-face' triage where the RN, LPN or Correction Medical Technician talks to the patient through a solid steel door . . . [W]ith no collection of objective data such as vital signs or a physical examination [t]his does not meet the definition of a professional assessment . . . . .[T]his increases the potential for harm to the patients." Dkt. 339 at 17.

59. Even where Defendants are attempting to improve segregation sick call, their other systemic inadequacies hamper reform. [redacted]

***Out of date, thoughtless, risky management of chronic diseases*:**

60. Although prisoners suffer from higher rates of chronic diseases than the general population, Defendants' management of chronic conditions is dangerously rigid, thoughtless, and out-of-date. The Expert Report identified a host of problems with chronic disease management in Defendants' prisons. "With regard to policy," the Report states, "the most important and overarching problem is a 'cookie cutter' approach to chronic disease management [which] dictates that all patients are. . .arbitrarily seen only three times a year regardless of how well or

poorly" their disease is controlled. This "only makes sense (and is safe) if patients' diseases are in good control. If not, then patients are exposed to the cumulative organ damage caused by inadequately controlled chronic disease." Dkt. 339 at 19.

61. The result, the Expert Team found, was a careless and risky approach to managing life-threatening conditions: "At every facility we visited, we encountered cases of patients with poorly controlled chronic disease going month without any active management of their disease process." "[W]e noted multiple instances in which patients experienced medication discontinuity for a variety of reasons, yet this went unrecognized and [] unaddressed . . .." Dkt. 339 at 19, 23.

62. Defendants' policies and protocols for specific diseases also put prisoners at needless risk. "[T]here is no IDOC Treatment Guideline for HIV, there is only the Wexford Health HIV AIDS infection Control Policy, which does not require that facility providers follow the HIV patients . . .. [T]hese patients were managed solely . . . via telemedicine . . .." Dkt. 339 at 19-20. "The HIV virus readily develops resistance mutations when medications are not taken exactly as prescribed. . . . We encountered numerous examples of patients going for days, weeks or months without their medications . . . and these treatment interruptions went unnoticed by the local providers." *Id.* at 20.

63. Unsurprisingly, these thoughtless, antiquated policies are manifested in harm to patients. At Stateville CC, a 55-year-old man with advanced HIV, on "deep salvage" therapy, reported in August that he had been getting only half his dose of prescribed medication; "[a]t the follow-up visit in *December* (one month overdue), this issue was not addressed." *Id.* at 65. "Considering that the patient's treatment options are very limited at this point," the Expert Team

wrote, "this magnitude of this error was particularly great." *Id.* (As of October 7, 2015, this prisoner was on "medical furlough" from Stateville.)

64. "With regard to the management of pulmonary disease," the Expert Report states, "the treatment guideline is seriously deficient, in that it only addresses the treatment of asthma and not of other obstructive lung diseases such as COPD and chronic bronchitis, which are common and important causes of morbidity and mortality in the U.S., and the treatment of which differs in important ways from the treatment of asthma." Dkt. 339 at 20. With respect to diabetes, there were fundamental failures to acknowledge the difference between Type 1 and Type 2 diabetes, or the need for individualized approaches to management of insulin regimes. *Id.* at 21. These treatment policy gaps are worse given the lack of appropriate medical training the Expert Team noted for many facility providers.

***Mismanagement and dangerous delays in scheduled offsite services*:**

65. Prisoners may need medical treatment a prison healthcare unit cannot provide, but in Illinois, access can be endlessly delayed or flat-out denied [redacted].

66. For offsite services, the Expert Team catalogued a litany of problems: "During our review of records, we found *breakdowns in almost every area*, starting with delays in identification of the need for the offsite services, delays in obtaining an authorization number, delays in being able to schedule an appointment timely, delays in obtaining offsite paperwork, and delays or the absence of any follow-up visit with the patient." Dkt. 339 at 29; (emphasis added).

[redacted]

[redacted]

[redacted]

72. [redacted] (Facility monthly primary medical service reports at 162 and 202), attached as Exhibit 16.

***Mismanagement of emergency onsite and offsite services*:**

73. The contractual and policy guidelines governing the provision of medical care to Illinois prisoners call for timely emergency treatment. However, the systematic mismanagement of medical emergencies is yet another of the many ways that Defendants' policies and practices put sick prisoners at unreasonable risk. When prisoners are sent out for emergency treatment, facilities make little effort to ensure that they have the records that enable them to care for the

patient when he or she returns. "A majority of the records we reviewed contained neither an emergency room report nor, when patients were hospitalized, a discharge summary, despite the fact that these documents are crucial for continuity of care." Dkt. 339 at 27.

74. The [redacted] to deny outside care also means delays or denials of emergency outside care. Reluctance to send prisoners out for emergency treatment despite obvious need was manifest in cases described by the Expert Team. In one instance, a patient with post-biopsy fever and an elevated pulse was kept in the prison infirmary for four days before he was sent to the emergency room. There, he was diagnosed with sepsis. "This patient complaining of fevers and tachycardia should have been sent out immediately." In another case, a patient with symptoms consistent with "acute blood loss" was placed in the infirmary and not sent to the hospital for over 36 hours; he died there two days later. "When you identify a patient who has acute ongoing blood loss, *to not send him out is incomprehensible*." Dkt. 339 at 25-26; (emphasis added).

***Poorly equipped prison infirmaries often housing patients who should have been sent to hospitals*:**

75. The problem of delaying or denying outside care is exacerbated by the conditions in the prison infirmaries themselves. They are dangerous. The infirmary beds may be in solid door cells with only a small window and no sight line to a nurses' station or anyone watching. Despite this, some infirmaries have no call system in place. "In the [Menard] infirmary," the Expert Team found, "patients are padlocked in their rooms and life/safety issues are a concern. . . . [T]here is no nurse call system." Dkt. 339 at 353. The Pontiac Correctional Center infirmary is dirty and beset by cockroaches and spiders. [redacted]

[redacted] At Big Muddy River Correctional Center, the prisoners call the care given in the infirmary not health care but "death care."

76. Many infirmary patients should not be in there at all. "We encountered numerous examples of patients who were admitted to the infirmary with potentially or actually unstable conditions which should have been referred to a higher level of care (i.e., outside hospital)," the Expert Report states. "In several instances, this resulted in actual harm to the patients." Dkt. 339 at 32.

77. Among the examples were a patient at Illinois River Correctional Center who had rapidly progressing paralysis, but was kept in the infirmary for two weeks despite his requests to be sent to a hospital. When he finally was transferred to a hospital ER, he was diagnosed with leukemia of the spine "and is now permanently wheelchair bound." Dkt. 339 at 32-33.

***Complete absence of any steps needed to provide routine dental care*:**

78. Routine dental care in IDOC facilities is functionally non-existent.

79. "[R]ecords at each institution," concluded the Expert Report, "revealed that routine care was almost always provided without a comprehensive examination, a treatment plan, a documented periodontal assessment, a documented soft tissue examination, and without [diagnostic imaging]. . . .As such, there is no real system in place to provide routine [dental care]." Dkt. 339 at 38.

***Staggering delays in access to dental care*:**

80. The lack of routine dental care is coupled with painful, sometimes almost unbelievable delays in access to dental procedures. The Wexford contract requires that "Vendor shall respond to dental emergencies within 24 hours," "evaluations must be provided within 14 days after the offender's request for routine care treatment" and "[u]rgent-painful cavities . . .

must be treated within three (3) business days," but these time frames are constantly disregarded [redacted].

81. "The lag time between an Inmate Request Form for pain and alleviation of the pain was unacceptable," observed the Expert Report. "It often took *four or more days* for urgent care patients to be seen. . . ." Dkt. 339, p. 38 (emphasis added).

[redacted] Egregious delays have been and remain the norm. [redacted]

83. [redacted]

[redacted] Exh. 16, *passim*.

***Disorganized, illegible, gap-riddled medical records*:**

84. Failure to maintain organized medical records endangers lives. Defendants' slap-shot, antiquated record-keeping, relying on ill-maintained paper files with unintelligible notes, creates such dangers every day. Failure to maintain complete records disables a prison's ability to monitor the care it provides, and physicians and other healthcare staff cannot provide appropriate treatment when basing their decisions on incomplete medical records.

85. For instance, when medications are not charted on a medication administration record (MAR), there is a great risk that those who rely on the MAR will not be able to catch failures and then administer medications appropriately. There is also the possibility that inmates will receive medications again, in error, if nurses do not chart the first administration. This risk is compounded by the further risk that prisoners whose medications are not charted will receive multiple medications that will cause adverse drug interactions and put them at risk of severe health complications.

86. The Expert Team noted widespread deficiencies in medical records in Defendants' facilities. Information was missing, was misfiled or never filed, records were difficult or impossible to decipher, or records were not maintained at all: "The quality of the medical records was poor at most of the facilities we visited. . . . In many instances, important

information was missing from the health records." "[At] NRC, nothing was properly filed no matter how long the patients were housed there." "In nearly all facilities, the handwriting of one or more providers was so illegible that it rendered the notes useless." "[O]ur review was seriously hampered by the lack of organized record keeping at [NRC]. Logs were either not reliably filled out, or not kept at all. It was impossible to discover the average age or length of stay of the population. Sick call slips were not filed in the records, nor were they routinely kept in any other location. . . ." "The medical health history section of the dental record was sketchy [and c]onditions that require medical attention were not red flagged.. . ." Dkt. 339 at 15-16, 39, 92.

87. Among the cases the Expert Report cites is that of a 70-year-old man at Stateville Correctional Center "who had a GU appointment scheduled for 11/6/13. This was to follow up on prostate cancer, *which did not appear on his problem list*; the list did include glaucoma. The report indicates that the patient needs a CT scan *and a bone scan*. There is *no physician follow up note* but there is a nurse note which indicates the patient *went for the CT scan, but there is no report from the CT scan nor are there any follow up notes by a physician.*" Dkt. 339 at 71 (emphasis added).

88. Like every problem here, this is not new. In the past, throughout their internal reports, [redacted]

[redacted] (Allen excerpts at 119:13-120:12), Exh. 13. [redacted]

89. Defendants have been planning for years to transition to an electronic medical record system, but have failed to do so. [redacted]

***Broken-down equipment, inadequate examination spaces, and widespread lapses in sanitation:***

90. Defendants' facilities are crippled by old, broken-down equipment or complete lack of equipment, insufficient space for healthcare examinations, and gross lapses in basic sanitation.

91. The Expert Team noted obvious problems of all kinds at virtually every facility they visited. "There were examples at each facility of either no identified clinic space to poorly equipped clinic space that provides no patient privacy . . .." Dkt. 339 at 17. At Pontiac Correctional Center, the "exam rooms" in each cell house are "mostly converted bathrooms and storage rooms [with] old and dilapidated equipment . . .." *Id.* at 175. At Menard, "the South Lower cell house sick call room had no sink for hand washing." "Much of the [dental] equipment was old, corroded, and badly worn. . . . Non-functional equipment was not out of the norm." *Id.* at 39, 334. Equipment issued to prisoners who need it, such as wheelchairs, can be equally broken and dysfunctional.

92. The problems of aging equipment are compounded by repeated lapses in sanitary procedures. "In regard to sanitation," states the Expert Report, "there are issues across the

system. . . . [E]xamination tables and stools, infirmary mattresses and stretchers [had] cracked and torn impervious outer coatings which do not allow for the items to be properly cleaned . . . In each instance, there had been no work order submitted to repair the item and no request submitted for purchase of new items." Further, "[Many] facilities are not using a paper barrier . . . on the examination tables, nor was there evidence of wiping down the examination table with a sanitizing liquid/spray between patients . . . ."; "Across all sites, infirmary linens were not been appropriately laundered and sanitized . . .." Dkt. 339 at 35, 37.

93. These deficiencies afflict not just medical procedure areas but dental as well: at the NRC intake dental exam, the Report notes, "[a]rea disinfection and clinician hygiene between patients was very poor. . ."; "[Dental area c]abinetry and countertops were usually badly worn, corroded or rusted, broken and not up to contemporary standards for disinfection"; "In several institutions, proper [dental] sterilization flow was not in place." Dkt. 339 at 11-12, 35, 39-40.

***No reliable system for infection control oversight*:**

94. Defendants' disregard for the health of the prisoners in their charge is compounded by the failure to establish – in their perilously overcrowded facilities – any reliable system of infection control oversight. "Infection control," the Expert Team concluded, "is a moving target across the system . . . ." "There is *not . . . any IDOC oversight and management of a system-wide infection control program*." Dkt. 339 at 35-36 (emphasis added).

***A mortality review process so flawed that there were serious deviations from the standard of care in 60% of inmate deaths reviewed by the Expert Team, almost all of which (89%) had multiple serious lapses*:**

95. The Expert Report catalogues, at each facility reviewed and in a separate appendix of system-wide deaths, dozens upon dozens of deaths of prisoners caused or hastened by the systemic deficiencies in Defendants' provision of healthcare.

96. The following case is illustrative: at Menard, "a 63-year-old man . . . died on 2/11/14 of complications following several cardiac arrests. . . . He was found to have hypertension in 2011, but blood pressure checks were discontinued by the MD . . . . He was not started on medication." When he "presented with chest pain, shortness of breath, and hypertension" in September 2013, [h]e was given a dose of clonidine and placed in the infirmary . . . No ECG was ordered. In fact, no other work-up or treatment was ordered." In January 2014, he again presented with shortness of breath and chest pain; he was treated with antibiotics. After admission to the infirmary, he was finally sent to a hospital ER, where he "was admitted with [congestive heart failure] and subsequently suffered several cardiac arrests and ultimately died." "It is not appropriate to treat a hypertensive urgency in a prison infirmary," the Expert Report states. "[T]he patient should have been sent to the outside [hospital] back in September when he initially presented with these symptoms. It is likely that his cardiac condition would have been recognized then . . . thereby substantially reducing his risk of death." Dkt. 339 at 364-65.

97. The Expert Team reviewed 52% of the non-violent deaths in IDOC from January 1, 2013 to June 1, 2014, plus 2 additional deaths from 2010. They applied an analytic taxonomy developed in *Plata v. Brown*, which sets out 14 different categories of "lapses in care": a lapse of care is when "a clinician has committed a *significant departure from the standard of care* that a reasonable and *competent clinician would not have committed* under the same or similar

circumstances. These categories include "failure to recognize "clinical 'red flags'"; "failure to identify and appropriately react to abnormal test results"; "[p]racticing outside the scope of one's professional capacity"; "[d]elay or failure in emergency response." Dkt. 339 at 42, 376, 402.

98. The Expert Team found "one or more significant lapses in care in 60% of the cases. "This is an unacceptably high rate of deviations from the standard of care." Further, of the cases with "significant lapses," 89% "had more than 1 lapses." Dkt. 339 at 376.

99. The Expert Report's mortality findings are notable not just for the record of pain and incompetence they detail, but also for the shoddiness and indifference of the procedure used by Defendants to review deaths, which in most cases permitted Wexford doctors to review the deaths that had occurred on their own watch, without any oversight by Defendants. In most of these cases, this system had failed to identify any problems at all. Dkt 339 at 42-43.

***No hospice or end-of-life palliative care*:**

100. Defendants claim that they provide "hospice" or end-of-life care. It is certainly true that many prisoners die in the facilities where they were incarcerated. [redacted] *See* 210 ILCS 60/1 *et seq*. Nor do they actually provide end-of-life care for those who are dying.

101. "[T]here are *no resources in place to assist health care staff in the care of patients who are dying* or in the management of common end of life symptoms," the Expert Team wrote. "It was obvious that once patients signed DNR (do not resuscitate) orders, they were often no longer treated for even simple reversible illness . . .. Even though DNR is an instruction not to

use CPR under circumstances when it is known to be futile, often simple treatment with antibiotics or hydration or suctioning can be effective and diminish suffering." Dkt. 339 at 43 (emphasis added). The Report adds, sadly, "There should be a specific guideline or policy language that describes hospice or comfort care for terminally ill patients, and clarify that 'do not resuscitate' does not mean, 'Do not treat.'" *Id.*

**Defendants Have Knowledge of These Systemic Deficiencies**

102. Defendants are well aware of these longstanding, systemic problems in the delivery of healthcare across all Illinois penal institutions. Despite the fact that Defendants know of the systemic failures in their healthcare-delivery system, they have chosen to disregard these problems and the risks they pose to prisoners.

103. Even before the Expert Team reviewed IDOC's health care system and concluded that "[T]he State of Illinois has been unable to meet minimal constitutional standards with regards to the adequacy of its health care program for the population it serves," in a 2012 report, JHA concluded that "there is insufficient external oversight of IDOC healthcare services, particularly with respect to services provided under contract by the private vendor, Wexford . . . While administrators in individual IDOC facilities are charged with performing quality improvement reviews and monitoring the delivery of healthcare services, they do not have the resources to perform comprehensive quality control monitoring and financial auditing of services under the Contract. The Office of the Illinois Auditor General, the entity that typically performs such comprehensive public financial audits, does not audit the Wexford contract." Exh. 5 at 6.

104. Despite Defendants' knowledge of these systemic deficiencies, these problems remain uncorrected.

105. On those occasions where Defendants have identified serious deficiencies in the delivery of healthcare to prisoners, the policies and practices employed by Defendants to correct the deficiencies are materially inadequate. These longstanding systemic deficiencies, which violate administrative and institutional directives [redacted], have not been corrected.

106. Despite having actual knowledge of these deficiencies and the serious risks they pose, Defendants have been deliberately indifferent to the inhumane conditions to which the inmates are exposed and have failed to make reasonable efforts to remedy those conditions.

107. Defendants' failure to correct these deficiencies ensures that needed treatment of prisoners throughout Illinois' prisons is inevitably delayed for months, and often for years, even in the most severe cases. As a result of Defendants' policies and practices described above, prisoners throughout Illinois have not received adequate or timely treatment for their medical or dental conditions, their conditions have deteriorated, and they have otherwise been subjected to wholly unnecessary pain and suffering, with no penological justification, in violation of the Eighth Amendment to the Constitution of the United States.

108. Defendants' longstanding, deliberate indifference to prisoners' healthcare needs endangers a large population in Illinois' prisons. Plaintiffs therefore seek to represent a class of all prisoners in the custody of the Illinois Department of Corrections with serious medical or dental needs.

**Named Plaintiffs**

109. The named Plaintiffs do not seek damages; they seek only declaratory and injunctive relief.

***Plaintiff Donald Lippert*:**

110. Plaintiff Donald Lippert ("Lippert") is a prisoner at Stateville Correctional Center. He was first incarcerated on or around February 29, 1996, and remains in custody to this day. Lippert was diagnosed with Type I Diabetes prior to his incarceration for which he requires twice-daily insulin to regulate his blood sugar. Although Lippert needs, and was prescribed, a medical diet for his diabetes in order to regulate his glucose levels, he has never received said diet. Over the years, Lippert has experienced multiple interruptions in care, including delays in receiving his insulin shots and failures to consistently check his blood sugar levels.

111. The correctional officers and medical staff at Stateville know that Lippert is an insulin-dependent diabetic. His medical directive requires that he take daily insulin with his meals and that he receive consistent Accu-check tests to monitor his blood sugar levels.

112. Lippert has consistently struggled to receive adequate medical treatment for his diabetes.

113. For example, beginning at or around 8:00 a.m. on May 1, 2010, Lippert began asking officers at Stateville Correctional Center on the 7:00 a.m. to 3:00 p.m. shift for his regular insulin shot. The officers ignored his pleas for medical help and he received laughs in return.

114. Not until approximately three hours later did Lippert receive an emergency shot of insulin from the Health Care Unit. His Accu-check results revealed a blood sugar level of 450 and the medical record noted he was hyperglycemic. Later that same evening, at around 9:00 p.m., Lippert was again denied his regular insulin shot and experienced another hyperglycemic episode.

115. Lippert has filed multiple grievances with Stateville Correctional Center to address the lack of attendant medical care for his diabetes. Lippert continues to receive inconsistent and unreliable medical care with respect to treatment of his Type I diabetes.

116. For example, on or around May 15, 2014, Lippert suffered another hyperglycemic episode after he was refused his required insulin shot, where he complained of weakness and dizziness.

***Plaintiff Milam Martin*:**

117. Plaintiff Milam Martin ("Martin") is a prisoner at Big Muddy River Correctional Center. Martin was first incarcerated in IDOC on or around March 25, 1983 and remains in custody to this day. Martin, who is now 59 years old, is partly paralyzed and confined to a wheelchair due to an injury he received while in prison. In fall 2011, the wheelchair Martin had been issued at Big Muddy was misassembled and dangerous; Martin repeatedly told healthcare staff that the chair would tilt and he was slipping through the gap in the back. A new wheelchair for Martin had been approved in spring 2011, but Big Muddy healthcare staff never got Martin the new wheelchair. On October 27, 2011, his defective wheelchair toppled over and Martin fell from it, hitting his head and suffering injuries to his right leg, knee and ribs. After the fall, Martin was finally given a new wheelchair, but he had continuing pain in his neck, back, knee, and especially his ribs. When he complained about the pain in his ribs to healthcare staff, he was told that the ribs would "heal themselves" and given Motrin. After complaining for two months about his rib injuries, Martin was finally sent out to a local hospital in Mount Vernon for a CT scan. The scan showed broken ribs. The response of Big Muddy healthcare staff was to claim that the CT scanning machine was broken and schedule him for another scan. Healthcare staff did not provide any wrap, medication or special mattress for the broken ribs.

118. Martin also believes he tore something in his knee during the October 27, 2011 fall, but no testing was ever performed to determine if this was true, despite his complaints to healthcare staff of pain in the knee and difficulty in standing.

119. Among the earlier injuries Martin received in prison was a broken jaw. At one time, he had a plastic molded brace to stabilize the jaw, but this was lost during one of Martin's transfers between prisons. He has repeatedly asked the dentist at Big Muddy for a replacement brace; without it, his jaw slips, especially when lying down, and it is very painful. But the dentist has not provided him with another brace, leaving Martin to try to stabilize his jaw himself by stuffing tissue in his mouth.

120. In May 2015, Martin came down with the flu. He had a fever of 103 and chills. Healthcare staff placed him in an isolation room in the infirmary at Big Muddy, with water and Tylenol, and left him alone in the room which has a solid door and no way to call for help. Defendants' records reflect that even during the first few days, when Martin was sickest, it could be six or more hours between the times when healthcare personnel checked on him in his locked cell. The room lacked any bars to help him stand up or move around. Martin could not eat the food he was given, but healthcare staff refused to give him a liquid diet. Martin was in the infirmary for almost six stressful days.

***Plaintiff Lewis Rice*:**

121. Plaintiff Lewis Rice ("Rice") is a prisoner at Menard Correctional Center. He has been incarcerated at Menard since on or around February 5, 2010. In or around July 2010, Rice started having chest pain and headaches. Around noon on July 27, 2010, prison staff were conducting a shakedown and Rice and others in the cell block were taken to the prison chapel. Rice developed a very severe headache accompanied by tightness and severe pain in his chest.

Rice told correctional staff several times that he was not feeling well. Ultimately he passed out. He woke up in the prison infirmary, where he was given Tylenol with a tiny amount of water which a nurse told him was for his back. Rice tried to tell the medical staff that the problem was not his back, because he had chest pain, and that he often had chest pains, dizziness, and headaches. Nevertheless, he was sent back to his cell house after only 5-10 minutes. Rice still had chest pains, and complained to correctional staff that he was still having chest pains, but they paid no attention. Shortly after returning to his cell, he collapsed again. When he woke up, he was again in the infirmary, where he was examined by Dr. Fahim, the medical director, and admitted to the infirmary for observation. He stayed in the infirmary for about four days, but then was released back to his cell again. Barely a week later, Rice passed out again waiting in a holding cell to be seen in health care for a checkup. Again, he was admitted to the infirmary. Ultimately, healthcare staff decided that Rice's problems were caused by a medication called Prazosin, which had been prescribed for Rice by the Menard psychiatrist who said it was a "dream suppressant." Rice was taken off Prazosin, but continues to this day to have headaches and chest pains, sometimes accompanied by chills. The headaches are frequent; the chest pains occur approximately every six months. In the past few years at Menard, when Rice has told doctors or nurses that he has chest pains, they have said it was "nothing," or told him to lie down and "breathe deep," or said that it was "probably just gas," or said nothing at all.

122. ECGs performed on Rice both before he was prescribed Prazosin and after he was taken off of it show cardiac abnormalities. One doctor at Menard told Rice that he needed a pacemaker; another doctor contradicted this. Rice has never been referred to a cardiologist or received a pacemaker. The only medication he has been prescribed for chest pains is aspirin, but he was taken off even that, though he is trying to persuade healthcare staff to put him back on it.

123. Rice has also been told that he has a separated bone in my shoulder, due to a past car accident. Rice gets a "double cuff" permit every year now as a result, which has to be approved by a doctor. On one occasion, when he saw doctor to renew the permit, the doctor told Rice that he needed surgery on the shoulder. Another Menard doctor told Rice the same. As it is, Rice is given Tylenol for the pain, and that is all. Rice cannot sleep on his right side because of the pain from his shoulder. Any lifting also causes Rice pain. This has been going on for ten years. Rice is not in any chronic clinic at Menard for his chest pains, headaches, or shoulder pain. Rice worries about his medical condition, and would like to know if something is wrong with his heart. He files regular grievances about his medical problems. He is told by the counsellors that "they're on top of it," but he does not get a response.

***Plaintiff Debra Pattison*:**

124. Plaintiff Debra Pattison ("Pattison") is a prisoner at Logan Correctional Center. She has been incarcerated in IDOC since on or about June 2006. Pattison suffers from severe degenerative arthrosis of her left knee which has left her in constant pain and almost entirely dependent upon a wheelchair to get around.

125. In or around June 2012, then incarcerated at Lincoln Correctional Center, Pattison stood up from a seated position and felt something tear in her left knee. She experienced immediate and severe left knee pain which prevented her from being able to move with ease or stability.

126. Three months later, in or around September 2012, Pattison received an MRI of her knee at an off-site hospital. The MRI revealed that Pattison had a complete anterior cruciate ligament ("ACL") tear, a partial posterior cruciate ligament ("PCL") tear, and other ligament damage. The following month, in or around October 2012, Pattison was evaluated by an off-site

orthopedic surgeon who confirmed her condition and stated that she needed a total knee replacement. Without this surgery, the doctor informed Pattison that she could lose total use of her leg. Although the surgeon wanted to perform the procedure immediately, he was unable to do so without authorization from Wexford. A request for this procedure in 2012, however, was denied by Wexford's collegial review.

127. Pattison returned to Lincoln CC where she lived full time in the health care unit. She experienced frequent pain, swelling, and inflammation around her knee, without any further treatment. In or around March 2013 Pattison was transferred to Logan CC. She was eventually moved into an ADA-accessible unit, and was given access to a wheelchair, which aided her mobility. However, she continued to experience knee pain and swelling, as well as numbness and tingling throughout her left leg.

128. In or around May 2013, Pattison's case was once again presented by IDOC to Wexford's collegial review. Wexford again denied this procedure. Pattison was then told she needed to lose 10 pounds before Wexford would consider approving the knee surgery. Over the next several months, Pattison lost a total of 28 pounds, and generally maintained this weight loss for two years in hopes of securing approval for this much needed operation.

129. The Expert Team visited Logan CC between March 31 and April 3, 2014. Pattison's records were reviewed by the Expert Team and discussed in the Logan CC report:

> This is a 50-year-old with severe degenerative arthrosis of her knee and claims to need a knee replacement. Chart review confirms that total knee arthroplasty had been recommended by an orthopedic surgeon prior to her arrival at Logan; however, the request was denied by collegial review after her arrival at this institution. Upon reviewing her chart, *it is abundantly clear that this patient does in fact require a knee replacement. Physical therapy will not help her*. This case was discussed with staff, who report that they will present the case to collegial review again and are prepared to appeal if it is denied.

(Dkt. 336 [Logan p. 28, Patient #4] (emphasis added)).

Following the Expert Team's visit, Pattison's case was again presented to Wexford collegial review in or around May 2014, and was once again denied, with a suggestion that Pattison lose even more weight (she weighed 204 pounds at the time of this denial, down from 228 in early 2013). However, it wasn't until after *another* Wexford collegial review denial in 2015 that Pattison was told she needed to get her weight down to 180 pounds before she would be considered for surgery. It has been three and a half years since Pattison's initial injury, yet she still has not received this critical procedure.

130. This lengthy delay in securing relief has resulted in the steady deterioration of Pattison's knee. In or around July 2014, two years after her initial injury, Pattison received an x-ray of her knee. The x-ray, she was told, revealed that her knee bones were twisted and the cartilage between the bones had been completely worn down. Pattison received a second x-ray of her knee over a year later in October 2015, which she was told revealed even further damage since the first x-ray.

131. Despite her knee deterioration, Pattison's wheelchair access has twice been interrupted. Pattison received a wheelchair at Logan in or around May 2013, which was then taken away in October 2013, supposedly to encourage weight loss. After experiencing heightened hip and leg pain in connection with her injury in or around June 2014, Pattison was again allowed access to a wheelchair. However, this wheelchair was taken away one again without explanation in October 2015, around the same time her second x-ray revealed even greater knee deterioration. Although Pattison has access to a walker on her living unit, and at times has had access to crutches, she has been unable to regularly and safely move about the facility without assistance from staff or other inmates. Having to do so without the use of a wheelchair only exacerbates her pain.

132. The only treatment Pattison has received for her knee injury is physical therapy. Starting sometime in 2013, Pattison started attending weekly physical therapy appointments at Logan which typically consist of a 10 minute bike ride or walk on a treadmill. Every week, Pattison complains to her physical therapist about severe knee pain, instability, stiffness, and swelling, yet her treatment plan does not change. Despite having participated in physical therapy for over two years, Pattison has not seen any improvement. As the Expert Team recognized in the spring of 2014, physical therapy will not help Pattison's condition.

133. Medications provided to Pattison at Logan have been ineffective at managing her knee pain and inflammation. Pattison typically only receives over-the-counter pain relievers, such as Tylenol and ibuprofen. On one occasion in 2015, Pattison received a cortisone injection in an effort to relieve pain and swelling, however this treatment only caused the pain to intensify and was discontinued. On another occasion in 2015, Pattison received Ultram for severe pain, which she took for three days, but this medication was not renewed. Pattison reports to nursing sick call on a frequent basis, often rating her pain level as greater than a 10 out of 10. Her pain is constant, and only seems to be getting worse with each passing week.

***Plaintiff John Ruffin*:**

134. Plaintiff John Ruffin ("Ruffin") is a prisoner at Dixon Correctional Center; he has been incarcerated in IDOC since on or about March 20, 2000. Ruffin's records are discussed in the Expert Report; he is Patient #9 in the "Nursing Sick Call" section of the Dixon CC report:

> This patient arrived at Dixon 2/18/2010. LPN sick call for complaint of right sided pain. SOAP format, date/time, vital signs and history of an old injury documented. No documented physical examination or assessment and referred to the physician. No documentation in the medical record as having been evaluated by the physician.

Dkt. 339 at 138.

135. Ruffin's spinal cord was partially severed in a shooting. There is shrapnel lodged in his shoulder and a bullet lodged between two neck vertebrae (on the right). Ruffin is wheelchair-bound, and he suffers from spasms and severe shooting pain on his right side. The pain disrupts his sleep. When Ruffin was first transferred to Dixon in 2009, he complained of pain, and was given ibuprofen. In 2010 he became "permanent" at Dixon and saw an LPN; nothing happened. He "put back in" for sick call, and in February saw a doctor who was the acting medical director at Dixon.[10] This doctor tried to get him approved to see a neurologist, but Wexford denied the consultation request. Ruffin continued to complain of pain for months. Finally, in June 2010, his shoulder was x-rayed (at Dixon), and a new medical director (Dr. Carter) saw him. Dr. Carter never physically examined Ruffin. Ruffin was still in pain and wanted to see a neurologist, but Dr. Carter told him that "he was getting old" and had arthritis. (Ruffin was 35 at the time.) Dr. Carter also said that "Wexford will never pay [for this], they're broke." Ruffin was sent back to physical therapy, but after examining him, the therapist said that physical therapy would do no good and Ruffin needed to "go out." Ruffin went back and forth with Dr. Carter until Dr. Carter finally "put in" for him to see an orthopedic surgeon, but the orthopedic evaluation never took place.

136. Dr. Carter left Dixon; another physician arrived. She "put in" for Mr. Ruffin to go to the UIC pain clinic, and this was approved by Wexford and occurred in March 2011. Ruffin was scheduled to go back for a CAT scan to determine his eligibility for an epidural injection to help the pain. Between "collegial review" and scheduling, the CAT scan did not occur until May. Thereafter, Ruffin had to go back to the UIC pain clinic, which (again, subject to collegial review and scheduling), did not happen until July. The UIC pain clinic determined that he should be given an injection of pain medication (into the neck area); this was supposed to happen within

[10] Apparently the records the Expert Team were given were not complete.

two weeks, but did not happen until August. The injection relieved his pain for only 2 weeks or so. He was sent back in November for another injection, and received a third one in January 2012. Although a collegial review in February 2012 approved Ruffin for another injection, scheduling delays meant that Ruffin – who was again suffering from severe pain and muscle spasms – did not receive another injection until June. By mid-July the pain had returned. This time, collegial review did not happen until September, and the injection appointment was scheduled for November. Unfortunately, this time the injection failed, and Ruffin was not returned to UIC for a successful injection until late February 2013. Ruffin had another injection in July 2013. He repeatedly told Dixon healthcare staff of his persistent pain and difficulty sleeping. Throughout this time, he was prescribed painkillers that did little or no good.

137. As early as 2012, the UIC pain clinic had recommended a medial (branch) block for Ruffin (a procedure in which an anesthetic is injected near small medial nerves connected to a specific facet joint). In March 2014, Ruffin requested a follow-up with the UIC pain clinic to discuss alternative treatments. This was approved in collegial review in April – but the appointment could not be scheduled. It finally happened in *December*. At last, in January 2015, Ruffin had the procedure, which relieved his pain until August. For the first time in years, Ruffin was able to sleep without pain medications. A follow-up procedure was approved in October, but it has not yet occurred, and Ruffin is once again in pain.

138. Although Ruffin has a chronic condition, he is not enrolled in a chronic clinic. This means that, to get his medications renewed, he has to go to sick call and pay the $5 copay.

139. Ruffin has also been attempting, so far unsuccessfully, to get a colonoscopy; he is now 40 and worried about a family history of cancer (his brother died of either prostate or colon

cancer, or both). He has been told by a doctor at Dixon that Wexford will not approve the colonoscopy because it is too expensive.

***Plaintiff Ezell Thomas:***

140. Plaintiff Ezell Thomas ("Thomas") is 73 years old, and currently incarcerated in Pontiac Correctional Center. Thomas entered IDOC in 1965 and again in August 1983.

141. Thomas suffers from several medical conditions including asthma, coronary artery disease, hypertension, chronic obstructive pulmonary disease ("COPD"), emphysema and has a history of prostate cancer and renal and kidney failure.

142. Thomas was first diagnosed with asthma, COPD, and emphysema in 2008, for which he was prescribed a host of medications, including two regular inhalers and an "emergency" inhaler. Since 2008, Thomas was allowed to maintain possession of his prescribed inhalers.

143. In 2013, Thomas began experiencing unusual weakness after standing for prolonged periods of time. Laboratory tests reflected a drop in his hemoglobin levels. He saw several nurses, physician assistants, and physicians for his complaints. While the medical personnel noted the drop in hemoglobin levels and noted that he suffered from anemia, no rectal exam was ever completed.

144. On or around December 24, 2013, Thomas was admitted to the health care unit at Pontiac with chest pain and was eventually sent to the local hospital, UIC for treatment. The doctors at UIC determined Thomas was in acute renal failure with a creatinine level of 4 (up from baseline of 1-1.5) and anemic, with a low hemoglobin level of 7 (for men, normal levels range from 13.5 to 17.5 grams per deciliter). Thomas was discharged back to Pontiac with the

recommendation that he undergo an outpatient colonoscopy, however, no colonoscopy was ever provided.

145. In January 2014, laboratory results continued to show drops in Thomas' hemoglobin levels. The medical director at Pontiac noted Thomas' iron deficiency anemia and prescribed him three iron supplements per day. Despite the medical prescription, Thomas only receives one iron supplement per day.

146. Around July 2015, Thomas had additional blood tests performed because lab results found an additional protein in his blood which suggested possible bone cancer. To date, Thomas has not received the results of those blood tests. UIC made the recommendation that Thomas return to UIC for follow up on the possible bone cancer issue, however, no such follow up appointment has been made for him.

147. Also in July 2015, Thomas' inhalers were confiscated. After being confiscated, he only had access to his inhalers two times per day instead of the prescribed four times. Due to the decrease in his prescribed medication, Thomas experienced significantly more trouble breathing, especially when lying down. Thomas lived in constant fear that he would suffer an asthma attack without the ability to treat it in the absence of his prescribed inhalers.

148. In addition, a physician at UIC has informed Thomas that he should be using different types of inhalers because the one type that is prescribed to him is harmful to his heart given his COPD diagnosis. When Thomas requested an alternative type of inhaler from Pontiac, pursuant to this recommendation, Pontiac refused the request and he was told the alternative inhalers were too expensive.

## CLASS CERTIFICATION ALLEGATIONS

149. All Plaintiffs bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of all prisoners in IDOC facilities with serious medical or dental needs.

150. **Numerosity**: The class is so numerous that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). As of October 31, 2015, there currently are approximately 47,000 inmates in the custody of the IDOC, all of whom are entirely dependent on Defendants' provision of medical or dental care. On any given day, there are thousands of prisoners in Defendants' facilities with serious, identified medical or dental needs.

151. **Commonality:** There are questions of law and fact common to members of the class. Such questions include, but are not limited to:

(a) Whether Defendants have failed to operate a healthcare system providing minimally adequate health care in violation of the cruel and unusual punishment clause of the Eighth Amendment;

(b) Whether Defendants are deliberately indifferent to the serious medical and dental needs of class members;

(c) Whether Defendants have routinely and systemically failed to employ adequate numbers of doctors, nurses, specialists and other medical and dental providers to ensure the delivery of constitutionally required healthcare;

(d) Whether Defendants have routinely and systemically failed to provide reasonably prompt medical and dental care;

(e) Whether Defendants have routinely and systemically failed to provide timely and appropriate emergency, outpatient, and other specialty treatment, including end-of-life care;

(f) Whether Defendants have routinely and systemically failed to properly keep medical records;

(g) Whether Defendants have routinely and systemically failed to provide safe and appropriate space, equipment, and sanitation for medical and dental procedures and care;

(h) Whether Defendants have routinely and systemically failed to identify and correct incompetent medical and dental treatment and providers;

(i) Whether Defendants have failed to promulgate and follow policies, practices and protocols reasonably necessary to ensure the delivery of constitutionally required healthcare; and

(j) Whether Defendants have failed to ensure compliance with policies, practices and protocols reasonably necessary to ensure the delivery of constitutionally required medical and dental care.

152. **Typicality**: The claims of the Plaintiffs are typical of those of the Plaintiff Class. Each of the named Plaintiffs is subject to Defendants' knowing failure to provide constitutionally adequate medical and dental care, and as their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the class's claims.

153. **Adequacy**: Plaintiffs are capable of fairly and adequately protecting the interests of the Plaintiff class and will diligently serve as class representatives. Plaintiffs do not have

any interests antagonistic to the class. Plaintiffs, as well as the Plaintiff class members, seek to enjoin the unlawful acts and omissions of the Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, inmates' rights litigation, and complex class action litigation, and have the resources necessary to fairly and adequately represent the class.

154. **Rule 23(b)(1)**: This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(1) because the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for the Defendants. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

155. **Rule 23(b)(2):** This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) because Defendants have acted, or failed to act, on grounds generally applicable to all members of the class, and because Defendants' policies, practices, actions, and omissions that form the basis of this complaint are common to and apply generally to all members of the class. The injunctive and declaratory relief sought is appropriate and will apply to all members of the class. All IDOC health care policies are centrally promulgated, disseminated, and enforced, and the failure to address the systemic deficiencies in services and staffing is the result of policies and practices of IDOC, not any particular person. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Plaintiff class.

## COUNT I
Class § 1983 Claim for Deliberate Indifference

156. Named Plaintiffs repeat and re-allege the allegations contained in paragraphs 1 through 155 as if fully restated here.

157. Defendants are aware that prisoners require adequate and timely medical and dental treatment.

158. Defendants are aware that the prisoners in their custody do not receive such treatment.

159. Due to the failures described herein, the Defendants have caused class members to suffer countless experiences of untimely and inadequate medical and dental treatment.

160. Defendants' ongoing deliberate indifference to the class members' medical and dental needs has deprived them of their right to be free from cruel and unusual punishment as secured to them under the Eighth and Fourteenth Amendments to the United States Constitution, has subjected them and continues to subject them to substantial risk of serious harm, and has resulted in actual physical harm.

161. Named Plaintiffs and the Class they represent have no adequate remedy at law to redress the wrongs suffered as set forth in this complaint. Named Plaintiffs and the Class they represent have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of the Defendants, as alleged herein, unless named Plaintiffs and the Class they represent are granted the relief they request. The need for relief is critical because the rights at issue are paramount under the United States Constitution and the laws of the United States.

WHEREFORE, the named Plaintiffs and the Class request that this Court grant them the following relief:

(a) Declare that the suit is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(1) and (2);

(b) Adjudge and declare that the acts, omissions, policies, and practices of Defendants, and their agents, employees, officials, and all persons acting in concert with them under color of state law or otherwise, described herein are in violation of the rights of named Plaintiffs and the Class under the Cruel and Unusual Punishments Clause of the Eighth Amendment, which grants constitutional protection to the Plaintiffs and the class they represent;

(c) Enter a mandatory injunction requiring the Defendants to submit and implement a plan describing the measures they will take to provide constitutionally adequate care and services;

(d) Preliminarily and permanently enjoin Defendants, their agents, employees, officials, and all persons acting in concert with them under color of state law, from subjecting named Plaintiffs and the Class to the illegal and unconstitutional conditions, acts, omissions, policies and practices set forth above;

(e) Award Plaintiffs the costs of this suit, and reasonable attorneys' fees and litigation expenses pursuant to 42 U.S.C. § 1988, and other applicable law;

(f) Retain jurisdiction of this case until Defendants have fully complied with the orders of this Court, and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction; and

(g) Award such other and further relief as the Court deems just and proper.

DATED: December 7, 2015

Respectfully submitted,

DON LIPPERT, LEWIS RICE, MILAM MARTIN, DEBRA PATTISON, JOHN RUFFIN, and EZELL THOMAS

By: /s/ Benjamin S. Wolf
*One of Their Attorneys*

Alan Mills
Uptown People's Law Center
4413 North Sheridan
Chicago, IL 60640

Benjamin S. Wolf
Camille E. Bennett
Lindsay S. Miller
Roger Baldwin Foundation of ACLU, Inc.
180 N. Michigan Ave., Ste. 2300
Chicago, IL 60601

Jason P. Stiehl
Robyn Marsh
Kristine Argentine
Seyfarth Shaw LLP
131 South Dearborn Street, Ste. 2400
Chicago, IL 60603

**CERTIFICATE OF SERVICE**

The undersigned, an attorney, certifies that on December 7, 2015, he caused a copy of the above and foregoing PLAINTIFFS' FOURTH AMENDED COMPLAINT (REDACTED) to be served on all counsel of record via the Court's electronic filing system (CM/ECF).

/s/ Benjamin S. Wolf