UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

WALTER D. BALLA, et al.,

Plaintiffs,

vs.

IDAHO STATE BOARD OF CORRECTIONS, et al.,

Defendants.

Case No. 1:81-cv-01165-BLW

ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR CONTEMPT [Dkt. 1090]

Plaintiffs in this matter are a class of prisoners who assert that existing injunctions remain necessary to ensure that the medical and mental health care delivery system at the Idaho State Correctional Institution ("ISCI") functions in compliance with Eighth Amendment standards. Defendants are Idaho Department of Correction ("IDOC") officials who allege that they and their contract medical provider, Corizon, Inc., have brought the system up to Eighth Amendment standards, although not in the exact manner ordered by the Court.

Now pending before the Court is Plaintiffs' Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt (Dkt. 1090) for Defendants' failure to follow the governing Court Orders (Dkts. 842, 849, 850, 930). Plaintiffs and the IDOC Defendants have filed extensive briefing on the issues (Dkts. 1090, 1132, 1161, 1171,

1175). On July 27 and 28, 2017, the Court held an evidentiary hearing where it heard witnesses and received exhibits (Dkts. 1191, 1188). Based on the entirety of the record, the Court GRANTS in part and DENIES in part the Motion for Contempt.

PLAINTIFFS' REQUEST TO HOLD DEFENDANTS IN CONTEMPT

I. Standard of Law

To find Defendants in contempt, the Court must determine (1) that Defendants violated the court order, (2) beyond substantial compliance, (3) not based on a good faith and reasonable interpretation of the order, (4) by clear and convincing evidence. *In re Dual-Deck Video Cassette Recorder Antitrust Litig*., 10 F.3d 693, 695 (9th Cir. 1993). Civil contempt "consists of a party's disobedience to a specific and definite court order by failure to take all reasonable steps within the party's power to comply." *Id*.

The contempt "need not be willful," and there is no "good faith exception" to the requirement of obedience to a court order. *In re Crystal Palace Gambling Hall*, 817 F.2d 1361, 1365 (9th Cir. 1987). "Good faith" is relevant to the contempt issue only to the extent that contempt can be avoided if the party based its action or inaction on "a good faith and reasonable interpretation of the [court's order].'" *Vertex Distrib., Inc. v. Falcon Foam Plastics, Inc*., 689 F.2d 885, 889 (9th Cir. 1982) (quoting *Rinehart v. Brewer*, 483 F. Supp. 165, 171 (S.D. Iowa 1980) (alteration in original)).[1] This defense applies to a

[1] When the Court speaks of good faith in this Order, it is using the term in a broader sense, as a prerequisite to the application of equitable principles, not to the standard of law governing contempt. As explained herein below, the IDOC officials did not read or interpret the Order at all, and, therefore, cannot argue that they interpreted the Order *in good faith*.

party who reasonably interpreted the court order and acted upon it, not to a party who ignored it.

"Substantial compliance" with the court order is a defense to civil contempt. *General Signal Corp. v. Donallco, Inc.*, 787 F.2d 1376, 1379 (9th Cir. 1986). A party can show substantial compliance even if it had "a few technical violations." *Id*. The key is whether, despite technical or inadvertent violations, the party "took all reasonable steps" to comply. *Id*.

II. Factual Findings

Having considered the evidence presented with the parties' briefing[2] and in the evidentiary hearing, the Court finds that Plaintiffs have established by clear and convincing evidence that Defendants were in contempt of the Court's June 2014 Order between June 6, 2014 and July 2016. However, Plaintiffs have not established that Defendants were in contempt after July 2016, or that Defendants are currently in contempt.

A. The Injunctive Relief Orders

1. In 1981, ISCI inmates filed the *Balla* class action lawsuit *pro se*, asserting various constitutional violations in the conditions of their confinement at IDOC's ISCI facility.

[2] Because a full-blown evidentiary hearing is not a requirement for a finding of contempt, the Court in a few instances cites to documents attached to the parties' briefing to which there was no objection. *See United States v. Ayres*, 166 F.3d 991, 995–96 (9th Cir. 1999); *Peterson v. Highland Music, Inc.*, 140 F.3d 1313, 1324 (9th Cir.), *cert. denied*, 525 U.S. 983 (1998).

2. The Court held an evidentiary hearing on the allegations. On November 1, 1984, the Court entered an injunctive relief order that—thirty-six years later—remains partly at issue in Plaintiffs' Motion for Contempt: Order 1, Adopt a special dietary program for medically infirm inmates; Order 3, Create 24-hour emergency medical care for inmates and hire a full-time physician; Order 4, Provide a properly-staffed medical delivery system; and Order 5, Establish a psychiatric care program. *See Balla v. Idaho State Board of Correction*, 595 F. Supp. 1558, 1583 (D. Idaho 1984) ("*Balla I*").

3. IDOC submitted compliance plans in response to the *Balla I* Order, which the Court approved on July 11, 1985. The original compliance plans and the Court's copies of those plans cannot be located.

4. In 2011, the Court considered a status report submitted by Plaintiffs detailing allegations of ongoing constitutional violations at ISCI. Dkt. 793 (addressing Dkt. 784).

5. On July 20, 2011, the Court appointed a medical special master, Dr. Marc Stern, to investigate the status of the medical and mental health delivery system at ISCI. Dkt. 806.

6. On October 17, 2011, the Court appointed psychiatrist Dr. Amanda Ruiz as deputy special master to assist Dr. Stern in evaluating ISCI's mental health delivery system. Dkt. 808.

7. In a report filed on February 3, 2012 ("Stern Report"), Dr. Stern found serious deficiencies in the delivery of medical and mental health care. Dkt. 811. Dr. Stern

opined that some of the conditions violated the prisoners' right to be protected from cruel and unusual punishment. The parties disputed the opinions contained in the Stern Report. *See* Dkt. 842.

8. Corizon, Inc., is the contract medical provider in charge of providing medical and mental health care to the prisoners at ISCI. Exhibit 1045 at 198. The IDOC hires its own chief psychologist. *Id.*

B. The Parties' Negotiations to Create a Modified Compliance Plan to Address the Stern Report

9. After the Stern Report was issued, Plaintiffs decided not to go to trial because of timing issues; the inmates estimated if they went to trial, it could be up to eighteen months before a substantive ruling was issued. *See* July 27-28, 2017 Evidentiary Hearing Transcript ("Tr.") (Dkt. 1191) at 595:9–12, 596:1–20, 597:109. The inmates opted for mediation because they desperately needed something they could enforce and thought a quicker substantive resolution would result from mediation. Tr. at 598:13–16.

10. The undersigned Judge presided over the mediation. The parties crafted the Modified Compliance Plans (collectively, "MCP") in and after the mediation sessions.

11. Attached to the Stipulated Motion were Appendices A and B, the negotiated working papers intended to begin addressing the problems identified by Dr. Stern. Tr. at 604:31–4.

12. Appendices A and B contain three columns of information: (1) Plaintiffs' concerns, based on the Stern Report; (2) the corresponding page numbers of the Stern Report; and (3) IDOC's proposed actions. Tr. at 605:20–25, 606, 607:1–13. In other words, Appendices A and B amounted to a preliminary compliance plan to put the decades-old injunctions into effect.

13. In the Stipulated Motion, the parties agreed that changes to Appendices A and B would be negotiated and finalized as Addenda A and B, to replace Appendices A and B, within six months (*i.e.* by December 2012).

14. On June 11, 2012, the Court granted the Stipulated Motion, and ordered it binding on the parties. Dkt. 849.

15. The Appendices and the Addenda include specific requirements that the IDOC (1) audit the workings of the medical and mental health system, and (2) put into effect certain changes to improve the workings of the medical and mental health care delivery system.

C. Preliminary Monitoring Stage between June 11, 2012 and June 6, 2014

16. In accordance with the Stipulated Motion, the parties began the preliminary stage of monitoring ISCI's medical and mental health delivery system in June 2012.

17. In 2012, IDOC "ground level" medical personnel who had not been involved in drafting the Modified Compliance Plan ("MCP") and Appendices A and B had to determine how to implement them. Tr. at 129.

18. Rona Siegert, who has been the IDOC Health Services Director since 2008, had a key role in the implementation determination. *Id.* at 12:19–22.

19. As part of her regular duties with the IDOC, Siegert's primary job is to oversee the contract between the IDOC and Corizon with respect to delivery of medical services. *Id*. at 12:25, 13:1–3. Siegert and her staff accomplish this oversight by performing system-wide audits. *Id.* at 13:5–8.

20. Siegert first became aware of the MCP and Appendices A and B in 2012, and she understood that they were court orders. *Id.* at 14:18–24. Siegert and the other IDOC personnel charged with implementing the MCP understood that they had to audit *everything* in the Appendices, and they reviewed the audit tools they already had in place and tried to use any of those that were applicable to the Appendices. *Id.* at 16:22–25, 17:1–2. In addition, Jim Cardona of IDOC created some *Balla*-specific audit tools. *Id.* at 62:16–24.

21. To the extent there was not already an IDOC audit tool that would collect the data needed for Appendices A and B, Siegert worked with Corizon to ensure that it collected the necessary data. IDOC did not repeat Corizon's data collection, but relied on and reported the data gathered by Corizon. *Id.* at 62:7–15, 681:11–18.

22. From 2012 to 2014, IDOC had Cardona collect data and had one nurse monitor conduct independent audits, in addition to having Corizon conduct their own audits. *Id.* at 678:1–25, 679:8–14. Siegert's team used National Commission on Correctional Health Care ("NCCHC") standards as the basis for their auditing. *Id.* at 681:1–10.

23. Between the data collected by Cardona and the data reported by Corizon, Siegert believed IDOC was auditing everything it needed to audit under the MCP. *Id.* at

66:24–25, 67:1–3. Nobody told Siegert she was not doing everything she needed to do. *Id.* at 67:4–6.

24. The IDOC team collected the data from the IDOC and Corizon audits and compiled it into a Health Services Report Card ("Report Card") that tracked the auditing system. Beginning in July 2012 and pursuant to the MCP, the reporting and reviewing of the auditing occurred when the class representatives, IDOC personnel, counsel for the parties, the nurse monitors, and Corizon personnel met together in monthly Monitoring Meetings. The Report Card functioned as a progress report to Plaintiffs at each monthly Monitoring Meeting. Tr. at 66:14–18.

25. During the Monitoring Meetings, the IDOC presented the auditing results and Plaintiffs had an opportunity to, and often did, question the content of the data the IDOC reported. The IDOC provided explanations. Tr. at 68:13–25.

26. The IDOC usually used the first hour of each Monitoring Meeting to present its report. The next hour was devoted to Plaintiffs questioning the data presented and bringing forward their concerns, including specific inmate medical issues and nonmedical issues that occurred in housing units, such as plumbing and water issues, that were not specific to the Appendices. *Id.* at 69:6–18. The IDOC typically investigated Plaintiffs' issues and reported some items back to Plaintiffs, but did not report back on issues that would have involved disclosing inmates' personal health information. *Id.* at 54:41–5, 69:19–25, 70:1–7.

27. During the preliminary monitoring period that began in June 2012, Plaintiffs and IDOC representatives also held two other types of meetings related to the *Balla*

audits. Nurse managers would attend monthly nurse manager meetings with Plaintiffs, and nurse monitors would hold weekly meetings with Plaintiffs. These weekly meetings—which were not required by the MCP—were eventually discontinued. *Id.* at 70–72, 73:1.

28. During this preliminary period, when Appendices A and B governed, these many meetings provided Plaintiff with opportunities to monitor and question what Defendants were auditing, implementing, and reporting. Class representatives were often told, however, that information was not available to them because of security and/or privacy concerns.

D. Monitoring Requirements and Dispute Resolution Process

29. The MCP provided that Monitoring Meeting topics were to include, in part: "(a) Review of a monitoring report prepared by Defendants and approved by Plaintiffs that concerns Defendants' compliance with the Modified Compliance Plans; (b) Review of statistical data prepared by Defendants related to Defendants' compliance with the Modified Compliance Plans; (c) Periodic review of Defendants' internal audits of the provision of special diets, medical care, and mental health care at ISCI" and "(d) Specific areas of concern which may be submitted by Plaintiffs or Defendants." Dkt. 842 § 5.2.

30. The MCP also required Plaintiffs to provide written notice to Defendants' counsel any time "Plaintiffs believe[d] Defendants [we]re not in compliance with th[e] Stipulation or the Modified Compliance Plans" or if the MCP was not "operating as the Parties intended." *Id.* § 7.1(a). Class representatives relied on the

information about compliance that Defendants provided to them, because inmates cannot collect their own data.

31. The MCP further provided that (1) Defendants' counsel had five days to respond to a written notice of non-compliance; (2) Plaintiffs were to send a second written notice if dissatisfied with the response; (3) the parties were to meet and confer within five days of the second notice; (4) if no resolution was reached, the parties were to meet with the ADR coordinator; and (5) if the issue was still unresolved, the parties could submit the dispute to this Court. *Id.* § 7.1.

E. The Parties' Course of Dealing Prior to June 6, 2014

32. Beginning in June 2012, the parties operated under the MCP and Appendices A and B while they negotiated the finishing touches to Addenda A and B.

33. However, the parties did not finalize the Addenda in six months, as required. Instead, the process took two years.

34. During the Monitoring Meetings, the parties held discussions about items that should have been, but were not, recorded on the Report Card. The parties approved the Report Cards—absent inclusion of these items—after the meetings. Tr. at 67:16–25.

35. Plaintiffs knew that the MCP required the IDOC to achieve at least 90% compliance with the MCP and NCCHC standards. Dkt. 1090-1 at 14.

36. Plaintiffs noticed that between 2012 and 2015, IDOC rarely reported compliance lower than 90%. It reported 100% compliance in virtually every category. *Id*.

37. Plaintiffs asked questions about the reported numbers, because those numbers did not seem to match the number of inmate complaints the class representatives fielded, and because consistently perfect scores seemed impossible. Plaintiffs also thought it was statistically impossible to be at 100% compliance all the time. Tr. at 654–55.

38. Neither party used the required dispute resolution process to ask that the auditing or monitoring be performed differently or that the Report Card format be changed to more closely track the MCP.

39. Addenda A (Exhibit 1001) and B (Exhibit 1002) were incorporated into a Court Order on June 6, 2014. Dkt. 930.[3] The parties argued over the date the official monitoring period should begin, and the Court adopted Plaintiffs' position that the official two-year monitoring period start date was June 6, 2014 (rather than October 2013, as Defendants contended) with an end date of June 6, 2016.[4] Dkt. 928 (Order resolving dispute).

F. The Parties' Course of Dealing After June 6, 2014

40. June 6, 2014, should have been the date that *all* parties involved in monitoring began to implement audits, Reports Cards, and modes of monitoring that complied with the 2014 Addenda A and B, rather than the 2012 Appendices A and B. However, that did not occur. Plaintiffs and Defendants did work together to

[3] The 2014 Order specified that the MCP was expressly incorporated into the Court's June 11, 2012 Order, pursuant to the Stipulated Motion to Modify Injunctive Relief. Dkt. 930.

[4] The monitoring period was subsequently extended to end in September 2017 as a sanction for some of the IDOC's employees' bad acts. Dkt. 983.

implement certain provision-of-care line items in Addenda A and B (for example, new pill call windows, discussed below). Tr. at 615:5-14.

41. Shockingly, after the final MCP with Addenda A and B was adopted as a court order on June 6, 2014, Health Services Administrator Siegert and IDOC personnel *did not even read* the new set of documents or re-evaluate the audit tools they had been using. Tr. at 19:16–25, 20:1–20.

42. The Court was shocked to learn that "ground-level" IDOC and Corizon personnel knew nothing about the MCP requirements. Corizon's ISCI site medical director had not been asked to read the Addenda, nor did he receive any formal training on them. *Id.* at 237–39. Consequently, the physician's assistants and nurse practitioners that the site medical director supervised received no instruction or training about the MCP requirements. *Id*. Similarly, witnesses who worked as IDOC correctional officers and mental health employees testified that they received absolutely no instruction or training on the requirements. *Id.* at 267–268, 358–359.

43. Only after being questioned by this Court did the IDOC confirm, through Siegert's testimony, that rather than changing to a new monitoring system when the Court Order of June 2014 was issued, Defendants continued monitoring as they had since 2012.[5]

[5] Neither party presented evidence showing whether, between 2012 and June 2014, the parties were monitoring exactly as required by Appendices A and B, and that information is not necessary to the Court's ruling here. Both parties testified (Plaintiffs through class representative Barry Searcy and

44. The record does not make clear why the parties did not significantly change their mode of auditing and monitoring after June 6, 2014.

45. Nothing prevented IDOC personnel from reading the 2014 Order or from trying to implement Addenda A and B.

46. The record *is* clear that both parties to varying degrees ignored the specifics of the 2014 Order *as it relates to auditing and mode of monitoring*. Both parties in good faith continued in their joint efforts to implement the *substance* of Dr. Stern's recommendations, as embodied in the 2012 Order, and to improve the *provision of health care* as to some of the line-item improvements required by the 2014 Order and Addenda A and B.

47. At several times during the monitoring period, Plaintiffs questioned whether Corizon was monitoring itself and asked where Corizon's numbers were coming from. At the Monitoring Meetings, IDOC officials would respond, "Corizon is providing this." Tr. at 655:16–25, 656:1–22. Therefore, Plaintiffs were on notice that, at least in some categories, IDOC was reporting numbers given to it by Corizon.

48. There is no record that Plaintiffs made any official requests to Siegert or other IDOC personnel asking them to change the audit tools they had been using once the 2014 Order was issued.

Defendants through Siegert) that, after Dr. Stern completed his report on the status of the medical and mental health care system, both parties began monitoring, conferring, and reporting to one another in some manner acceptable to both parties. This is confirmed by the absence of any information in the record showing that one party asked the other party to audit or monitor differently.

49. To Siegert's knowledge, and as shown by the record, Plaintiffs never requested copies of IDOC's or Corizon's raw data, and Siegert knows of no reason IDOC would not have been able to provide it. *Id.* at 73:4–9.

50. Neither party noticed or expressed concern that, after June 2014, the Report Card did not match the requirements of Addenda A and B.

51. The record reflects that, in and after June 2014, Defendants did not say *how* they were auditing, and Plaintiffs did not make a formal inquiry. *Id.* at 17:17–25, 18:1–6. Both Plaintiffs and Defendants actively participated in the type of auditing and reporting that Defendants selected, and there were no formal requests for changes to the auditing or reporting or requests for court intervention.

52. Plaintiffs cited to the 2014 Addenda several times as part of their monitoring, in order to call Defendants' attention to certain line-item provision-of-care improvements that needed to be addressed. *Id.* at 622–23. Therefore, Defendants were on notice that Plaintiffs generally expected Defendants to be following the 2014 Addenda.

53. For example, the MCP required the IDOC to build a pill call station with four pill call windows. Class representative Barry Searcy recalls reminding the IDOC that the MCP required not just the physical windows, but that the windows be staffed with four persons. *Id.* at 611–12. This issue was raised and resolved in the Monitoring Meetings. At the conclusion of the process, Searcy "thanked IDOC and Corizon for getting all four windows staffed every day." *Id.* at 653:4–19.

54. The few required substantive improvements that Plaintiffs raised with Defendants were handled as line items and resolved through the MCP dispute resolution process. Between June 2014 and September 2015, though Plaintiffs raised substantive issues regarding the 2014 Addenda, Defendants' 2012 *mode* of monitoring was never questioned or rejected in wholesale fashion.

55. Because they were in good faith working through problems in the mediation process specified in the MCP, in 2014 and 2015 the parties did not reach the stage of filing a contempt motion regarding compliance. In Searcy's words: "We were actually still trying to get this thing to work. We were trying to bring these things, bring them to their attention, get responses back. That's what we agreed was our understanding of what we agreed is that we would bring problems to them, and they would work to get them resolved." *Id.* at 615:5–14.

56. Both parties continued the 2012 mode of monitoring, with a few references to the 2014 line-item provision-of-care requirements, for approximately 63% of the official monitoring period, until Defendants informally self-reported in September 2015 and formally reported in October 2015 that they had deviated from the 2014 Order in their method of monitoring.

G. IDOC's Realization of its Deviations and Reporting to Plaintiffs

57. Ashley Dowell became Deputy Chief of Prisons in March 2015 and was charged with overseeing and executing *Balla* in May or June of 2015.[6] She became aware

[6] Ashley Dowell became Chief of Prisons for the IDOC in March 2017. Tr. at 264. She was a Deputy Chief in 2014, but in a different division that was not associated with *Balla*. *Id.* at 266.

of potential problems with *Balla* compliance when she had discussions with mental health staff at ISCI during which staff member Laura Watson indicated that she had not seen Addenda A and B before. *Id.* at 267–268. In addition, Brian Lewis, the clinician who had taken over the mental health monitoring of the *Balla* case, pulled Dowell aside and said he had some concerns that monitoring was not occurring as required by Addenda A and B. *Id.* at 267–269. At that point, Dowell called counsel and informed them that there may be a problem. *Id.* at 268.

58. Unlike the IDOC officials previously in charge of *Balla*, Dowell took swift and effective action to identify and rectify the areas of noncompliance.

59. In July 2015, Dowell began a series of meetings with IDOC and Corizon officials to discuss the fact that the IDOC had not been complying with the exact terms of the MCP. Attendees included Dowell, Warden Yordy, Mark Kubinski (attorney), Colleen Zahn (attorney), Dr. Craig,[7] Brian Lewis, Aaron Hofer, Connie Smock (director of nursing), Connie Lowder, Jeannie Hunter, Jessyca Tyler-Leekley, Megan Austin (nurse monitor), Joni Lemons (nurse monitor), and Zarah Martin (nurse monitor). *Id.* at 76:12–25, 77:1–6, 269, 457–59, 270:13–24.

60. Over the course of about thirty-five hours of meetings, Dowell's team did a word-by-word, line-by-line review of Addenda A and B to determine where they were in and out of compliance with the MCP. Prior to that time, Plaintiffs never called attention to the fact that there was information missing from the Report Card, or

[7] No other identifying information was provided by the parties.

asked why the information was missing. *Id.* at 78:3–19, 305; *see generally* Exhibit 1001.

61. Keith Yordy has been warden of ISCI since January 2014. He became aware of the deviations from the MCP when he was told by Dowell, and he participated in the process to identify the deviations and come up with an action plan to address them. Tr. at 457–59.

62. As a result of the review, IDOC staff identified: (a) proposed fixes that involved amending the MCP to make the process match what was actually happening on the ground; (b) changes that were required because items described in the Addenda could not be accomplished as written; (c) instances where current IDOC policy conflicted with MCP provisions, with a proposal that IDOC policy govern; (d) instances where IDOC proposed to Plaintiffs that IDOC be permitted to perform things slightly differently; (e) audits that IDOC wanted Siegert, rather than other staff, to perform to relieve the burden on other staff; and (f) requests to allow audits to occur on a different day. *Id.* at 77–81, 460.

63. Some of the reasons for the deviations were justified, and others were not.

64. The result of the IDOC team meetings was a chart called the "Deviation Matrix." The most recent Deviation Matrix contains Plaintiffs' responses to Defendants' disclosures and proposed solutions, as well as Defendants' replies. *Id.* at 305–308; *See generally* Exhibit 1075.

65. Defendants specifically outlined the justifiable reasons for their deviations in the Deviation Matrix. *See* Exhibit 1003. For example, as to Addendum A, p. 10, Item

8, Action 2, Defendants proposed "amending the current Stipulation to permit the Health Services Director to conduct the audit, and to permit the audit to occur for records from two weeks prior because it would be impossible to measure compliance with the 14 day follow-up period." *Id.* at 10. Another example is Addendum A, p. 11, Item 10, Action 1, where Defendants proposed "amending the current Stipulation to provide for rescheduling no-show offenders who had a valid reason for no-showing, as opposed to those who decide they do not want to attend their scheduled appointment. Automatically rescheduling all no-show offenders, would prevent other offenders from being seeing and run the risk of repeat no-shows, thus depriving other offenders of medical appointments." *Id*. at 14-15.

66. Dowell directed IDOC counsel to provide the information about the deviations to Plaintiffs' counsel. Tr. at 310.

67. On October 9, 2015, IDOC attorney Colleen Zahn sent Plaintiffs' attorneys a letter providing the Deviation Matrix and indicating that internal audits had revealed that the IDOC was not in compliance with 101 of the MCP's monitoring, auditing, and reporting requirements. IDOC made four broad admissions of serious, even egregious, failures to comply with the MCP requirements: (1) it had not complied with Addenda A and B since they were approved; (2) it relied on Corizon's audit numbers rather than its own; (3) it had failed to report or had misreported statistics at the monthly Monitoring Meetings; and (4) it had not updated Plaintiffs when it

changed its policies, but it was following formal policy rather than the requirements of Addenda A and B. *See generally* Exhibit 1; Tr. at 274–275, 460.

68. After the IDOC held team meetings and created and implemented new auditing procedures, Dowell believed the IDOC was doing everything it needed to do to comply with the MCP. Tr. at 302.

H. IDOC's Implementation of the Revised Auditing Procedures

69. After the new audit tools were developed, the IDOC held about thirty-five hours of meetings discussing the audit tools, and spent about ten hours tracking compliance regarding the new audits. As the meetings on the line-by-line review and work on the audit tools concluded, Dowell set up the Incident Command System ("ICS") to track progress on *Balla* on a weekly basis. *Id.* at 311–12.

70. The ICS meetings have consisted of giving management's perspective on updates, going over action items that arose in the monthly Monitoring Meetings and nurse monitoring meetings, discussing concerns, and receiving reports from various section chiefs: one report goes over action items, one talks about facility operations, and one addresses administrative issues. The team holds a round table and addresses questions and concerns from team members at that time. Legal counsel for IDOC also attends. *Id.* at 312–13.

71. The new audit tools were provided to Plaintiffs' counsel. *Id.* at 317. The IDOC requested that Plaintiffs agree to amend the MCP as described in paragraph 61 above.

72. While waiting for Plaintiffs' response to the requests for changes, the IDOC moved forward with correcting the failures noted above. *Id.* at 318.

73. Some of the fixes identified in the deviation meetings were easy and immediate; others required creation of *Balla*-specific tools and took longer to implement. *Id.* at 78–80. For example, the Medication Administration Records ("MARs") audit took a while to correct: there were multiple discussions regarding how to conduct the audit, and the nurse monitors eventually figured out how to accomplish the audit by enlisting other resources to assist them, rather than hiring an additional auditor. Exhibit 1082 at 1-3; Tr. at 273–74, 314–19.

74. Defendants changed the content of the Report Card provided to Plaintiffs at the monthly Monitoring Meetings to reflect only those items required by Addenda A and B. Tr. at 81–83. They realized the Report Card contained a lot of information not required by the Addenda, and decided to omit the excess. *Id*.

75. IDOC staff implemented most of the new *Balla*-specific audit tools in February and March of 2016.[8] *Id.* at 317–21. At that time, they had not received a response from Plaintiffs to the October 2015 letter and Deviation Matrix.

76. In April 2016, after much research and consultation with the class representatives, Plaintiffs' counsel formally responded to the October 9, 2015 letter and the Deviation Matrix. *See generally* Exhibit 2005; Tr. at 316.

[8] As discussed more fully below, the biannual staff suicide training requirement was not completed until July 2016.

77. The first audits reported to Plaintiffs in the revised Report Card format occurred in April 2016 (each Report Card addresses the previous month's audits). Tr. at 320–21. At that time, Plaintiffs objected that the Report Card was not compliant, and Dowell advised them to put their complaints in writing. *Id.* at 322.

78. Plaintiffs followed up with a letter from Plaintiffs' counsel to IDOC counsel about the new Report Card format on February 15, 2017, almost a year after the new Report Card format was disclosed to them. *Id.* at 322, 325; Exhibit 2006.

79. After the fixes were fully implemented in 2016 (to the extent IDOC chose to implement fixes, whether the parties agreed or not), staff regularly performed about forty *Balla* audits to comply with Addenda A and B. Tr. at 83:12–21.

I. Evidence Showing Plaintiffs' Course of Dealing from June 2014 to September 2015

80. Plaintiffs raised line-item provision-of-care improvement issues from the 2014 Addenda with Defendants from time to time (for example, fully staffing the pill call windows). These issues were discussed and resolved between the parties via the preliminary stages of the MCP dispute resolution process without having to resort to Court intervention, as the MCP was designed to work. Those issues that were not raised in the dispute resolution process were recognized and rectified by Dowell's team's efforts between September 2015 and July 2016 (for example, biannual suicide training).

81. There is no evidence showing that any particular IDOC official or employee actually was aware of the noncompliance issues until a mental health clinician

noticed it in late 2015, prompting Dowell and other IDOC officials to undertake their review of the MCP as described above. For example, Warden Yordy believed the IDOC was compliant based on Shane Evans's reports and based on what was going on in the Monitoring Meetings. *Id.* at 529–30.

82. It is clear that the class representatives had continuing questions about the accuracy of Defendants' auditing and informally verbalized their concerns to Defendants, but there is no evidence that Plaintiffs gave Defendants formal written notice of noncompliance or that Plaintiffs gave Defendants formal written notice that the MCP was not operating as intended under the mandatory provision in MCP § 7.1(a) —a requirement of the agreement to address unresolved issues—at any time prior to the IDOC's September 2015 self-disclosure. However, Plaintiffs' inaction was, in part, due to Defendants' representations that they were auditing properly.

83. There is no evidence that either party made any formal efforts to change the course of the parties' monitoring between the 2012 Order to the 2014 Order. For example, no party made an effort to change the Report Card, the major reporting and monitoring tool, to comply with the 2014 standards after the 2014 Order was issued. *Id.* at 683:13–19. In fact, in 2015, when Defendants changed it to more closely track Addenda A and B, Plaintiffs *opposed* the changes, and no agreement has been reached on a new format. *Id.* at 320-21.

84. There is no evidence that either party formally raised the issue that the mode of monitoring had not changed to comply with the 2014 Order with the Mediation

Special Master, who had been available to mediate disputes since the inception of the MCP (formerly as the Court's ADR coordinator).

J. Stipulated NCCHC Audit

85. The MCP provides for a compliance audit of the medical and mental health delivery system to determine whether Defendants have met the conditions of the injunctions. Dkt. 842 at 7. The parties stipulated that the NCCHC—in particular, NCCHC Resources Inc. ("NRI"), a subsidiary of NCCHC—would conduct the audit ("NCCHC audit"). The parties also stipulated to particular auditors. Exhibits 2001–04; Tr. at 213–16.

86. As part of an accelerated case management plan that replaced the mediation special master with a court facilitator, the Court moved up the parties' stipulated audit from July 2017 to May 2017. This was an effort to determine the progress of the medical and mental health delivery system changes, because it had been five years since the MCP was adopted. Dkts. 1004, 1009.

87. After the Court was provided with a copy of the Deviation Matrix, pursuant to the new set of case management procedures, and in light of the impending end of the extended monitoring period, the Court and court facilitator encouraged the parties to create a workable monitoring plan going forward, to have the medical and mental health system evaluated by NCCHC earlier rather than later, and to wrap the allegations of past wrongdoing into the termination proceedings if feasible.

88. The NCCHC audit occurred in May 2017, with a report issued in June 2017 that reviewed the time period from May 2016 to May 2017. The audit concluded that

"the prison has a well-run health care and mental health care system." Exhibit 2000 at 3.

89. Dr. Brent Gibson is the chief health officer of NCCHC and also works for its subsidiary, NRI. He was with the audit team that audited ISCI in May of 2017, but was not an auditor. Tr. at 213–18.

90. The audit tools were created by NRI with the help of counsel. *Id.* at 213–18.

91. The NCCHC audit lasted about five days. NRI auditors reviewed the time period from May 2016 to May 2017, and they were permitted to look back farther if needed. Auditors met with a randomly-selected group of inmates, *Balla* class representatives, and counsel. The audit did not cover 2014, 2015, or the first four months of 2016. *Id.* at 222.

92. In preparation for the audit, Warden Yordy gave directions to staff to cooperate with the NRI auditors, provide full access, answer questions, and provide any information requested. *Id.* at 525.

93. Siegert and her staff participated in the NRI audit, met with auditors, answered their questions, and provided them with all of the information requested. *Id.* at 130.

94. The auditors indicated that they had received all the information needed to complete the audit. *Id.* at 218–21.

K. Plaintiffs' Complaints and Defendants' Responses about the IDOC Mode of Monitoring

95. Plaintiffs allege, but have not shown, that the IDOC and Corizon did not audit *at all* for clinical competency. The record showed that clinical competency of the medical staff was, in fact, reviewed in biannual contract audits, even if those competency reviews were not being done in *Balla*-specific audits.[9] *Id.* at 84:20–25, 85:1–9. *Balla*-specific audits for clinical competency began in the spring of 2016 when all new audit procedures were implemented. *Id.* at 317–21.

96. Plaintiffs allege that the audit for medication distribution consists only of recording whether a conversation occurred. *Id.* at 108:21–25. But Siegert explained that the audit includes Nurse Manager Zarah Martin meeting with patients to review the problem and attempt to resolve the problem, and that most problems are resolved at the meeting. *Id.* at 109:1–22.

97. Plaintiffs allege that not every inmate who experiences a medication distribution issue is interviewed. It is entirely possible that not every single medication complaint is caught in an audit; however, there is no evidence in the record of a systemic issue with medication distribution.

98. Plaintiffs also allege that the "concern and grievance review" audit consists only of reviewing timeliness of concern and grievance responses. *Id.* at 109:23–25,

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[9] The Court uses the term "competency" in a general manner here, meaning that staff were audited to determine whether they knew how to provide competent care. The NCCHC standards did not permit a doctor with a license limited to prison health care to practice in a prison, and, yet, at some points in time before his full-use license was reinstated, Dr. Agler worked at ISCI. Obviously, this would not have met the higher "competency" standards of NCCHC, but it would have met the lower competency standards of the Idaho State Board of Medicine. *See* discussion on Dr. Agler, *infra*, at ¶ 110, *et seq*.

110:1–4. However, Siegert clarified that the concern and grievance review audit consists of the following: (1) Siegert retrieves all the concern forms that have been submitted to the medical unit in a month, which is usually between 350 and 400 forms; (2) she reviews each for a timely response; (3) she reads the complaint and the response, to ensure that the response was appropriate, polite, professional and that it addressed the issue raised by the inmate; (4) when she finds a problem with the response, she makes copies of them; and (5) she addresses the problematic responses with Aaron Hofer and Connie Smock. *Id.* at 110–11.

99. The Court finds Siegert credible as to her explanations of the monitoring, based on her personal knowledge in supervising and conducting the audits and her demeanor at the hearing.

100. Plaintiffs have pointed to no evidence of ongoing systemic issues with the medical or mental health system that amount to violations of the Eighth Amendment's Cruel and Unusual Punishments Clause. *Id.* at 641–45.

101. During the NCCHC audit, Plaintiffs gave the NRI auditors a list of fifty-three names of inmates who were meant to serve as examples of systemic issues regarding health care. *Id.* at 644. "NRI's physician monitor completed medical records reviews on all fifty-three and found no outstanding critical health, mental health, or dental issues." Exhibit 2000 at 86. As to the "Patient Chart Review" conducted by the NRI physician auditor, NRI was "unable to substantiate any medically significant denial or delay in care." *Id*. at 87.

L. IDOC's Compliance from May 2016 to Present

102. As of May 2016, Defendants were deemed by NCCHC to be operating the medical and mental health system at ISCI in compliance with the MCP and Addenda A and B, as measured by the audit tools prepared by counsel and NRI. *See generally* Exhibit 2000.

103. As of July 2016, Defendants had completed the biannual staff suicide training, the last of the requirements to bring them into compliance with the MCP and Addenda A and B.

104. By the time Plaintiffs filed their motion for contempt in March 2017, Defendants were making every effort to comply with the 2014 Order, as the May 2017 NCCHC audit demonstrated.

III. Conclusions of Law

A. Past Contempt

While Plaintiffs' contention that Defendants were doing nothing is inaccurate, because Defendants continued to audit and improve the ISCI medical and mental health delivery system using the tools developed for compliance with Appendices A and B, the Court concludes that Defendants violated the 2014 Court Order beyond substantial compliance as demonstrated in the Deviation Matrix between June 11, 2014 and July 2016. Defendants have not shown that the violations were based on a good faith and reasonable interpretation of the Order, because Defendants did not even read the Order. By not reading the Order, Defendants did not take all reasonable steps within their power to comply; in fact, they failed to take the first necessary step toward compliance.

Defendants have no viable defense to the request that they be held in contempt for their past failure to follow the 2014 Order. Defendants' evidence was aimed at showing not that Plaintiffs *filed their motion* too late, but that Plaintiffs *complained*—not at all at first, and *then too late*—that Defendants did not change their system of auditing and monitoring from the 2012 preliminary system to the 2014 final system of monitoring. The evidence tends to show that once Plaintiffs and Defendants engaged in a course of auditing and monitoring the ISCI medical and mental health delivery system in 2012 pursuant to the Order adopting the 2012 Stipulation to Modify Injunction with Appendices A and B, they both continued to monitor in that manner. Further, neither party changed or demanded that the other party change procedures in order to monitor in accordance with the 2014 final Addenda A and B. This is not to say that Plaintiffs did not raise line-item provision-of-care issues from the 2014 Addenda with Defendants; it is to say that they focused on the substance of line-item issues in the 2014 Addenda, and not on the form of the auditing set forth in those documents.

Thus, Plaintiffs appear to have failed to use the MCP's dispute resolution process to formally raise their questions about Defendants' auditing. However, this is of little relevance to the Court's determination of past contempt, because Defendants nevertheless had an independent duty to read and implement the Court Order. They did not, and were therefore in contempt of this Court between June 11, 2014 and July 2016.

B. Present Contempt

Substantial compliance requires that a party make every reasonable effort and taken all reasonable steps to comply with a court order. To their credit, it was

Defendants—and specifically, Dowell—who eventually noticed and raised the issue of the deviant monitoring. As soon as Dowell's team realized it was out of compliance, it worked swiftly and hard to remedy all deficiencies. The Court concludes that some of the requirements of Addenda A and B were impossible to comply with, some were impracticable, and some called for Plaintiffs' good faith re-negotiation.[10] Plaintiffs appear to not be amenable to some of IDOC's requested changes to the Addenda A and B requirements (such as its request to change the Report Card to more accurately reflect the requirements of Addenda A and B). Nevertheless, it appears that IDOC has now achieved substantial compliance with the MCP, and thus with the Court's Order.

Since June 2016, the IDOC has continued to implement the MCP in good faith, monitoring its internal workings to a degree not seen before in the history of this case. For example, when Warden Yordy discovered a training supervisor had falsified training records, causing the IDOC to be out of *Balla* compliance, Yordy immediately took steps to discipline that employee, notify Plaintiffs, and re-set the training schedule deadline. By July 2016, all ISCI employees had undergone biannual suicide training, bringing the IDOC into substantial compliance with the MCP. The IDOC regularly performs about forty *Balla*-related audits to remain in compliance. Based on the evidence before the Court, the Court concludes that Defendants were not in contempt as of July 2016, nor are they today.

[10] *See* paras. 63–64.

PLAINTIFFS' REQUEST FOR DAMAGES

I. Standard of Law

In the federal courts, monetary recovery for civil contempt may be either remedial or coercive. *United States v. United Mine Workers of America*, 330 U.S. 258, 303–04 (1947). A remedial compensatory award for past instances of contempt is to remedy injuries resulting from the contumacious behavior. *Id*.

An award of compensatory damages must be based on the complainant's actual losses sustained from the past contumacious acts or omissions. *Id*. at 304. The party requesting damages bears the burden of bringing forward evidence to show it suffered actual loss, and that the loss was caused by contumacious acts or omissions. *Gen. Signal Corp. v. Donallco, Inc*., 787 F.2d 1376, 1380 (9th Cir. 1986).

On the other hand, a coercive remedy, as its name implies, compels future compliance. *Id*. A coercive remedy can be in the form of an order to do or refrain from doing something, or in the form of sanction payable to the Court, not the other party. *Gen. Signal Corp. v. Donallco, Inc*., 787 F.2d 1376, 1380 (9th Cir. 1986) (citing *Winner Corp. v. H.A. Caesar & Co*., 511 F.2d 1010, 1015 (6th Cir. 1975) (purpose of limiting prevailing party to actual losses in civil contempt actions would be defeated by allowing prevailing party to collect coercive civil contempt fine)).

Importantly, the Prison Litigation Reform Act ("PLRA") prohibits the Court from ordering an extension of the monitoring period as a coercive remedy absent a showing of continuing Eighth Amendment violations. *Hallett v. Morgan*, 296 F.3d 732, 742–44 (9th Cir. 2002); 18 U.S.C. § 3626.

II. Factual Findings Relevant to Damages Issue

After considering the evidence before it, the Court finds that there is insufficient evidence that the deviations in the mode or substance of auditing and monitoring or failure to implement line-item provision-of-care improvements prior to March 2016 caused Plaintiffs any actual damage. The Court also finds that the mental health and medical delivery system is currently, and was during the relevant time period, operating in accordance with NCCHC standards.

i. Offender #15[11]

a) Auditing Related to Dr. David Agler

110. Plaintiffs attempted to show that IDOC's failure to audit according to Addenda A and B caused Corizon to employ a doctor with a restricted license, which in turn caused Offender #15 injury.

111. Addendum A requires that Corizon review healthcare professional personnel records for verification of current licensure. Exhibit 1001 at 8. Addendum A also refers to NCCHC Standard P-C-01 under the training/recruitment/selection process/orientation requirement, which requires that no medical professional be permitted to work in the prison with a restricted license that limits practice to

[11] The parties have stipulated that the inmates referred to in these proceedings should be identified by number rather than name. The key to this numbering system is found in Exhibit 1 to the Sealed Stipulated Motion to Redact Inmates' Names from Hearing Transcripts. Dkt. 1199-1. However, the "Offender Key" stipulated to by the parties identifies only fourteen inmates and does not include this particular inmate. Therefore, the Court refers to this inmate as Offender #15. The parties are familiar enough with the record in this case to discern the identity of Offender #15.

correctional institutions. The 2012 Appendix A did not contain this particular point. *See* Dkt. 842 at 17.

112. As of September 23, 2010, Dr. Agler was restricted for five years to practicing medicine in a men's only prison where another healthcare provider or administrator was employed, or to practicing in the community where he was closely supervised by another doctor. Tr. at 245–48. The restriction was the result of a stipulation and order of the Idaho State Board of Medicine, which suggested that Agler may have used his position as a physician to engage in improper sexual contact or conduct with female patients. Exhibit 1016 at 1-2. Agler denied the allegations, but entered into the stipulation voluntarily. *Id.*; Tr. at 256.

113. Offender #15 entered ISCI and the long-term care unit on July 16, 2015, with pressure sores associated with his paraplegic condition. Exhibit 8. He was given regular wound care at ISCI and was told to wear Prevalon boots to protect his heels from contacting his mattress. Tr. at 195.

114. On August 18, 2015, Dr. Migliori noted that Offender #15 had developed a draining blister on his right foot. By August 25, 2015, Offender #15 had developed a two-by-two centimeter break down his left heel. Exhibit 8 at 17.

115. On September 5, 2015, Licensed Practical Nurse Cynthia Marria noted that Offender #15 refused to wear his Prevalon boot heel protectors. *Id.* at 21.

116. Offender #15 received continual care for his heels in the medical unit. *Id.* at 21-27.

117. On September 22, 2015, Dr. Migliori debrided Offender #15's heels; the left heel wound was closed, but the right was open and was therefore covered after cleansing, debriding, and application of an antibiotic. *Id.*at 27.

118. By September 25, 2015, Offender #15 had developed a "dollar-sized" blister on his left heel. *Id.* at 30.

119. On October 16, 2015, both heel wounds were debrided. *Id.* at 34.

120. On October 27, 2015, Dr. Migliori diagnosed Offender #15 with osteomyelitis and put him on Levofloxacin and ordered continuing judicious heel debridement. *Id.* at 38-39.

121. On October 29, 2015, Dr. Travis Kemp told Dr. Migliori by telephone that the probable best course of action would be bilateral amputations because of the osteomyelitis and the limited mobility caused by the weight of his legs. *Id.* at 40.

122. On November 17, 2015, Dr. Migliori checked Offender #15's heels and found that both were infected and swollen despite Bactrim/Levofloxacin. *Id.* at 46.

123. On November 24, 2015, Offender #15 saw Dr. Kemp, who recommended bilateral through-the-knee amputations. Offender #15 agreed to proceed with the recommendations. *Id.* at 49.

124. Dr. Agler took over Offender #15's treatment on December 1, 2015.[12] Tr. at 201:10–25. On that date, Dr. Agler noted in the record that surgery was scheduled and ordered that pain medication and antibiotics be continued. Exhibit 8 at 52.

125. On December 8, 2015, Dr. Agler noted that Offender #15's leg spasms would be resolved when the surgery was completed, but Dr. Agler nevertheless increased the dosage of Bactofin because that medication had apparently been helpful for the spasms before. *Id.* at 57.

126. On December 15, 2015, Dr. Agler noted that the office was working to get an appointment for the surgery with a new orthopedic surgeon versus scheduling the surgery with Dr. Kemp, as previously advised. Dr. Agler urged, "Surgery needed ASAP." *Id*. at 54.

127. Offender #15 complained at the evidentiary hearing that Dr. Agler never looked at Offender #15's wounds, nor did he debride them. Plaintiff discussed this with Dr. Agler, and Dr. Agler told Plaintiff that he was scheduled for the amputation and there was nothing Dr. Agler could do. Tr. at 202. Offender #15 described the wounds as black and very foul-smelling, like "roadkill." *Id.* at 202–03.

[12] It is unclear when Dr. Agler first began working at ISCI. The Court takes judicial notice of another case on its docket which tends to show that Dr. Agler was working at ICC, a different facility that was a private prison not subject to the *Balla* injunction, in August 2011 (*see* Case No. 1:12-cv-00036-BLW, *Gisel v. Agler*). Plaintiffs attempted to show that employing Dr. Agler at either facility was contrary to the contract terms between IDOC and Corizon, but the ICC information is irrelevant to the ISCI MCP.

128. Dr. Agler knew that osteomyelitis is a bone infection that can spread. *Id.* at 240. Dr. Agler did not debride Offender #15's heels because, in Dr. Agler's opinion, it was not medically indicated. *Id.* at 241.

129. Dr. Agler made his decision based on the following:

> [O]steomyelitis is an infection of the bone itself. And debriding a wound is cutting away skin tissue that is infected. If you are looking to debride bone itself, you'd have to do that in a surgical setting, so I wasn't able to do that. The fact was, as I recall, he was on prophylactic antibiotics at the time, so he was being treated. Debriding it not only was not indicated, but actually may have made things significantly worse, might have caused continued skin infections, worsening skin infections, bleeding and so forth. So I was trying to do no harm.

Id. at 261–62.

130. As of December 23, 2015, twenty-two days after Dr. Agler took over care of Offender #15, the five-year restriction on Dr. Agler's license expired, and he returned to the status of physician with a full-use medical license. *Id.* at 260.

131. While Offender #15 was waiting for his amputation surgery, nurses bathed and cleaned him regularly. They also changed his dressings and kept his heel "bandaged, wrapped very well." *Id.* at 209.

132. Offender #15's legs were amputated on January 4, 2016. *Id.* at 194–95.

133. In November 2016, a federal court jury found Dr. Agler deliberately indifferent to the medical needs of Offender #4,[13] one of his prisoner patients at a different

[13] Plaintiffs' counsel represented in his questioning that the prisoner had been treated at ISCI. That misrepresentation was corrected on cross-examination. Tr. at 253–55.

facility. At that time, Dowell and the IDOC revoked Dr. Agler's security clearance so that he could no longer work at any of the prisons. *Id.* at 253–54.

134. Had Defendants been auditing as they should have under Addendum A, rather than Appendix A, they could have prevented Dr. Agler from treating Offender #15 at ISCI while Dr. Agler's license was restricted, between December 1, 2015, and December 23, 2015. However, there is nothing in the record indicating that Dr. Agler treated Offender #15 inappropriately; rather, the treatment appears reasonably appropriate given that the amputation had already been ordered.

135. The Idaho State Board of Medicine standards and the NCCHC standards are directly at odds with each other regarding doctors practicing with restricted licenses. Because the allegations against Dr. Agler consisted of improper sexual conduct with female patients, the Board authorized Dr. Agler to continue to practice in only certain settings, one being an all-male prison. Contrarily, the NCCHC standards do not permit someone who has a license that is restricted to practicing in a prison setting to work at a prison. However, NCCHC's Dr. Gibson, an expert on prison health care standards, did not know, and there is no evidence in the record of, the theory behind that standard. Tr. at 230. Here, there is no connection between the reason for Dr. Agler's restriction and Plaintiffs' alleged damages.

136. There is no evidence showing that IDOC's manner of monitoring related to Dr. Agler's status of working with a restricted license at ISCI prior to December 23, 2015, caused Offender #15, or any other ISCI patient, harm or injury.

b) Auditing Related to Nurse Joni Lemons

137. Plaintiffs also attempted to show that Nurse Monitor Joni Lemons audited in an improper manner, or not at all, during certain times when Offender #15 had bed sores. The audits showed that Offender #15 did not complain of anything during the audits. Tr. at 169; *see generally* Exhibits 5, 6, 7. Offender #15 testified that the only reason he did not make complaints that were recorded on Lemons's written audits was that he did not know what Lemons's purpose was in performing the audits and thought she knew what was going on with his legs through her review of the medical charts. Tr. at 200–01.

138. Offender #15's testimony regarding Lemons's allegedly deficient auditing was not credible, because each week he signed off on Lemons's audits stating that he had received adequate hygiene, medication, and food and had no other concerns.

139. Offender #15's contention that medical staff refused to help him put on the Prevalon boots is also not credible. The medical records show that Offender #15 refused to wear the boots. Offender #15's contention is not supported by any corroborating evidence, such as offender concern forms, Health Services Requests (HSRs), or grievances complaining of lack of help. The record also reflects that Offender #15 liked to do things "his way," such as popping wheelies in his wheelchair, getting into beds other than his own, and refusing help for some transfers between beds. *Id.* at 88–89.

140. Lemons credibly testified that outside of the context of the audits she recalled Offender #15 verbally complaining that his sores were getting worse, but that the

complaints occurred only after he was cleared for amputation. Lemons testified only to what she knew and remembered; she was quick to admit when she did not remember something or did not do something.

ii. Offender #3

141. Plaintiffs vaguely allege that in January 2017, IDOC's failure to monitor according to Addenda A and B caused Offender #3 to suffer frostbite and amputation of some of his fingers. Dkt. 1090-1 at 21.

142. Offender #3 is an inmate with dementia who frequently wandered away from his assigned cell or bunk. Tr. at 621–22.

143. At a Monitoring Meeting prior to November 19, 2015, class representatives suggested that Offender #3 should be placed in different housing. Offender #3, who was housed in Unit 9, had been wandering into other inmates' cells. Class representatives were concerned that he was going to be assaulted if he wandered into the wrong inmate's cell, because Unit 9 is a little "rough and tumble." Tr. at 622.

144. Offender #3 was moved from Unit 9 to Unit 14, another dorm setting, where he was found in other people's beds, which again caused class representatives a concern. *Id.* at 621–22. At the November 19, 2015 Monitoring Meeting, Dowell reported that Offender #3 had been moved to the medical annex. *Id.*; Exhibit 1024 at 8. There is no evidence that inmates complained that the medical annex was improper housing for Offender #3.

145. Although some IDOC officials, including Dowell, Yordy, and the IDOC Move Coordinator, knew of Offender #3's wandering, Offender #3 was placed in the seventy-eight-bed medical annex, an open, dorm-style building classified as general population. Tr. at 440, 466, 468, 470–71, 621.

146. The "medical annex" inmates are not necessarily given more medical care than those in general population, though the name implies otherwise. Rather, it is a newer building that officials chose to locate near the medical building, and, hence, its name became "the medical annex." *Id*. at 464; Exhibit 2016. Inmates assigned to the medical annex can come and go, but the medical infirmary and long-term care units are more secure. Tr. at 440–41. Some of the inmates in the medical annex were young and healthy, while others were geriatric, had Alzheimer's disease, or had a variety of other conditions, including cerebral palsy and HIV/AIDS. *Id.* at 421–22, 441–42.

147. Sergeant Payton, who worked in the medical annex, attempted to mark Offender #3's uniform with stripes so he could be easily identified when he wandered, but that was deemed an unauthorized act, and officials forbade him from doing so. *Id.* at 512–13. Warden Yordy said not everyone knew what the stripes signified, and Yordy was concerned about signaling that an inmate was different from others. *Id.* at 513. IDOC officials did not propose any alternative solution to keep Offender #3 safe.

148. An option for Offender #3 would have been the long-term care unit, located downstairs in Medical Building 20, but it has only fifteen or sixteen beds, and it is

"pretty full" most of the time. *Id.* at 464. It takes a physician's order to be assigned to the long-term care unit. *Id.* at 523–24. The Court notes that another option might have been housing Offender #3 in the twenty-nine-bed medical unit (the infirmary). *Id.* at 528.

149. In January 2017, Offender #3 wandered away from his housing unit and was outdoors in sub-zero weather for about an hour and a half. No one in his housing unit recognized that he was missing. It is unclear whether officers who walked the yard every hour missed seeing him, they saw him but did not suspect anything wrong, or they did not actually walk the yard every hour.[14] *Id.* at 466–72.

150. On January 6 or 8, Offender #3 was admitted to the infirmary for frostbite, and some of his fingers were amputated. He was given a prescription for the pain medication Ultram. He was medically assessed regularly between January and April to treat his frostbite. *Id.* at 92–96.

151. Offender #3 was relocated to the long-term care unit after recovering from the incident. *Id.* at 471.

152. This is an unfortunate incident, but there are no connections between it and the manner in which the IDOC monitored the *Balla* injunctions. There are no medical or mental health records in the evidentiary record before the Court showing Offender #3's history of medical or mental health assessments by which a

[14] There is also a report stating that Offender #3 reported to a nurse that he fell down some stairs at the gym before he went outside to walk the track. Tr. at 531–32; Exhibit 2007 at 104. Offender #3 also testified at trial that his fingers "got . . . taken away" because he "had too much laundry." Tr. at 550. Obviously, Offender #3 had little ability to relay what happened to him, but whether he fell inside, outside, or both is not material; that he suffered frostbite is.

connection might have been shown, if one existed. Without more, this appears to have been a security issue that should have been aimed at IDOC security officials in an individual lawsuit, not a medical issue falling under the MCP.

iii. Offender #10

153. Plaintiffs attempt to show that IDOC's failure to audit in accordance with Addenda A and B caused the suicide death of Offender #10.[15] Plaintiffs point to several deviations from Addenda A and B: (1) Dr. Stern recommended that inmates who have mental illnesses should not be considered for hire as suicide watch companions, and, consequently, all suicide watch companions should have emotional stability screening before being hired; (2) the clinician who evaluated and cleared Offender #10 to be a suicide watch companion had not renewed her license; and (3) a six-month evaluation of Offender #10 was not performed.

a) Use of Inmates with Mental Illnesses as Companions and Failure to Do Pre-Hiring Mental Stability Screening

154. Plaintiffs obtained Offender #10's prison and mental health records but only submitted selected parts to show that Offender #10 had a history of multiple prior suicide attempts, had a family history of suicide and suicide attempts, was diagnosed with several mental health conditions, was on several types of psychiatric medication, had missed several dosages of her medications, and had

[15] Offender #10 was a gender dysphoric inmate. Because Offender #10 identified with the female gender, the Court refers to her with feminine pronouns.

lived in the Behavioral Health Unit during most of her imprisonment. Exhibits 1050–53, 1055–60.

155. Several witnesses testified about Offender #10's mental stability screening, the gap in time when IDOC was not performing screenings, and the type of training clinicians received to perform the screenings, as follows.

156. Tyson Hansen, currently the *Balla* compliance manager and a licensed mental health provider, served as the suicide companion coordinator and the psychiatric treatment coordinator between 2014 and 2016. Tr. at 358–30, 413–14. He was not a licensed mental health provider at that time, and his position did not require it. *Id.* at 413–14.

157. In his former position as suicide companion coordinator, Hansen reported to the clinical supervisor (a position requiring a mental health clinician license). *Id.* at 666–67.

158. Hansen had never seen the MCP or Addenda A and B before September 2015, when Dowell and other IDOC officials began meeting to determine whether they were in compliance. At that time, he learned of MCP areas with which he was not compliant with respect to his job as the suicide companion coordinator. *Id.* at 360–61.

159. Hansen found three deviations from the MCP related to his work area. First, inmate companions were not being assessed for emotional stability at the time of their application. *See generally* Exhibit 1073 (Stern Report). Beginning in February 2016, however (four months *before* Offender #10 was hired to be a

companion), each applicant *was* screened for emotional stability before being hired. There was a gap of time between September 2015 and February 2016, when IDOC knew applicants were not being screened and when it started the screening, but that is irrelevant to Offender #10, as she had not yet been hired as a companion. Tr. at 369–70.

160. Jeremy Clark, an Idaho-licensed clinical professional counselor, was the clinical supervisor of the ISCI Behavioral Health Unit from about July 2015 to June 2016. As clinical supervisor, he was responsible for training inmate companions, conducting the shadowing component of that training, and holding regular meetings with the companions. *Id.* at 661–67.

161. In 2016, Clark became the person responsible for collecting the *Balla* data on the mental health side. Each month he collects a data set, consisting of random numbers of inmates and their files, and reviews them for things such as mental health screenings, treatment plans, mental health assessments, and DOR recommendations. He also looks at suicide risk management numbers and suicide risk management training. *Id.* at 661–62.

162. After becoming involved in *Balla*, Clark provided mental health clinician training on how to do the suicide watch companion assessments, including instructions to clinicians to "[e]nsure you review the medical file, ensure you meet with the inmate, ensure you review all the stuff to determine that stability." *Id.* at 668.

163. Clinician Amy Houser performed an emotional stability assessment of Offender #10 (to what extent is unknown) on June 18, 2016, as a prerequisite to Offender #10 being approved as a companion. *Id.* at 698; Exhibit 1049.

164. There is no evidence in the record showing whether Houser received Clark's training before screening Offender #10.

165. There is insufficient evidence in the record whether Houser had reviewed Offender #10's medical file before approving her to be a companion.

166. Houser wrote in her June 18, 2016, screening notes: "We discussed intricacies of being a companion, and [Offender #10] feels comfortable with the job descriptions. [She] discussed [her] current coping skills and how [s]he would manage any stressors. And [s]he denies SI [suicidal ideation], HI [homicidal ideation], and SIB [self-injurious behavior]." Tr. at 373–74.

167. Based on Houser's screening, Hansen approved and hired Offender #10 to be a suicide watch companion in June 2016.

168. Offender #10 had a suicide watch companion shadow training on July 2, 2016, and then started work. Exhibit 1047.

169. Plaintiffs are concerned that Offender #10 had attempted suicide more than once while in IDOC custody, with the latest attempt in May 2016, just one month before her appointment as a suicide watch companion. *See* Exhibit 1058.

170. There is insufficient evidence in the record to show that Offender #10 committed suicide *because* she was a suicide watch companion. The record reflects that she tended to try to commit suicide during manic-depressive cycles. Exhibit 1055. She

assured two mental health professionals within five days of her suicide that she was stable, was non-suicidal, and was using coping mechanisms. Exhibits 1064, 1065. She recently had been harassed by other inmates due to coming out as a gender dysphoric ("GD") inmate, but she told the mental health professionals that she planned to reach out to other GD inmates to help her work through the incident. Exhibit 1065.

171. Plaintiffs cite to the Stern Report to bolster their assertion that persons with mental health issues should not serve as companions. Tr. at 627–28. Stern wrote that "the [suicide watch] program operates without adequate screening of the participants in contrast to the current policy and principles of safe patient care. Some applicants chosen have significant mental health issues themselves." Exhibit 1073 at 32. Plaintiffs omit the next sentence, which shows that this cautionary recommendation is intended to protect the inmates *being watched*, not the inmates *doing* the watching: "This [failure to screen companions] puts the inmates they work with at risk." *Id.*

172. The is no evidence of a connection between the IDOC's past failure to screen companions and the suicide of Offender #10, who *was* screened.

173. The parties have not pointed to any section in the MCP that required additional training for clinicians to perform the assessments.

174. The record also reflects that the thrust of the MCP provisions from which the IDOC deviated was not to protect the mental health of the companions, but to protect the inmates who were being watched.

b) Clinician's License Lapse

175. As set forth above, Mental Health Clinician Amy Houser performed the mental stability screening of Offender #10 in June 2016.

176. Houser was previously licensed in Idaho but her license lapsed for unknown reasons, and she was therefore practicing without a current license from November or December 2016 to sometime in or after February 2017. Tr. at 332–33. Offender #10's assessment did not take place during the time frame when Houser was unlicensed.

177. There is no evidence to show that at the time Houser evaluated Offender #10, she was not working under a valid, current license.

c) Sixth-Month Evaluation

178. The second deviation from the MCP at issue is that IDOC was not performing six-month reviews of companions to determine whether the companions were still emotionally stable enough to do the job. Hansen started making sure this was done (consisting of a combination of a review by himself and a clinician) in August 2015, because Dr. Craig asked him to do so, rather than as a consequence of Dowell's September 2015 meeting about MCP deviations. Id. at 369–72.

179. Offender #10 worked as a suicide watch companion without reported incident between July and November 2016. Exhibits 1047, 1061.

180. Plaintiffs have endeavored to prove that the IDOC's failure to conduct a six-month evaluation on Offender #10 to determine whether she was still emotionally stable enough to function as a companion contributed to Offender #10's suicide.

Offender #10 began work at the earliest in July 2016, after her training. Six months from July 2016 was January 2017.

181. On November 21, 2016, Offender #10 was involved in a suicide watch where the following incident occurred, as described in the Companion Watch Program Attendance Report: "While [Offender #10] was watching the patient, the patient scratched his leg in a way that [Offender #10] was unaware until the patient showed [Offender #10] the blood on his hand. The watch was transferred to acute watch due to the patient's behavior. [Offender #10] asked for some time off to process what had happened. Program Supervisor Hansen and I agreed with [her]." Exhibit 1061.

182. Following that incident, Offender #10 had a mental health evaluation by Clinician Y. Ponder that was specifically aimed at determining whether Offender #10 was mentally stable enough to continue as a companion. Tr. at 389–90. Clinician Ponder evaluated Offender #10 and cleared her for continued work as a suicide companion. *Id.* at 408. This was at the five-month mark.

183. Offender #10 took a week off in November, then called in sick rather than appear for work, but afterwards resumed work at some point. Exhibit 1061; Tr. at 391; Dkt. 1149-9.

184. Offender #10 was further evaluated on January 25, 2017, by Psychiatrist Scott Eliason, and found to be at low risk of suicide. Exhibit 1064. This was at the six-month mark, but was not specifically designated a six-month suicide watch companion reassessment.

185. Offender #10 completed her last watch on January 28, 2017. Dkt. 1149-9.

186. At the behest of security staff, Offender #10 was evaluated again by Ponder on January 29, 2017. Offender #10 "denied any current suicide ideation" and "did not report plan or intent." Exhibit 1065.

187. Offender #10 hanged herself later that day. Exhibit 1066.

188. The record reflects that the three evaluations of Offender #10 were the functional equivalent of having had a six-month suicide watch companion reassessment. The record further reflects that the required six-month assessment was for the purpose of making sure the inmates on suicide watch were not harmed, not for the purpose of preventing harm to the suicide watch companions.[16]

189. Perhaps the most pertinent health care record observation of Offender #10 was from her January 2015 suicide attempt: "It should be noted that precise prediction of suicide and other self-injurious behavior is difficult, of limited reliability, and diminishes significantly over time." Exhibit 1055.

190. IDOC mental health personnel Hansen, Houser, Ponder, and Eliason all determined that Offender #10 was fit to be a companion or was at low risk to commit suicide, both on initial assessment and in three reassessments. Tr. at 391–92, 409–10.

[16] While preventing harm to suicide watch companions is an important goal, the MCP and the Stern Report are focused on potential harm to the inmates on suicide watch, and the contempt motion is focused on the auditing required by the MCP and the Stern Report.

191. The record does not show a causal link between the MCP deviations and Offender #10's suicide.

192. To the extent that Plaintiffs complain that mental health providers performed the mental health assessments badly, such claims would be more appropriately brought in individual lawsuits based on state tort or federal civil rights law.

iv. Offender #9

193. Plaintiffs attempt to show that Offender #9 would not have died had IDOC conducted its auditing according to Addenda A and B, because Offender #9 was a Spanish speaker who was not provided with an interpreter for his medical visits.

194. This attempt fails, because Lemons did, in fact, conduct the HSR audits, and Offender #9's HSRs were not among those in the "ten percent plus one" of audited records that was generated on the review list, such that Lemons could have intervened in his treatment. Tr. at 178:1–12.

195. The medical records show that Offender #9 was a fifty-eight-year-old man with no ongoing serious medical conditions. Exhibit 1011 at Bates No. IDOC003778.

196. Offender #9 completed an HSR form on March 30, 2016. Exhibit 1012 at Bates No. IDOC 022418. He was triaged and evaluated on April 5, 2016. *Id.*

197. The parties contested whether Offender #9 appeared for evaluation at the medical unit on March 30, 2016 and not triaged until April 5, 2016; or whether he simply wrote up and signed the HSR form on March 30, 2016 and did not actually go to the medical unit until April 5, 2016. Tr. at 139–40.

198. Several items from the record seem relevant to the date controversy. Offender #9 HSR stated he did not speak English and needed a Spanish interpreter. Exhibit 1012 at Bates No. IDOC 022418. In a Monitoring Meeting on February 25, 2016, Dowell advised that non-English speakers should write their request for an interpreter "directly on the HSR at the time of submission so they can be set up in advance." Exhibit 1027 at 5; *see also* Tr. at 624–27 (testimony that officials were telling inmates to place the request for an interpreter on their HSR so that "officials can have an *interpreter ready when the inmate comes in*." (emphasis added)). That statement and the fact that the HSR form bears the instruction, "Place this slip in medical box or designated area," seem to show that the medical department receives the HSRs "ahead" of the inmate's visit (although the medical box may be in the sick call area and "ahead of time" may mean while the inmate is waiting to be triaged). Exhibit 1012 at Bates No. IDOC 022418.

199. However, Siegert explained that "[e]ach unit is assigned a time to come to medical for sick call. So when they come, they bring their health service request with them. When they arrive, it's stamped as triaged at that time, and they're seen in sick call right after the triage." Tr. at 148.

200. Supporting Siegert's explanation is the fact that nothing in Offender #9's chart indicated that he, in fact, presented himself at sick call on March 30. *Id.* at 138–40.

201. In any event, the audit did not cover Offender #9's HSRs. Thus, Plaintiffs have not connected the auditing to any harm that might have occurred if Plaintiff requested care on March 30 but did not receive it until April 5.

202. Offender #9's HSR, signed on March 30, 2016, shows that he was seen and triaged on April 5, 2016. Exhibit 1012 at Bates No. IDOC 022418. Offender #9 was assessed by LPN Alyssa Turpin. He complained of bruising on the side of his nose bridge, soreness under each eye, ongoing sinus problems, ear pain, and itching in his ear canal. His eyes, ears, nose, throat, neck, and lungs were assessed as normal. *Id*. at Bates No. 002419. It was noted that he was using or was advised to use Claritin. *Id*. at Bates No. 022420. Turpin checked a box stating that that "[t]he patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care," as well as the box for "verbal" rather than written instructions. *Id*. at Bates No. IDOC 022418–022420. Nothing indicated Offender #9 and the nurse could not communicate.

203. Offender #9 returned to sick call on April 8 with fever, chills, a cough, and a sore throat. Correctional Medical Specialist Cindy Hoopes scheduled him to see a provider the same day. *Id*. at Bates No. IDOC 002416. At this point, his temperature was 101 degrees. LPN Jan Drake told him to take Acetaminophen, increase fluids, rest, and return in the afternoon to have his vital signs taken again. *Id*. at Bates No. IDOC 003778.

204. Offender #9 returned in the afternoon, and his temperature was within the normal range at 98.2 degrees. He was seen by an unidentified provider. That provider and Offender #9 had a meaningful conversation about his illness. Offender #9 communicated that he had not been drinking many fluids, and his bunkmate had been ill with a cough lately. The provider concluded Offender #9's illness was

most likely viral. *Id*. at Bates No. 022412. The provider specifically noted: "Discussed clinical findings and implications as well as [illegible] medication/use and SE/AE [likely, 'side effects' and 'adverse effects']. Pt verbalizes understanding and agrees with plan" and had no further questions or concerns. *Id*.

205. After the provider's notes, Jan Drake entered another note: "Verbal instructions given to pt to have unit security call ER if he worsens." *Id*. at Bates No. IDOC 022411.

206. Offender #9 came to sick call again the next day—Saturday, April 9—saying, "been here 3x [three times]," which again indicates Offender #9's ability to communicate with the provider. *Id*. at Bates No. IDOC 022414. Offender #9 complained of a non-stop cough, difficulty breathing, and lots of phlegm. He reported he was taking or was told to take the medication Tussin. His temperature was 98.7 degrees. He was scheduled to be seen in the clinic on April 12, 2016. *Id*. at Bates Nos. 022411 and 022414; Exhibit 1011 at Bates No. 003778.

207. The record shows that Offender #9 did not come to his appointment on April 12. Exhibit 1011 at Bates No. 0037780. The reason is unknown. Offender #9's unit was notified of his no-show. A report shows that an officer went to Offender #9's cell and advised him to return to the medical unit. *Id*.

208. Between April 12 and April 16, 2016, Offender #9 appeared at the medical department for a urinalysis. Nurses did not indicate in the medical records that Offender #9 reported that he was in pain or suffering or sick when he came to do his urinalysis. Tr. at 124:20–25, 125:1, 134:21–25, 135:4–13.

209. On April 17, 2016, Offender #9 was found nonresponsive in his cell. He was transported to the hospital, and he died of sepsis secondary to necrotizing pneumonia on April 18, 2016. Exhibit 1011 at Bates No. 003777.

210. Siegert explained that sepsis and pneumonia are not always fatal and can be treated. Tr. at 44:18–25, 45:1. However, in this particular case, Siegert found the medical care was appropriate, and she did not identify any potentially preventable errors of omission or commission in her mortality review of Offender #9's death. Exhibit 1011 at 003777.

211. Because Offender #9's records were not part of the audit conducted by Lemons, Plaintiffs have not established a causal link between Defendants' mode of auditing and Offender #9's death. Nevertheless, Plaintiffs have shown that there is some question whether Offender #9 would have died had the providers offered him different treatment. Offender #9's death may therefore be more appropriately the subject of an individual civil rights action, rather than a contempt motion in this case. Defendants' failure to comply with Addenda A and B did not contribute to Offender #9's death.

v. Offender #8

212. Offender #8 was a fifty-nine-year-old inmate with diagnoses of Hepatitis C with cirrhosis and esophageal varices with banding, who died at ISCI during the MCP auditing period. Exhibit 1014 at Bates No. IDOC 000676.

213. Offender #8 submitted an HSR on December 23, 2014, at a different IDOC facility. He was diagnosed as having a hernia at the other facility. He was

transferred to ISCI on either December 23 or 24, 2014. Upon arrival at ISCI, he was medicated and his hernia was reduced. *Id.*

214. On the morning of December 25, 2014, Offender #8 vomited a large amount and indicated that he was feeling better. It appears likely that he was seen by Physician's Assistant Brown at that time, but Brown's note is undated. *Id*.

215. Offender #8 continued to complain of nausea and vomited a third time. The first assessment showed hyperactive bowel sounds, reduced hernia, and a low-grade fever. Reassessment showed a hypoactive hernia. The provider was contacted with this information. Offender #8 then had projectile hematemesis (vomiting of blood), and the provider was contacted again and gave orders. *Id.*; Tr. at 124–26.

216. The provider was contacted again when Offender #8 continued to have hematemesis. Exhibit 1014 at Bates No. IDOC 000676. He was given an IV. His ammonia level was 121. *Id*.

217. On December 26, 2014, about 2:15 a.m., the IV was "pulled out," and Offender #8 declined to have the IV restarted. *Id.*

218. That same day, at about 6:20 a.m., Offender #8 vomited after being given Lactulose. *Id.*

219. The provider notes reflect that around 9:15 a.m., Offender #8 had increased confusion. After evaluation, he was sent as an emergency to the emergency room for further evaluation. He was admitted to the hospital the same day, December 26, 2014, and he died in the hospital on January 2, 2015. *Id*.

220. Offender #8's cause of death is noted as "aspiration of esoph varceal bleed as a comp of liver fail from . . . ." *Id.* at Bates No. IDOC 000675 (showing an expandable computer form, but not including the rest of this note as submitted to the Court.)

221. Upon a review of Offender #8's records, Siegert opined that the care he received during the twenty-four hours he was in the infirmary was inappropriate. She made Corizon aware of her concerns. Tr. at 127.

222. From Siegert's review of the records, she believed that the issues resulting in the projectile vomiting of blood should have been caught and remedied before Offender #8's symptoms reached that point. *Id.* at 49–50. Her other findings included: failure to follow up may have contributed to Offender #8's death; lack of training and education may have contributed to Offender #8's death; there were preexisting conditions in Offender #8's medical file that should have been caught; diagnoses should have been made (a failure to diagnose issue was present) or treatment was delayed; and the physician's assistant may not have had adequate training or employed the training that he did have. *Id.* at 50–53.

223. Neither party included the hospital records in the evidentiary record. It is unclear whether Offender #8's death was preventable if he already was in liver failure, but it appears his symptoms of aspiration of bleeding caused by liver failure might have been lessened or prevented, as noted by Siegert.

224. Siegert opined that none of the *Balla* audits would have prompted an intervention into the care of the individuals for whom she performed a mortality and morbidity review. *Id.* at 128. Plaintiffs have submitted no evidence to the contrary.

vi. Offender #16's[17] Allegations

225. Offender #16 alleged that an unidentified inmate who had the flu was placed in a bed next to another unidentified inmate who just had heart surgery. Tr. at 107.

226. Siegert's investigation of the medical records revealed that the first inmate had received a flu shot that year and did not have the flu, and there was no notation in the record that he had the flu during that time. The second inmate did not have open heart surgery, but had a heart catheterization, a minimally invasive procedure (angioplasty) that should not have rendered the inmate vulnerable in terms of his immune system. *Id.* at 107–08.

227. The Court finds these allegations to be unsupported and unrelated to any auditing issue.

vii. Damages Related to Mortality Rates and Suicide Incidents

a) Mortality Rates

233. Plaintiffs allege that the IDOC's violations of the MCP led to increased mortality rates at ISCI.

234. There were fifty-four inmate deaths at ISCI between June 2012 and June 2014. There were thirty-one inmate deaths at all other facilities during that same time

[17] The Court uses "Offender #16" here for the same reason it uses "Offender #15." *See* note 11, *supra*.

period. The average population at ISCI during that time period was 1,600. Tr. at 31:21–25, 32:1–17.

235. Plaintiffs believe that the ISCI mortality rate was unusually high because ISCI was not the only prison that housed inmates who were at a higher risk of death. In all other Idaho male prison facilities, there are individuals who are over the age of sixty, who have abused alcohol prior to coming to prison, and who have Hepatitis C. Moreover, they add, in Idaho, all females with every type of medical condition reside at one main female prison. *Id.* at 137. In other words, there are sick, ill, and elderly patients at every prison, and yet more deaths happen at ISCI.

236. Plaintiffs rely on a mortality report for state prisons compiled by the United States Department of Justice ("DOJ"). Dkt. 1132-37. The Court takes judicial notice of the existence of this public record. The 2014 overall national mortality rate for state prisoners was 275 per 100,000 prisoners, and the median mortality rate was 267 per 100,000 prisoners. Idaho's reported rate per 100,000 prisoners was 307 in 2014.

237. Plaintiffs used only the deaths at ISCI to calculate ISCI's mortality rate at 812 per 100,000 prisoners. Dkt. 1090-1 at 19. The DOJ report shows deaths of inmates per state, rather than deaths at specific facilities. Without more investigation, it is impossible to know whether other out-of-state facilities that function as that state's main infirmary, like ISCI, have lower mortality rates than ISCI.

238. A comparison among Idaho's male prisons shows that more deaths do happen at ISCI, but all other male prisons send their sickest patients to the ISCI facility. Tr.

at 135. While it is true that inmates with serious medical conditions are housed at other prisons, Plaintiff has not shown to what extent they are or are not transferred to ISCI if their condition becomes life-threatening. ISCI has the best and largest infirmary and the only long-term care unit in the IDOC system. *Id*. at 127–28.

239. Further, Plaintiffs' comparison of the mortality rate at male and female prisons is unsupported by any facts. There is not enough information in the record regarding the life span of females versus males, the number of females with long sentences, the age of the females in prison, the overall health of female prisoners entering prison, the types of illnesses and disease that beset females, or any other factors that might show the female population can or cannot be distinguished from the ISCI male population. This particular argument is completely unavailing.

240. There is no evidence demonstrating that IDOC's mode of monitoring had anything to do with the ISCI mortality rate from 2014 to 2016.

241. There is no evidence that Plaintiffs used the MCP dispute resolution process to notify Defendants that Plaintiff suspected that IDOC's mode of monitoring was linked to a high mortality rate at ISCI.

242. As of April 28, 2016, the IDOC ceased including notices of death on the Report Card because of privacy issues regarding the deceased inmates. Tr. at 647; Exhibit 1029 at 11. Plaintiffs thought this impeded their ability to monitor; however, this information was readily available to counsel under an Attorney Eyes Only ("AEO") policy. Tr. at 330; 647.

243. A discussion of mortality reviews recorded in the April 28, 2016 Monitoring Meeting minutes highlights the speculative nature of some of the claims arising from the ISCI deaths: "Mr. Searcy asked what the process was for declaring someone dead. Ms. Siegert responded that it could be a health care provider or a doctor. A mid-level provider would be acceptable—a PA could do this. Mr. Searcy said the question comes about in light of the offender death that occurred last week. Mr. Searcy said offenders were very upset by the conflict between what offenders saw on the tier and what was reported on the news. The news reported the offender was declared dead at the hospital hours later, while the offenders on the tier said he looked dead before he left." Exhibit 1029 at 11.

244. The claim for contempt and damages regarding the number of deaths that occurred at ISCI during the monitoring period cannot be sustained on the evidence provided to the Court.

b) IDOC Mortality and Morbidity Reviews

245. Concerning the IDOC Mortality and Morbidity Reviews ("mortality reviews"), the Court is unable to find any causal link between IDOC's mode of conducting mortality reviews and the mortality rate at ISCI, or any link between the mode of monitoring and the deaths that occurred, even in instances where Siegert noted that medical care may have been inappropriate.

246. Addendum A requires that Health Services Director Siegert "conduct an internal review of mortality cases," including that she "review[] the offender's medical record, attend[] the mortality and morbidity review conducted by the contract

medical provider and complete[] the IDOC morality review form." Exhibit 1001 at 19. To fulfill these duties, Siegert does a thorough review of the medical record, prepares a short narrative of the events surrounding the death, fills out the form, and meets with Corizon (the regional medical director and staff who participated in caring for the patient). She also prepares a national report for each death. Tr. at 109–12.

247. The purpose of the mortality review is to identify areas for improvement. In some instances, a mistake was made or an early test result went unheeded. *Id.* at 110–120. From her mortality reviews in 2014, 2015, and 2016, Siegert made note of possible preventable errors and other omissions that may or may not have contributed to patient deaths. Those errors and omissions were discussed with Corizon's regional medical director and any staff who actually participated in the care of the patient. *Id.* at 111.

248. Siegert did not report the omissions or possible preventable errors found in the mortality reviews to Plaintiffs. *Id.* at 51–53. Such reporting was not required by the MCP. *See generally* Exhibit 1001.There has been no showing that, had Siegert reported the issues, it would have made any difference in the monitoring or in preventing other bad outcomes.

249. The Deviation Matrix shows that the IDOC failed to conduct "serious incident reviews (SIRs)" in most of the mortality reviews from 2014 to 2016.[18] Exhibit

[18] An SIR was conducted in Offender #20's death, as discussed below.

1075 at 33. Plaintiffs have not established what an SIR is or how the failure to conduct one caused Plaintiffs any harm. Plaintiffs' response to the Deviation Matrix only asserts that Plaintiffs are entitled to these reviews conducted under Addenda A and B.

250. Nor is there any showing that any other *Balla* audit would have prevented any of the outcomes Siegert found in the mortality reviews or that she could have actually intervened in the care of the individuals for whom she performed the reviews prior to their deaths. Tr. at 129.

251. Errors and omissions can happen in medical treatment. Auditing serves the purpose of finding errors and omissions, and bringing those to the attention of health care personnel, so that the errors and omissions are not repeated. Here, the auditing is performing as intended when Siegert sits down with Corizon physicians and the personnel who cared for the decedents to review errors and omissions.

252. As to the errors and omissions themselves, none of the mortality reviews shows any particular systemic problem with the medical and mental health delivery system at ISCI. The estates of the decedents may, or could have, pursued these claims in individual state tort or civil rights lawsuits if they believed the errors and omissions rose to the level of deliberate indifference.

253. For example, Offender #2's intake lab results showed that his liver enzymes were elevated. No one informed him of that, and no one followed up, but it turned out he had Hepatitis C (whether he knew this at the time of intake is unknown). About

one year later, at age sixty-three, Offender #2 died of "ESLD [likely, 'end-stage liver disease'] due to complications of Hepatitis C." Exhibit 1006 at Bates No. IDOC 000695. Plaintiffs have not shown that the problem at intake was systemic, nor have they shown that auditing exactly as Addenda A and B required would have changed the outcome.

254. Another example is Offender #1, a wheelchair-bound inmate who entered IDOC custody in June 2008 and died in November 2014, at the age of seventy-nine. The suspected cause of death was a cardiac event and the confirmed cause of death was acute myocardial ischemia. Siegert performed the mortality review of Offender #1 and found the following: (1) he was "in poor health with diagnoses of CAD, DM, HTN, A-Fib and CKD;" (2) he went to take a shower and was found unresponsive in his wheelchair after about twenty minutes; (3) at 7:30 a.m., the patient was determined to be pulseless; (4) a Corizon LPN put the patient on the floor and then called to find out his "code status" before initiating CPR; (5) upon finding out that the patient was a DNR (likely, "do not resuscitate"), medical staff did not initiate CPR; (6) the patient's POST (likely, "physician orders for scope of treatment") stated he did not want chest compressions but did want rescue breathing, use of an AED (likely, "automatic external defibrillator"), and aggressive interventions; and (7) at 8:20 a.m., the patient was pronounced dead. Exhibit 1007 at Bates No. IDOC 000710. Siegert identified "potentially preventable errors of omission or commission associated with opportunities for improvement in systems and processes unrelated to the event." *Id*. at Bates No. IDOC 000709.

255. Siegert's review of the medical records reflects that the Corizon emergency responder for Offender #1 noted there was no audible pulse and no audible blood pressure for Offender #1. Siegert does not believe the ER's decision to call for a code status contributed to Offender #1's death, but she identified calling for a code over resuscitation efforts to be an area for improvement to discuss with Corizon. Tr. at 120.

256. This appears to have been a one-time incident that reflects a need for correctional officer training and a clarification about what is to be done when a patient is nonresponsive with unknown POST instructions. There is no evidence that there was a systemic problem related to this incident or that any lack of or deficiency in auditing caused Offender #1 harm. In fact, the opposite appears true: Siegert's mortality review identified an area where inappropriate care was given, so that improvements could be made.

257. Offender #7 was a seventy-six-year-old man with "poorly controlled diabetes due to patient[']s non-compliance with diet, medication and CDP visits, longstanding diabetic foot ulcer, myocardial infarction with LV failure, and pulmonary hypertension." Exhibit 1009 at Bates No. IDOC 000686. He had surgery for a chronically infected/osteomyelitis foot in June 2015. Tr. at 121:2–4. Siegert determined that Offender #7 had submitted an HSR in January 2015 complaining of difficulty breathing, but that he had not been appropriately referred to a provider. *Id.* at 121:14–22. That was six months before he died, and there is nothing in the record suggesting that his death—noted as due to complications

from diabetes—had anything to do with a respiratory issue like the one he complained of in January 2015.[19]

258. In two instances, one on May 7, 2015 (Offender #20) and one on January 10, 2013 (Offender #2), medical intake personnel arguably did not follow through with test results or notifications of conditions that should have been further tested or treated. Two incidents more than two years apart do not make a pattern or indicate a systemic problem. However, because Siegert was auditing, she was able to catch these isolated problems and bring them to the attention of Corizon supervisors and the staff who missed the issues, to improve the system. This is the purpose of the audits.

c) Suicides in Segregation Unit

259. The majority of all suicides at ISCI occur in segregated housing. Tr. at 43, 478.

260. Offender #5, a forty-eight-year-old with multiple psychological diagnoses, committed suicide while in segregation on September 6, 2015. He was placed on suicide watch on August 25, 2015, because he had disclosed a plan to hang himself. He was assessed each day by mental health staff. While on suicide watch, he had a dirty urinalysis. He was approved to be transferred from suicide watch to

[19] Siegert did perform a mortality review and IDOC did a SIR on the death of a thirty-one-year-old inmate who was in good health other than his diagnosis of hypertension. Proposed Exhibit 1013 (Dkt. 1188-1). The inmate died after being in custody for about one month. Siegert noted that he was not taking any medication for hypertension, nor was he being followed in the chronic care clinic. Siegert determined that the failure to provide any treatment for his hypertension was likely an oversight of the intake staff. An autopsy was conducted, and the confirmed cause of death was not hypertension but acute methamphetamine toxicity. There is no evidence that the failure to follow up by intake personnel regarding the hypertension had anything to do with his death from methamphetamine toxicity. The parties did not seek admission of Proposed Exhibit 1013 at the hearing.

segregation on August 28, 2015. Prior to placement there, he had a mental health screening, where he denied suicide ideation. He was cleared for placement in restrictive housing, where he lived for about a week until he hung himself on September 6, 2015. Exhibit 1010 at Bates No. IDOC 000691–000692; Tr. at 121:23–25, 122:1–19.

261. Defendants identified deviations that were occurring about the same time period that Offender #5 died. *See generally* Exhibits 1, 1003. At the evidentiary hearing, Plaintiffs attempted to show that the changes were not implemented before Offender #5 died.

262. One deviation identified by Defendants was that the Training Sergeant rather than the Mental Health Clinical Supervisor had been auditing suicide prevention training for ISCI Staff. *Id.* at 52–53. However, no evidence in the record demonstrates a causal link between the supervision of the training and Offender #5's death.

263. Another deviation was that, in 2015, IDOC staff were being trained annually when they should have been trained biannually. The last training before Offender #5's death would have been in January 2015, because the next annual training was held in January 2016. Tr. at 482. Staff should have been trained again in June 2015, a few months prior to Offender #5's death. *Id.* at 484.

264. The Court has seen no evidence linking the suicides described above to omissions by the IDOC personnel who were supervising these inmates at the time of death, or to the lack of the required June 2015 training session.

265. At the hearing, Plaintiffs pointed to the bad acts of Training Sergeant Marc Sandrus, who was in charge of ensuring that all staff had their second training of the year by June 30, 2016. Tr. at 504-511. Most staff were trained by that date, but four or five staff members were not. *Id*. at 507. Sandrus fabricated the training records, rather than require the staff to attend the training. *Id.* at 484–87; Exhibits 2, 3.

266. There is no evidence that any IDOC official other than Sandrus was involved in the fabrication of training records. Nor is there evidence that IDOC officials condoned his behavior. When Warden Yordy discovered the fabrication, Sandrus was demoted, his pay was reduced, and he was assigned to a different facility. *Id.* at 611. The Court finds that Sandrus unilaterally chose to falsify the training records and that no other officials were involved.

267. All IDOC staff completed the second training by July 31, 2016. *Id.* at 481–85. Accordingly, on that date IDOC became compliant with the MCP requirement that it provide biannual suicide prevention training.

viii. Plaintiffs' Other Allegations of Omissions and Harm

268. Plaintiffs made other allegations of omissions and harm, including that inmates helped other inmate patients bathe, a patient gave himself an injection with a nurse's approval, and the medical annex smelled foul because some of the occupants were incontinent. Dkt. 1090-1 at 21; Tr. at 106, 477-78. The record shows no systemic issues or actual harm as a result of these anomalies.

269. In addition, the record shows that once IDOC had notice of these wrongs, it took steps to remedy them. There is no evidence that auditing differently would have changed the outcome of the above-listed incidents.

III. Conclusions of Law

A. Compensatory Damages

Addressing Plaintiffs' requests for compensatory damages, the Court concludes that Plaintiffs have not shown a causal link between Defendants' deviations from the 2014 Order and the evidence of damages or harm presented in their briefing and at the hearing. Nor have Plaintiffs shown that any of the damages or harm—regardless of a causal link—amounted to systemic Eighth Amendment violations. Plaintiffs pointed to a few instances of potential harm—some of it security-related rather than medical- or mental-health related—that would have been better addressed in individual state tort or civil rights lawsuits focused on the individual provision of care, not a motion for contempt purporting to show that the type of auditing an institution conducted caused systemic harm.

The Court also concludes that some of the Plaintiff's allegations, in particular, were unsupported by any evidence. For example, it would have been easy to find out the exact dates of Amy Houser's mental health clinician license lapse and omit that evidence because it did not support Plaintiff's damages, but Plaintiffs suggested, without supporting evidence, that the lapse was connected to Inmate #10's suicide. Plaintiffs continued to suggest at the hearing that IDOC's failure to screen suicide watch

companions occurred during the time frame when Houser assessed Inmate #10 for that position, after they were aware that the evidence clearly showed otherwise.

B. Coercive Relief

Finally, given the favorable NCCHC evaluation and Plaintiffs' failure to show that Eighth Amendment systemic issues remain as to the matters raised in the Motion for Contempt, as well as this Court's finding that Defendants are in compliance with the Addenda as of July 2016, the dictates of the PLRA prevent the Court from ordering any further monitoring in this case.[20] Similarly, the fact that there is no present contempt counsels against coercive monetary sanctions.

ORDER

Accordingly, **IT IS ORDERED** that Plaintiffs' Motion for Contempt (Dkt. 1090) is GRANTED IN PART and DENIED IN PART. Plaintiffs' request that Defendants be held in contempt is GRANTED as to the period from June 6, 2014 and July 2016. However, Plaintiffs have not established that any class member suffered harm as a result of any violation; such harm is required for an award of compensatory damages.

The Court does not determine at this time what remedy is appropriate to address Defendants' past contempt. However, the Court notes that the PLRA bars a remedy of further monitoring and, in any case, equitable defenses may apply to any equitable remedies sought.

[20] This Court makes no findings as to whether Defendants are currently operating in compliance with the Eighth Amendment such that termination of monitoring would be appropriate.

The Court also notes that an award of attorney's fees may be appropriate for Plaintiffs' attorneys' work in establishing IDOC's past contempt. Much of Plaintiffs' briefing was scattered, and some was opportunistic and aggrandizing, but the Court recognizes that this was in part a response to IDOC's neglect, malfeasance, or willfulness in ignoring the Court's orders between 2014 and 2016. The Court finds that Plaintiffs' "throw everything at the wall" approach to this Motion was due in part to a lack of information, conclusory and false information about compliance provided to Plaintiffs by IDOC, and a lack of trust caused by Defendants' delay in implementing the Court's June 2014 Order. While Plaintiffs' arguments were somewhat haphazard and some of their evidence extraneous, Plaintiff's Motion for Contempt is not wholly without merit: Defendants clearly failed to take reasonable steps to comply with the Court's June 2014 Order until Dowell took over and began the process of addressing Defendants' noncompliance.

With this is mind, the Court leaves the determination of the most appropriate remedy to the presiding Idaho judge, to be determined when that Court rules on the upcoming termination motion in this case.

DATED: September 28, 2017

David O. Carter

DAVID O. CARTER
UNITED STATES DISTRICT JUDGE