IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF MALHEUR
251 B St. W #3 Vale Oregon 97918

Case No: 20CV19590

MARK E. LAWSON
Plaintiff

v.

BRAD CAIN, Superintendent, Snake River Correctional Institution
Defendant

OPINION AND ORDER ON PLAINTIFF LAWSON'S HABEAS CORPUS PETITION

From February 22 through 25, 2021, the court held an evidentiary hearing/trial in this habeas corpus action. Due to the pandemic and in light of the various geographical locations of the hearing participants, the parties appeared remotely by WebEx video. Katharine Edwards appeared on behalf of Plaintiff Mark Lawson; Assistant Attorney General Yufeng Luo appeared on behalf of Defendant Brad Cain; Plaintiff Lawson appeared by video from Snake River Correctional Institution.

After carefully considering Plaintiff Lawson's claims in the context of the pleadings, the evidence submitted by both sides,[1] and the arguments of the parties, the court concludes that, consistent with the findings below, Plaintiff's First Claim is DENIED, Plaintiff's Second Claim is GRANTED, and Plaintiff's Third Claim is GRANTED IN PART.

I. Procedural Posture

Plaintiff seeks habeas corpus relief under ORS 34.362 based on allegations that conditions of confinement violate Plaintiff's state and federal constitutional rights as an adult in custody (AIC).

The court dismissed Plaintiff's Claim Four in response to Defendant's Motion to Dismiss. Three claims remain for the court to decide:

> *Claim One*, "Cruel and Unusual Punishment in Failure to Provide Preventative And Management Measures." This is a COVID-conditions-claim that alleges Snake River Correctional Institution's (SRCI's) handling of the deadly COVID-19 virus constitutes deliberate indifference to Plaintiff's serious medical issue and creates a serious risk of disability or death from the virus. Plaintiff asserts this failure violates the Eighth Amendment to the United States Constitution and Article I, section 16, of the Oregon Constitution.
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> *Claim Two*, "Cruel and Unusual Punishment in Failure to Provide Adequate Treatment and Diagnosis of Plaintiff's Serious Medical Conditions", to wit, Plaintiff's Chronic Obstructive Pulmonary Disease

[1] Pursuant to the stipulation of the parties, the court has also considered testimony of the two expert witnesses, Dr. Gulick and Dr. Baskerville, offered in the partially consolidated matter of *Skelton v. Cain*, 20CV24540, where such testimony is generally relevant to this case as well. In particular, the court considers Dr. Gulick's testimony regarding whether fever is a symptom of COVID-19, the value of mass testing in incarceration settings, and his personal experience treating people infected with COVID-19. Due to the consolidation of these matters, both cases proceeded to trial the week of February 22, 2021, and the court took testimony from witnesses in order of witness availability for efficiency. Dr. Baskerville, in particular, spoke in his rebuttal testimony in response to not only Dr. Gulick's testimony in this case, but in the *Skelton* matter as well.

(COPD), emphysema, methamphetamine-use disorder, and likely lung damage from tuberculosis and history of smoking tobacco. As to this claim, Plaintiff alleges that for many months Defendant has failed to provide adequate medical care for his serious breathing condition. Plaintiff asserts this failure violates the Eighth Amendment to the United States Constitution and Article I, section 16.

Claim Three, "Unnecessary Rigor in Failure to Provide Preventative And Management Measures." Similar to Claim One but raised under a different constitutional provision, this is a COVID-conditions-claim that alleges SRCI's handling of COVID-19 constitutes unnecessary rigor in that Defendant lacks the capacity to adequately prevent, test and treat COVID-19 at SRCI and that failure constitutes unjustifiable abuse and risk of serious physical injury or death. Plaintiff asserts this failure violates Article I, section 13, of the Oregon Constitution.

II. Legal Framework For Plaintiff's Claims

A. Types Of State Habeas Claims And Burden Of Proof

State habeas corpus petitions may raise two types of claims: (1) that the institution is subjecting the AIC to further imprisonment or restraint not justified under the original sentence and (2) that the AIC is suffering "other deprivations … of a kind which, if true, would require immediate judicial scrutiny, if it appears to the court that no other timely remedy is available…." *Penrod v. Cupp*, 283 Or 21, 28, 581 P2d 934 (1978). Plaintiff's case involves the latter type of claim in that Plaintiff alleges immediate judicial scrutiny is necessary to address both Defendant's alleged lack of preventative measures that create an unnecessarily dangerous environment due to COVID-19 (Claims One and Three) and Defendant's alleged failure to adequately care for Plaintiff's serious medical issue COPD (Claim Two).

Regardless of type of claim, the standard of proof in state habeas proceedings is the same. A plaintiff bears the burden of proof by a preponderance of the evidence. *Billings v. Gates*, 323 Or 167, 182 n 18, 916 P2d 291 (1996).

B. Hazardous Condition Claims Under Article I, §16, And The Eighth Amendment

As noted above, Claim One alleges Defendant's management of the COVID-19 pandemic and the resulting hazardous conditions at SRCI constitute cruel and unusual punishment that require immediate judicial scrutiny. As such, *Bedell v. Schiedler*, 307 Or 562, 770 P2d 909 (1989), is particularly relevant. In *Bedell*, the plaintiff alleged that the ventilation system in the institution where she was housed as an AIC was faulty and ill-designed such that plaintiff was forced to breathe "noxious, stale and unhealthy air" resulting in clogged sinuses, severe headache, dry skin, and a persistent sore throat. 307 Or at 564, n.3. The court found the plaintiff had adequately pled an Article I, section 16, claim in that she alleged "that the environment in which she is confined unnecessarily subjects her to serious health hazards." 307 Or at 570. The court explained that if AICs "are entitled to reasonable and necessary medical care" under both the Unnecessary Rigor Clause (citing *Sterling v. Cupp*, 290 Or 611, 625 P2d 123 (1981)) and the Eighth Amendment (citing *Estelle v. Gamble*, 429 US 97, 104-06 (1976)), then "it reasonably follows that they are also entitled to an environment that does not unnecessarily subject them to serious health hazards." 370 Or at 570. Therefore, a plaintiff has a right to seek relief under Article I, section 16, and the Eighth Amendment for claims that an institutional environment unnecessarily subjects them to the threat of serious health hazards. *See also Helling v. McKinney*, 509 US 25 (1993) (analyzing claim of hazardous environment under the Eighth Amendment); *Money v Pritzker*, 453 FSupp3d 1103 (ND Ill 2020) (considering AIC claims for deliberate indifference to a serious risk of harm due to COVID-19 danger in incarceration setting under the Eighth Amendment).

The court finds that the framework for cruel and unusual punishment claims due to environmental hazards is the same under the state and federal constitutions. *Billings*, 323 Or at 180. While *Billings* addressed a claim that care for a serious medical issue was deficient rather than that an environment was unnecessarily dangerous, the court concludes that the same, two-component analysis is equally applicable. The court has not identified Oregon law that explains the two-component analysis in the context of an environmental hazard claim. The U.S. Supreme Court has considered cases in this context and the court finds the discussion in *Helling*, 509 US at 31-36, helpful.

The first, objective, component requires a plaintiff to prove by a preponderance of the evidence that he is being exposed to an unnecessarily dangerous environment. *Helling*, 509 US at 25. *See also Bedell*, 307 Or 570; *Billings*, 323 Or at 180. The court must consider "more than a scientific and statistical inquiry into the seriousness of the potential harm and the likelihood that such injury to health will actually be caused by exposure to" the allegedly dangerous condition. 509 US at 36. Indeed, this objective inquiry:

> … also requires a court to assess whether society considers the risk that the [AIC] complains of to be so grave that it violates contemporary standards of decency to expose anyone unwillingly to such a risk. In other words, the [AIC] must show that the risk of which he complains is not one that today's society chooses to tolerate.

Helling, 509 US at 36.

In the context of environmental hazard claims, "the subjective factor, deliberate indifference, should be determined in light of the prison authorities' current attitudes and conduct." *Helling*, 509 US at 36. The *Helling* Court noted that the adoption of institutional policies to address the environmental hazard "will bear heavily on the inquiry into deliberate indifference[,]" including evidence on how the institution is administering the policies. *Id*. at 36-37.

A prison official acts with deliberate indifference when he "knows of and disregards an excessive risk to prisoner health or safety." *Farmer v. Brennan*, 511 US 825, 837 (1994). "Deliberate indifference requires the defendant to have a subjective 'state of mind more blameworthy than negligence,' *Farmer*, 511 U.S. at 835, closer to criminal recklessness." *Swain v. Junior*, 958 F3d 1081, 1089 (11th Cir 2020) (citations modified). *See also Money*, 453 F Supp 3d at 1132 (considering deliberate indifference in COVID-19 environmental claim: "The record simply does not support any suggestion that Defendants have turned the kind of blind eye and deaf ear to a known problem that would indicate 'total unconcern' for the inmates' welfare.").

C. Inadequate Medical Care Claims Under Article I, §16, And The Eighth Amendment

The analytical framework for inadequate medical care claims under the state and federal constitutions are one and the same. *Billings*, 323 Or at 180 ("We hold that the Eighth Amendment's 'deliberate indifference to serious medical needs' standard is the appropriate standard under Article I, section 16."). Medical claims require a plaintiff to establish two components.

The first, objective, component requires a plaintiff to prove by a preponderance of the evidence that he suffers from a serious medical condition and that the defendant has failed to adequately treat the seriousness of the plaintiff's serious medical condition. *Billings*, 323 Or at 180 ("The inmate plaintiff also must establish the existence of a 'serious' medical condition. A medical condition is serious when, if untreated, it would have a significant adverse effect on an inmate's daily activities, resulting in substantial and recurring pain or discomfort, or would create a significant risk of permanent disability or death.").

The second, subjective, component requires a plaintiff to prove by a preponderance of the evidence that a defendant has been deliberately indifferent in responding to the serious medical condition. *Billings*, 323 Or at 180. *Billings* discussed at length the "deliberate indifference" subjective component:

> Deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain, whether the indifference is manifested by prison doctors in their response to a prisoner's serious medical needs or by prison guards in intentionally denying or delaying access to medical care, or in intentionally interfering with prescribed treatment. *Id*. at 104–05. The "deliberate indifference" standard is not intended to insulate prison staff from judicial scrutiny of decisions made in the course of diagnosing and treating prison inmates. But, for the reasons explained above, it is true that an inmate ultimately will fail to prove an Article I, section 16, violation if the inmate establishes nothing more than an honest difference of medical opinion about correct diagnosis and necessary treatment. *See Estelle*, 429 US at 105–06 (so stating with regard to Eighth Amendment); *Sanchez v. Vild*, 891 F2d 240, 242 (9th Cir.1989).

Billings, 323 Or 180–81 (internal citations modified). Thus, this deliberate indifference standard implies an intent requirement on the part of the defendant. *See also Wilson v. Seiter*, 501 US 294, 300 (1991) ("The source of the intent requirement is not the predilections of this Court, but the Eighth Amendment itself, which bans only cruel and unusual punishment."). When a claim involves an allegation of failing to provide care for a serious medical condition, "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if [the official] knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 US 825, 847 (1994).

D. Framework For Plaintiff's Unnecessary Rigor Claim

The court must resolve the dispute between the parties as to whether claims brought under the Unnecessary Rigor Clause of the Oregon Constitution, Article I, section 13, involve both objective and subjective components like claims brought under the Cruel and Unusual Punishment provision of Article I, Section 16. Defendant argues that the standard is the same for claims under section 16, and section 13. Plaintiff argues that Unnecessary Rigor claims under section 13 do not require Plaintiff to prove a subjective component or specific mental state.

The court agrees with Plaintiff. *Sterling v. Cupp, supra*, contains a detailed discussion of claims raised under the Unnecessary Rigor Clause of Article I, section 13. Male AIC Sterling objected to female guards patting down male AICs and having access to male AICs while they showered. The court went through the history of Article I, section 13, and determined that the focus of the clause was whether the particular practice at issue, taken in the context of the unique needs of a correctional setting, was necessary. 290 Or at 617-24. The court concluded that an objection to a particular institutional practice was "overcome when and to the extent that the circumstances" of the practice to which plaintiff objects is justified by necessity. *Id*. at 632.

Bedell v. Schiedler, 307 Or 562, 564, 770 P2d 909 (1989), is consistent with *Sterling*. *Bedell* involved an Eighth Amendment/Article I, section 16, Cruel and Unusual Punishment claim. In the context of discussing the contours of a section 16 claim, *Bedell* referenced section 13 rights as guaranteeing that AICs "are entitled to an environment that does not unnecessarily subject them to serious health hazards." 307 Or at 570. Note 7 in *Bedell*, which appears immediately after this quoted text in the opinion, cites section 13, *Sterling*, and *Estelle v. Gamble*, 429 US 97, 104-06 (1976), the U.S. Supreme Court decision

setting forth the framework for AIC medical claims under the Eighth Amendment. 307 Or 570, n. 7. The court interprets *Bedell* to reflect that section 13 claims do not involve a subjective component or proof of intent; rather, a plaintiff must prove that a defendant unnecessarily subjected the plaintiff to a serious health hazard.

Fox v. Zenon, 106 Or App 37, 41, 806 P2d 166 (1991), is consistent with this conclusion. *Fox* held that a plaintiff had sufficiently stated a claim under section 13 by alleging that the plaintiff was suffering an ongoing and serious health hazard standard and that no other timely alternative remedy existed. Similarly, *Schafer v. Maass*, 122 Or App 518, 858 P2d 474 (1993), held that plaintiff's allegation that he was "subjected to ongoing and periodical assaults" by defendants in the Intensive Management Unit at the Oregon State Penitentiary "would be recognized as an abuse to the extent that it cannot be justified by necessity." *Schafer* concluded that based on that allegation: "We hold that petitioner has alleged a deprivation of section 13." This line of Oregon cases is consistent with the finding that claims under the Unnecessary Rigor Clause of section 13 require only that plaintiff prove that the practice in question is abusive and not required by necessity. Accordingly, the court will apply this standard to Plaintiff's Third Claim.

III. Brief Overview Of Evidence Before The Court

Plaintiff presented two witnesses at trial/evidentiary hearing: Plaintiff Mark Lawson and Dr. Mark Baskerville, M.D.

Regarding Plaintiff Lawson, the court finds that while he does have an interest in the outcome of this litigation, he testified credibly. He came across to the court as a somewhat stubborn person, but an honest one.

Regarding Dr. Baskerville, he is licensed to practice medicine in Oregon and Maryland. He was a student, educator, and medical doctor at Johns Hopkins Hospital for 17 years. He has four board certifications: emergency medicine, critical care, anesthesiology and addiction medicine. He works at Oregon Health Science University in the intensive care unit (ICU) caring for critically ill patients as well as in the emergency room (ER) caring for walk-ins, many of whom use the ER for general medical care. He testified that the vast majority of his time in medicine since April 2020 has been spent caring for critically ill COVID-19 patients. *See also* Plt. Ex. 1, Att. A. The court qualified Dr. Baskerville as an expert and found his testimony to be extremely credible. The only shortage in Dr. Baskerville's experience as it pertains to this matter is a lack of experience practicing medicine in a correctional setting; however, the parties agree that the same standard of care applies within and without the institution. Dr. Baskerville interviewed Plaintiff and reviewed his records but is not his medical provider.

Plaintiff submitted four exhibits: Exhibit 1 is the Declaration of Dr. Baskerville (submitted in an updated form at the time of evidentiary hearing/trial) and Attachments. Exhibit 2 is the declaration of Plaintiff Mark Lawson. Exhibit 3 is an excerpted form of Plaintiff's medical records. Exhibit 4 is the declaration of Donald Skelton, another AIC at SRCI.

Defendant presented two witnesses: Assistant Superintendent (AS) of Oregon Department of Corrections (ODOC) Jason Bell and Chief Medical Officer at SRCI, Two Rivers Correctional Institution, and Powder Ridge Correctional Institution, Garth Gulick, M.D. Dr. Gulick testified that he has practiced medicine at SRCI for 17 years, the last 16 of which he has served as the CMO. Dr. Gulick also operates a clinical practice outside the institution called Valley Family Healthcare where he works on Fridays. The court qualified Dr. Gulick as an expert and while the court finds that his testimony was honest, as examined

below, the record gives rise to concerns over the reliability of some of his opinion as well as the strength of his medical conclusions about an appropriate course of treatment in light of Dr. Baskerville's testimony and evidence from the CDC.

Defendant introduced six exhibits: Defendant's Exhibit 101 is the Declaration of Joe Bugher with Attachments; Defendant's Exhibit 102 is a Declaration of Dr. Dewnsup with Attachment; Defendant's Exhibit 103 is the Declaration of SRCI Assistant Superintendent Jason Bell with Attachments; Defendant's Exhibit 104 is a Second Declaration by Dr. Gulick; Defendant's Exhibit 105 is a set of Plaintiff's medical records at SRCI, and Defendant's Exhibit 106 is a 2-page updated excerpt of medical records for Plaintiff that were missing from Defendant's Exhibit 105.

With the consent of the parties, the court admitted four additional exhibits as Court Exhibits: Centers for Disease Control (CDC), *Symptom Profiles of a Convenience Sample of Patients with COVID-19 –United States, January-April 2020* (07/17/2020) (Ct. Ex. 1); CDC, *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails – Six Jurisdictions, United States, April – May 2020* (08/21/2020) (Ct. Ex. 2); CDC, *Symptoms of Coronavirus* (02/22/2021) (Ct. Ex. 3); and CDC, *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities* (12/03/2020) (Ct. Ex. 4).

IV. Analysis Of The Claims In Plaintiff's Case

Plaintiff's claims relate to allegations that Defendant has failed to adequately respond to the COVID-19 pandemic that that such failure is a violation of the Eighth Amendment to the U.S. Constitution and a violation of the Oregon Constitution, Article I, section 16's prohibition on Cruel and Unusual Punishment (Claim One), that Defendant's provision of medical care to Plaintiff's serious underlying conditions violates the Eighth Amendment and Article I, section 16 (Claim Two) and that Defendant's failure to adequately respond to the COVID-19 pandemic is also a violation of the Unnecessary Rigor Clause of Article I, section 13, of the Oregon Constitution (Claim Three).

A. Findings of Fact

SRCI houses 3,000 AICs at various security levels. Def. Ex. 103 at ¶3. SRCI is the designated ODOC facility for treating COVID-19 AICs from around the state. Def. Ex. 103 at ¶9. This is because SRCI's infirmary has six negative pressure cells and round-the-clock nursing care. *Id.*

As explained by Dr. Gulick, when a staff member or AIC has a positive COVID-19 test, the institution must remain on Tier 4 status for 14 days. Tier 4 status means that the entire institution is placed on quarantine, resulting in increased monitoring and decreased programming. *See also* Def. Ex. 101, ¶69. Tier 4 also means that inmates cannot have non-mandatory visits or leave the institution for work or other purposes absent a special need. AICs have reduced freedom within the institution, including decreased access to the yard. Meals are eaten in housing units. SRCI has been on Tier IV status since July 2020.[2]

Plaintiff is a 62-year-old AIC at SRCI. He transferred to SRCI in 2016.

1. Defendant's Efforts To Prevent COVID-19 At SRCI

Defendant has introduced significant evidence of ongoing and evolving efforts by the ODOC to prevent and combat COVID-19. *See* Def. Ex. 101-103, including attachments. Defendant's Joe Bugher

[2] *See generally* ODOC COVID-19 Infection Prevention, Testing, and De-Escalation Protocol, https://www.oregon.gov/doc/covid19/Documents/tiered-protocol-institutions.pdf (last visited 03/23/2021).

Declaration notes: "ODOC recognizes that COVID-19 prevention policies…must be implemented at the institutional level to be effective." Def. Ex. 101 ¶79.

Masking is required for all ODOC employees, including those at SRCI. ODOC sent an email to all staff on May 15, 2020: "ALL staff and adults in custody in Oregon Corrections Enterprises (OC) work areas are required to wear OCE-provided utility masks at all times. That directive was sent out from OCE Administrator Ken Jeske earlier this week." Def. Ex. 101, Ex. 6 at 1. At that time, if staff were six feet apart, they were not required to wear face coverings unless they were culinary or healthcare-type workers. *Id*. On July 13, 2020, ODOC staff were notified by email that due to reports that staff were not following the face covering rules, ODOC was facing legal action. Def. Ex. 101, Ex. 10 at 1. The email warned: "If we do not pull together and wear our face coverings when we can't maintain six feet of social distancing, we may be mandated to wear masks at all times." *Id*. *See also* Def. Ex. 101, Ex. 14 (OSHA Temp. Rule 437-001-0744 (Nov. 16, 2020) at 6 ("Mask, face covering or face shield requirements. Each employer must ensure that all individuals … at the workplace or other premises subject to the employer's control wear a mask, face covering or face shield as source control in accordance with the requirements of the Oregon Health Authority's Statewide Mask, Face Covering Face Shield Guidance.") and at A-19.

By August 4, 2020, AICs were required to wear face masks any time they left their bunk or cell area. AICs who refused to wear masks "will be handled through progressive discipline." Def. Ex. 101, Ex. 11 at 1.

On November 18, 2020, the Governor's new Executive Order required all persons to mask while in any indoor work setting regardless of distance to others, unless the person was in a private, unshared office or they were eating or drinking and at least six feet from any other person. Def. Ex. 101, Ex. 15 at 1. SRCI has imposed this rule on all staff. Def. Ex. 103 at ¶14.

As both AS Bell and Dr. Gulick testified, proper mask wearing among staff and AICs at SRCI continues to be a problem. Regarding AIC compliance, AS Bell testified that AICs are subject to discipline for mask noncompliance, but recognized that enforcement was inconsistent. He testified that discipline for mask noncompliance by AICs raised a security issue because SRCI did not want to risk the AICs organizing and resisting SRCI officials.

Regarding staff, AS Bell testified that the first step for mask violations is to counsel the staff member privately. The second step is to have the conduct noted in their working file. The third step involves issuance of a letter of expectation. The fourth step is a letter of reprimand. The fifth step requires the staff person to meet with the Superintendent. The sixth step is a predismissal hearing. *See also* Def. Ex. 103 ¶14. AS Bell testified that only one staff member had progressed in discipline to step six for mask violations.

AS Bell explained that staff at SRCI mostly live in Idaho where masks are not required. He explained that it is difficult for staff to understand why masks are required in one state and not the other. He stated that very few people wear masks in Idaho. He testified that staff are not required to take the COVID-19 vaccine. He testified that he considered recording himself as he received the COVID-19 vaccine in order to offer proof that it was safe, but determined doing so would be more harmful than helpful because issues related to the vaccine are so polarizing with staff. He has directed staff not to share their personal views about the vaccine with AICs.

Similarly, Dr. Gulick testified that he is at war with COVID-19 misinformation in SRCI. He described how staff are on the whole very conservative and have doubts about the virus and the vaccine. He said

that the staff views on the pandemic percolate from staff to AICs, including misinformation and conspiracy theories. He testified that misinformation is totally engrained in staff and some of the AICs. He testified that many staff believe that masking is stupid and that the virus is harmless.

Dr. Gulick testified that staff are temperature-checked and screened for COVID-19 symptoms before entering SRCI. *See also* Def. Ex. 103 at ¶11. Dr. Gulick testified that there is no mandatory COVID-19 testing for staff, nor can SRCI force staff to take a COVID-19 test.

AS Bell testified that AICs can file a grievance to report staff who fail to wear masks but that AICs fear retaliation for reporting. He further testified that there is potential for retaliation by staff in positions of power over AICs. Dr. Gulick repeated this observation.

Plaintiff testified at length about SRCI staff and AICs failing to mask correctly. *See also* Pl. Ex. 2. In fact, Plaintiff spontaneously interrupted his testimony in this matter to note for the record that as he was testifying, he observed through a window two unmasked staff members walk down the hall. *See also* Pl. Ex. 4 (Skelton Decl.: "Mask wearing is minimally enforced. I observe staff and [AICs] frequently having nose or mouth uncovered because the mask is raised or lowered.").

In an August 17, 2020, "COVID-19 Infection Prevention Assessment: SRCI", DOC Chief Audit Executive Eli Richie detailed results of an August 6, 2020, inspection of SRCI. Def. Ex. 103, Att. 1. The assessment noted that "[t]he vast majority of AICs and staff wore face coverings in alignment with expectations" (*id*. at 1) but also noted: "Two of the three staff in the tower near the back entrance were not social distancing or wearing face coverings." *Id*. at 5. The assessment recommended that SRCI "[w]ork with transport unit staff to promote social distancing and face-covering use in transport staff work and break areas." *Id*. at 6. *See also* Def. Ex. 103 at ¶21.c.

In addition, according to the testimony of AS Bell, pursuant to Oregon Occupational Safety and Health (OSHA) guidelines SRCI recently began unannounced COVID-19 Assessments conducted by SRCI staff and AICs. Def. Ex. 103, Att. 2 (02/06/2021 Assessment). However, as noted in the February 10, 2021 Assessment:

- Are staff/contractors wearing facing coverings while inside? *No.*
- Are AICs wearing face coverings while inside? *No.*
- Are staff/contractors and AICs wearing their masks appropriately? *No*.
- Are mask and face coverings available to everyone upon request? *No*.
- What areas & percentage of staff/contractors are not wearing face coverings?
  Majority of staff do wear them religiously. Others do not. 80% do. Some staff remark to AICs that they already had covid. Observed AICs and Staff pull down masks to talk and or do not wear them properly.
- What areas & percentage of AICS are not wearing face coverings?
  80% of AICs wear masks, lower them to talk in dayrooms and when officers are not in the area. In unit they wear them less, when out of the unit, they wear them because of staff being present. Again, more relaxed when staff not present.

Def. Ex. 103, Att. 2 at 4.

A second assessment was done on February 12, 2021:

- Are staff/contractors wearing facing coverings while inside? *No.*

- Are AICs wearing face coverings while inside? *No.*
- Are staff/contractors and AICs wearing their masks appropriately? *Yes.*
- Are mask and face coverings available to everyone upon request? *Yes.*
- What areas & percentage of staff/contractors are not wearing face coverings?
  One officer was not wearing during the assessment, had mask on when we came back through. Extra masks are available to issue the staff and AICs.
- What areas & percentage of AICS are not wearing face coverings?
  Several AICs were not wearing masks or not wearing them correctly in ever area toured.

Def. Ex. 103, Att. 2 at 4. These records document the continued problems with proper masking at SRCI. These observations are consistent with the testimony of AS Bell, Dr. Gulick and Plaintiff. *See also Skelton v. Cain*, 20CV24540, Order Denying Plaintiff's Motion for Enforcement of the Parties' Order at 1 (03/22/2021) (declining to find Defendant in violation of settlement agreement but noting "Plaintiff presents unrebutted evidence that he has observed [SRCI] officers moving throughout SRCI (and while around [AICs] without wearing masks.") and 2 ("Of course, that the evidence establishes that Officers Ross and Ali are routinely (and seemingly without consequence) violating SRCI's established mask policy is not exactly an endorsement of SRCI's policy or its enforcement of that policy.").

The masking issues are multiplied by not only the conspiratorial beliefs about COVID-19 virus and vaccine, but also by SRCI's handling of AICs who test positive. Due to a lack of resources, AICs who are suspected of COVID-19 exposure or infection are moved to isolation in SRCI's disciplinary unit called IMU-E. Pl. Ex. 4 ¶¶ 26-31 (Declaration of SRCI AIC Donald Skelton). Despite SRCI's efforts to make the placement less onerous on AICs, Plaintiff, AS Bell, and Dr. Gulick all testified that AICs viewed placement in IMU-E as punishment. Plaintiff and Defense evidence established that AICs hide symptoms to avoid placement in the IMU-E and that some AICs threaten others against reporting symptoms of illness. Pl. Ex. 4 ¶31.

2. Plaintiff's Relationship With Medical Staff At SRCI

Plaintiff testified that when he was an AIC at Oregon State Prison he enjoyed a therapeutic relationship with his ODOC doctor. He does not enjoy a therapeutic relationship with Dr. Gulick. Pl. Ex. 2 ¶18. Plaintiff testified that he did not trust Dr. Gulick and that he wrongly characterized his interactions with Plaintiff. Plaintiff admitted telling Dr. Gulick that he was doing alright, but explained that he meant alright under the circumstances. Many of the problems appear to come down to failures to communicate. The court is sympathetic to Plaintiff's lack of trust in light of his experiences with medical staff at SRCI.

Dr. Gulick testified that AICs do not get to pick their doctor, but that they could request a second opinion. A second opinion is provided by another medical provider at SRCI. The court is sympathetic to Dr. Gulick's situation as well. He is charged with overseeing the health of 3000 AICs at SRCI, a great many of whom are medically vulnerable, in the midst of a deadly pandemic. The court can merely imagine the difficulty in marshaling patience to deal with AICs, some stubborn and untrusting, and many of whom entertain conspiracy theories about the pandemic and ODOC's true intentions.

Dr. Baskerville testified that in dealing with patients who are stubborn and communicate poorly, it is all the more important to obtain objective measures of their health. When such patients suffer from moderate to severe COPD, oxygen saturation measures provide objective evidence as to the efficacy of their pulmonary functioning.

3. Plaintiff's Serious Medical Conditions

Plaintiff suffers from COPD, possible hepatitis C virus infection, gastroesophageal reflux disease, alcohol use disorder, methamphetamine use disorder, and a 60-pack-per-year cigarette smoking history. These conditions, combined with his age, make Plaintiff a medically vulnerable person at high-risk for devastating or deadly impacts were he to become infected by COVID-19. Plaintiff testified, consistent with the Declaration, that he is terrified of contracting COVID-19 and lives in constant fear. *See also* Pl. Ex. 2 ¶19.

Plaintiff declined receipt of the COVID-19 vaccine on January 16, 2021. Def. Ex. 106 at 78; Pl. Ex. 2 ¶17. He testified that he was wary of the vaccine since it was not FDA approved but testified that even if it were approved, he would still be reluctant. Plaintiff denied that he was offered counseling at the time of declination. Pl. Ex. 2 ¶17. He stated that his biggest concern was over the possible side effect of breathing difficulty and that because Plaintiff already has trouble breathing, he did not want to take on the risk. Plaintiff testified that information from other AICs and some staff affected his view of the safety of the vaccine.

Dr. Baskerville counseled with Plaintiff about the vaccine and tried to convince him to take it. As of the time of trial, Plaintiff was considering the possibility but remained skeptical. Plaintiff is not completely opposed to vaccines; he received the influenza vaccine in October 2020. Def. Ex. 105 at 80.

4. Defendant's Treatment of Plaintiff's Serious Medical Conditions

(i) Defendant's Treatment Of Plaintiff's COPD

Plaintiff informed intake staff upon admission in July 2018 that he had COPD. Def. Ex. 102 at 49. He reported that he had last used his Albuterol inhaler two months prior. Def. Ex. 104 at 2. He displayed no wheezing at intake. *Id*. Dr. Gulick first saw Plaintiff for his COPD in August 2018 and scheduled a follow up in six months. Def. Ex. 104 at 2.

Records of the June 27, 2018, intake document that Plaintiff complained to medical staff that he experienced shortness of breath due to his COPD. Def. Ex. 105 at 2 & 5. Chest x-rays were taken in August 2018 for another purpose. Def. Ex. 104 at ¶5; Def. Ex. 105 at 19. The report from the exam states:

> LUNGS AND PLEURA:
> The lungs are symmetrically well expanded. Large volumes. Straightening of the pulmonary vascular markings
> Pulmonary vascular markings are not obscured.
> Large bulla right upper lobe.
> No regional consolidation, pulmonary edema, pneumothorax or pleural effusions.

Def. Ex. 105 at 19.

As for medications, Dr. Gulick prescribed Plaintiff an Albuterol inhaler in September 2018. Def. Ex. 104 ¶11. Dr. Gulick also prescribed Tudorza Pressair inhaler, which he testified represents the next step in COPD care beyond an Albuterol inhaler. Def. Ex. 104 at ¶12; Def. Ex. 105 at 39. Plaintiff refilled the Turdorza prescription in October 2018. Def. Ex. 105 at 51.

In December 2018, Plaintiff underwent a spirometry test to evaluate his pulmonary functioning. Def. Ex. 104 ¶14; Def. Ex. 105 at 23-26. The results showed that he suffered moderate to severe airway

obstruction. Def. Ex. 104 ¶14. His forced vital capacity score (FEVA) was 52% FEVA value; below 80% "reflects abnormally low values." Def. Ex. 104 ¶14. The report states Plaintiff's breathing test "shows moderate to severe airways obstruction. … The result usually indicates asthma that is poorly controlled." Def. Ex. 105 at 26. Both doctors testified that formal spirometry is the gold standard in assessing pulmonary function in COPD. *See also* Pl. Ex. 1 at ¶15.

In March 2019, Plaintiff refilled his Tudorza Pressair prescription. Def. Ex.105 at 44. According to Plaintiff's medical records of his Special Needs Reviews for his COPD, Plaintiff reported that he felt "much better" on June 27, 2019, and that he was not using his inhaler. His peak flow test result was 270. No oxygen saturation is noted. Dr. Gulick classified Plaintiff as having moderate to severe COPD in fair control, but asymptomatic. Def. Ex. 105 at 7 (first column). Dr. Gulick's plan was to "follow" Plaintiff's COPD. *Id*.

Dr. Gulick saw Plaintiff on January 29, 2020, for the six-month Special Needs Review for COPD. Dr. Gulick reports that Plaintiff refused treatment for his COPD at that time, that he was not prescribed Albuterol, and that he also had no current prescription for Tudorza. Def. Ex. 104 ¶18. The Special Need Review Chart reflects[3] that during this meeting with Dr. Gulick, Plaintiff claimed that he was asymptomatic for COPD and continued to not use his inhaler. Def. Ex. 105 at 7 (second column). The chart notes that Plaintiff was unable to perform the peak test. Dr. Gulick noted his classification that Plaintiff was moderate to severe COPD remained the same. Def. Ex. 105 at 7. He wrote that Plaintiff's control of COPD was "good." Under "status", Dr. Gulick noted that Plaintiff's COPD was "worse but asymptomatic." Under "Plan", he noted that Plaintiff "refused treatment."

Plaintiff's Tudorza inhaler prescription was discontinued in September 2019. Def. Ex. 102 at 36.

Plaintiff requested a refill of his Albuterol inhaler on March 30, 2020; the request was filled nine days later on April 8, 2020. Def. Ex. 104 ¶13; *see also* Def. Ex. 105 at 13, 29 & 54. Dr. Gulick reports that Plaintiff has never informed ODOC that Albuterol was not helpful. Def. Ex. 104 ¶119. Progress Notes from April 6, 2020 reflect that Dr. Gulick wrote: "spiriva being no help. Inhaler needs refill. Chest negative. OK new albuterol and follow up" Def. Ex. 105 at 13.

Dr. Gulick conducted the third Special Needs review of Plaintiff's COPD on November 18, 2020. Def. Ex. 105 at 69. Viewing the results from the three Special Needs Reviews is relevant to Dr. Gulick's opinion that no change in the current course of care is appropriate:

Date	6/27/2019	1/29/2020	11/18/2020
Exacerbations Recent Sx History	Feels much better	Claimed asymp[tomatic]	No issues
Medications	0 inhaler use now	0 inhaler	Albuterol
PEFR or %PEFR	270	Couldn't	Couldn't
Classification	Mod-Severe by PFT	Same	Same PFT

[3] Dr. Gulick's handwriting on the Special Needs Chart is difficult to read, but he read aloud his chart notes during the hearing.

Control	Fair but asymp[tomatic]	Good	Good
Status	Better with exercise	Worse but asymp[tomatic]	Good
Plan f/u by severity	1. COPD-Follow 2. DJD 3. Osteopenia	1. COPD-refused tx 2. Osteopenia	1. COPD-[unintelligible] 2. Osteopenia

Dr. Baskerville vociferously disagrees with Dr. Gulick's opinion that no change in Plaintiff's COPD treatment is warranted. He opines that in light of (1) the 2018 formal spirometry test, (2) Plaintiff's April 2020 report that Spiriva no longer works, (3) the fact that he is back on his Albuterol inhaler in November 2020, and (4) further considering Plaintiff's reports that he struggles to breathe, that another formal spirometry test is needed. He further opines that this is need is particularly urgent in the context of a deadly pandemic involving a virus that attacks the lungs, Plaintiff's other comorbidities, and his resistance to taking the COVID-19 vaccine.

(ii) Albuterol Prescription Refills

Related to Plaintiff's COPD treatment is the issue regarding Defendant's wording on Plaintiff's prescription for Albuterol. The instruction provides: "SHAKE WELL AND INHALE 1 OR 2 PUFFS DEEPLY INTO LUNGS FOUR TIMES DAILY IF NEEDED (INHALER MUST LAST 6 MONTHS)" *See, e.g.* Def. Ex. 105 at 28.

While Plaintiff had been infrequently using the inhaler, the instructional issue may not seem at first blush of critical importance. However, since Plaintiff reported to Dr. Gulick in November 2020 that he once again was relying on the Albuterol, this issue becomes important in Plaintiff's case. As to this practice, Dr. Baskerville attested:

> However, the prescription indicates that he can take two puffs up to four times per day. Each inhaler contains 200 puffs. At the prescribe[d] usage, the inhaler will last 25 days. However, [Plaintiff] is mandated to make it last six months. This makes no sense, either. Rationing albuterol inhalers in the midst of a deadly pandemic with a respiratory virus is unconscionable.

Pl. Ex. 1 at ¶17.

Dr. Baskerville testified that such limits on albuterol inhalers make no sense, particularly for Plaintiff who is persistently symptomatic and in light of the fact that COVID-19 symptoms can begin suddenly. He testified that considering Plaintiff's age, comorbidities, and current state of health, if he were to be infected by COVID-19, his chance of survival is estimated at 50%.

Dr. Gulick testified that these "MUST LAST" limits on refills were aimed at the medical providers, not at the AICs. However, Dr. Gulick acknowledged that the direction is listed alongside the instructions to the AIC as to how to use the medication. Dr. Gulick testified that the refill limits were necessary to avoid abuse. He explained that by abuse, he meant other AICs forcing the AIC with the albuterol prescription to give them access to the medication. He explained that non-prescribed AICs may wish to use Albuterol to

enhance their performance in sports or that an AIC would crush the medicine and snort it. Dr. Gulick's intent to protect the AIC with the Albuterol inhaler must be weighed against the high need for an asthmatic AIC to have access to an inhaler for emergency use during a deadly pandemic.

Dr. Baskerville testified as a physician board certified in addiction medicine that he had never heard of a person abusing albuterol and that it would be almost impossible for a person to obtain a high from it. He further testified that regardless of that risk, including a limit such as the "MUST LAST" limits on Plaintiff's Albuterol medication fell beneath the standard of care. Dr. Baskerville testified that such improper limits will condition patients to ration their albuterol and can create a worst-case scenario in which an AIC is without sufficient medication in a time of extreme need, such as in the face of a sudden onset of symptoms from COVID-19.

(iii) Plaintiff's Hepatitis Infection

Plaintiff reported on intake at SRCI in 2016 that he was a hepatitis C carrier. Def. Ex. 105 at 2 & 4. He disclosed this belief again to SRCI medical in July of 2018. Pl. Ex. 1, Att. H. Dr. Gulick acknowledged that SRCI medical staff should have flagged this disclosure because hepatitis C is a contagious disease that it is curable with medication. Dr. Gulick testified later that he ordered a test for Plaintiff. Dr. Gulick testified that Plaintiff showed no other signs of the disease and that his medical records showed no evidence of liver dysfunction.

Dr. Baskerville testified that the medical staff's failure to test Plaintiff when he disclosed his hepatitis C status was not only an example of poor performance by medical staff. He stated that Plaintiff's potential status as a hepatitis C carrier is separately important because the latest research suggests that hepatitis carriers should be considered high-risk for the severe COVID-19 infection. *See also* Pl. Ex. 1 ¶¶9, 18.

Dr. Gulick testified that there is no increased COVID-19 risk to hepatitis C carriers. Even setting aside this disagreement, SRCI medical staff's failure to appreciate Plaintiff's disclosure and test/treat him as appropriate is relevant to the overall quality of medical care at SRCI.

(iv) Plaintiff's COVID Flow Sheets

Defendant identified Plaintiff as a person with underlying medication conditions that make him particularly vulnerable to COVID-19. Def. Ex. 104 ¶21. Per DOC procedure, AICs who are particularly vulnerable to COVID-19 are given regular screenings to monitor for infection. Def. Ex. 102 at ¶¶34-36. Included in Defendant's Exhibit 105 are the COVID Flow Sheets for Plaintiff for the months of July through December 2020. Def. Ex. 105, 58. The information collected on the Flow Sheets for Plaintiff is inconsistent. While staff initially took his temperature regularly, that practice fell off by October 2020, with only five entries for the latter half of December 2020. Def. Ex. 105 at 58-63. *See also* Pl. Ex. 1 ¶25. Despite his COPD, and despite the fact that Plaintiff is medically vulnerable, there is no medical evidence to suggest that SRCI has been monitoring his oxygen saturation during the pandemic.[4]

/ / /

[4] Even in the "Special Needs Review" in January 2020 and November of 2020, at which times Plaintiff was unable to complete the peak flow test, medical staff did not document his oxygen saturation.

5. Dr. Baskerville's Expert Opinion On Defendant's Care Of Plaintiff

Dr. Baskerville opines that Defendant has failed to adequately manage Plaintiff's COPD. Particularly troubling to Dr. Baskerville is Dr. Gulick's opinion that no change in care for COPD is needed. Dr. Baskerville stated that such a conclusion, in light of the medical record, is "nonsensical and reckless medical care." Pl. Ex. 1 Updated Declaration ¶15.

Dr. Baskerville testified that the "MUST LAST" instructions on the albuterol inhalers also fell below the standard of care. He testified that this instruction on the emergency breathing device of an AIC with moderate to severe COPD during a viral pandemic was unconscionable. Pl. Ex. 1 ¶17.

Finally, Dr. Baskerville noted that the lack of oxygen saturation measurements in Plaintiff's file are further evidence of the failure to adequately treat Plaintiff's COPD. He stated that a lack of formal spirometry since 2018 for a person like Plaintiff falls below the standard of care and is "nonsensical and reckless medical care" during the COVID-19 pandemic. Pl. Ex. 1 at ¶15. Dr. Baskerville recommends that Plaintiff be urgently referred for a consultation with a pulmonologist for formal spirometry and optimization of his COPD therapy.

B. Conclusion On The Facts

The court concludes based on the above findings that Plaintiff has not received adequate medical care for his COPD and that this failure is further aggravated by Defendant's failure to ensure mask wearing so as to ensure the health and safety of the AICs for whom Defendant is responsible.

V. Weighing The Evidence

Throughout its factfinding above, the court made observations regarding the reliability of testimony and evidence. Mindful that a mere honest difference in medical opinion is insufficient for Plaintiff to satisfy his burden of proof, the court offers additional findings as to the basis for its decision to grant relief. The court must assess whether the evidence reflects an honest difference in medical opinion, or whether this case presents two substantively different opinions worth differing degrees of weight based on the doctors' background, training, experience, specialties, and against the framework of the latest research on COVID-19.

A. Observations Of The Two Testifying Doctors' Expertise About COVID-19

In addition to the observations made above regarding reliability of the bases of the doctors' opinions, the court finds relevant additional testimony from the two doctors regarding their beliefs as to symptoms, testing, and experience in treating COVID-19 patients.

(i) <u>Fever As A Symptom Of COVID-19</u>

In terms of diagnosing symptoms of COVID-19 and assessing the seriousness of a COVID-19 infection, Dr. Gulick testified that he did not believe that fever was an indication of COVID-19 infection. He testified that in the roughly one thousand COVID-19 patients he has treated, very few had fever. Of those who did experience fever, Dr. Gulick testified it was likely from a secondary infection.

This belief is contrary to the testimony of Dr. Baskerville, who testified unequivocally that fever, cough, and shortness of breath are the well-established triad of COVID-19 symptoms. Dr. Baskerville's testimony is consistent with CDC guidance documented in Court Exhibit 1, the July 2020 CDC report entitled "Symptom Profiles of a Convenience Sample of Patients with COVID-19" which found that 96%

of symptomatic COVID-19 patients reported fever, cough or shortness of breath and 80% reported fever alone (Ct. Ex. 1 at 3 & 4). *See also id*. at 2 (noting fever (measured or subjective), cough, or shortness of breath as "frequently described among COVID-19 patients" and as "classified as typical signs or symptoms."); Ct. Ex. 2 at 2 (CDC: Symptoms of Coronavirus (Feb. 22, 2021)).

Dr. Gulick's belief as to the relevance of fever as a symptom also conflicts with the attachments to Joe Bugher's Declaration submitted by Defendant:

- CDC *Interim Guidance on Management of [COVID-19] in Correctional and Detention Facilities* (Dec. 3, 2020) – advising that in screening for symptoms of COVID-19 corrections staff "should include the following questions: Today or in the past 24 hours have you had any of the following symptoms? Fever, felt feverish, or had chills?" Def. Ex. 101, Ex. 1 at 24;

- OHA *Coronavirus Disease 2019 (COVID-19) Interim Guidance on Management… in Correctional and Detention Facilities* (Apr. 5, 2020) – stating "**Symptoms** – Symptoms of COVID-19 include fever, cough, and shortness of breath." Def. Ex. 101, Ex. 2 at 4.

- ODOC *Centralized Plan for COVID-19* (Oct. 19, 2020) stating "**Symptoms** – Symptoms of COVID-19 include fever, cough, shortness of breath…." Def. Ex. 101, Ex. 3 at 5.

- ODOC Flyer, *Help Us Stop The Spread Of … COVID-19* (undated), noting "If you have a …fever… please come back when you are feeling better." Def. Ex. 1010, Ex. 5 at 2.

- ODOC Health Services FAQ, *What Are The Symptoms Of COVID-19?* (Apr. 27, 2020) – listing as first on the list of "most common symptoms" "Fever". Def. Ex. 101, Ex. 5 at 4.

- ODOC Health Services FAQ, *What Is … COVID-19?* (Apr. 27, 2020) – "Patients with COVID-19 can have mild to severe respiratory illness off associated with flu-like symptoms: fever and/or chills." Def. Ex. 101, Ex. 5 at 5.

- ODOC *Staff Screening Tool* (undated) – "Assess Symptoms: Yes/No Fever". Def. Ex. 1010, Ex. 8.

- ODOC *Infection Prevention Readiness Assessment Tool for COVID-19* (undated) – "Active Screening at Facility Entrance" to include temperature check and symptom questions about whether person has had fever in last 14 days. Def. Ex. 101; Ex. 12 at 2.

In addition, Dr. Gulick's testimony that fever is not a symptom of COVID-19 is contrary to the ODOC COVID Flow Sheets used to monitor AICs for COVID-19 infection. Def. Ex. 105 at 58-68. Overall, Dr. Gulick's denial of fever as a symptom of COVID-19 is relevant to the court's decision as to the reliability of his medical opinions.

(ii) Mass Testing In Incarceration Settings

Regarding mass COVID-19 testing at SRCI, Dr. Gulick testified that he considered testing "harmful" and stated that it "can be the enemy." He testified that he believed the risk of false positives from mass testing outweighed the benefit to the institution.

Dr. Gulick said they could not require inmates to be tested for COVID-19 other than in relation to transports. He said that because AICs did not want to be placed in IMU-E, 15-20% of AICs refuse to be

tested and they hide their symptoms. Of the remaining AICs who will consent to rapid testing, Dr. Gulick testified that 1/100 rapid tests will result in false positives, which would in turn result in extended Tier 4 status for SRCI, which means that the entire institution remains under quarantine. In order to be truly effective, he testified, SRCI would be required to conduct a complete lockdown and test AICs and staff three times over a 14-day period to truly capture all positives.

Dr. Gulick testified that he was unfamiliar with the CDC August 21, 2020, report on mass testing in incarceration settings. Ct. Ex. 2. As the CMO of the largest institution in Oregon, the only institution with medical care available 24 hours per day/7 days per week, and the primary institution charged with caring for AICs ill with COVID-19, Dr. Gulick's lack of familiarity with the CDC report on the value of testing in institutions is relevant and important, even if he is not the ultimate decision maker as to testing polices.

The CDC's report, "Mass Testing for SARS-CoV-2 in 16 Prisons and Jails – Six Jurisdictions, United States, April-May 2020" is an 8-page report detailing the CDC's research on the value of testing. The report recognizes many of the struggles detailed by Dr. Gulick about how difficult it is to track, treat, and prevent COVID-19 within institutions. Consistent with Dr. Gulick's testimony, the report sets forth the unique challenges in incarceration settings, including dense housing of populations of unhealthy people who face a risk of severe illness if infected by COVID-19. The report acknowledges the added difficulty of introduction into and spread within the institution by staff ingress/egress and by AIC transfers. In the face of all of these challenges, the report concludes: "In correctional and detention facilities, broad-based SARS-CoV-3 testing provides a more accurate assessment of disease prevalence than does symptom-based testing and generates data that can potentially help control transmission." This opinion of the CDC from August 2020 is contrary to Dr. Gulick's opinion on the efficacy of mass testing. *See also* Ct. Ex. 4; CDC, *Testing in Correctional & Detention Facilities* (Mar. 17, 2021) (most updated CDC guidance, continuing to recommend testing).[5]

The court recognizes that the Dr. Dewsnup Declaration from October 2020 is not fully consistent with the CDC guidance. That declaration, dated October 15, 2020, recognizes the value of testing in a correctional setting but also states as of that date: "'mass testing' is not considered to be highly effective by OHA and is still recommended to be used with caution." Def. Ex. 102 ¶48.

As discussed above, SRCI has been on Tier 4 since July 2020 and this status means reductions in programming, visitation and other institutional operations. *See also* Def. Ex. 101, ¶69. Dr. Gulick testified that the risk of false positives in mass testing (and therefore extended Tier 4 status) outweighed the overall benefit of testing AICs and staff on a wide scale. This view, inconsistent with not only Dr. Baskerville's opinion on the subject, but with the CDC as well, is relevant to the reliability of Dr. Gulick's medical opinion.

(iii) Experience Treating COVID-19 Patients

As noted above, Dr. Gulick testified that he has treated nearly one thousand COVID-19 patients. When asked to clarify, Dr. Gulick testified that of those thousand, he directly interacted with very few of AICs sick with COVID-19, specifically those who were placed in the infirmary. Dr. Gulick explained that as the CMO at SRCI, he considers himself to have treated all COVID-19 positive AICs at SRCI, whether he directly treated them or not.

[5] *See* https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html (last visited 03/23/2021).

Dr. Baskerville testified that his medical practice has been concentrated on the treatment of critically ill COVID-19 patients in the intensive care unit of OHSU since April of 2020. He also treats less ill COVID-19 patients in the ER, a place that many people use in lieu of a primary care practice. Dr. Baskerville interacts with pulmonologists and other specialists regarding proper treatment of patients with COVID-19 on a daily basis at OHSU. His testimony displayed an expertise in the latest COVID-19 science and care, including a fluency in the various CDC reports with the latest studies on prevention, symptoms and treatment. Dr. Baskerville testified that he receives day-to-day and hour-to-hour updates from the CDC, Johns Hopkins and other experts as to how to best prevent, identify and treat COVID-19 infections.

Dr. Gulick has 17-years of experience providing medical care to AICs in an institutional setting. Dr. Gulick recognized that the care he has directly provided to COVID-19 AICs includes only pre-hospitalized and post-hospitalized patients. He has no experience in critical care but considers the care he provides in the infirmary to constitute low level hospital care. Dr. Gulick has no experience in the intensive care or critical care other than a single AIC who refused treatment and who died at SRCI. He treats patients outside SRCI at his clinic, but Dr. Gulick did not testify about caring for COVID-19 patients in that context.

On the whole, the court finds that both doctors testified honestly, but in terms of their expertise on COVID-19, Dr. Baskerville is far more knowledgeable about the virus. For the past year he has treated patients on the front lines at OHSU's ICU and ER, alongside a variety of specialists. Dr. Baskerville receives constant updates on the latest scientific understanding about the virus and implements that knowledge into his care for patients. Dr. Gulick's opinions on fever as a symptom of COVID-19 and the efficacy of testing at stopping the spread of the virus undermines the reliability of his medical opinion on the many relevant questions of fact related to this topic. The court has no doubt that Dr. Gulick does his best to care for patient AICs – sometimes very stubborn ones – under extraordinarily difficult circumstances, including a pandemic with stressed AICs and staff, some of whom believe the entire public health crisis is a hoax. That said, the reliability of the two experts on issues related to COVID-19 is far from equal. The court weighs the evidence accordingly.

VI. Decisions On The Claims

A. Claim One: Cruel And Unusual Punishment For Failure To Provide Preventative and Management Measures To Combat COVID-19 At SRCI

Based on the above findings of fact, the court concludes as to Claim One:

As to the first, objective, component of Plaintiff's environmental hazard Cruel and Unusual Punishment claim, Plaintiff has proven by a preponderance of the evidence that COVID-19 as managed at SRCI presents an unnecessarily dangerous environment with specific regard to the failures in mask wearing and the risk those failures pose to Plaintiff. *Helling*, 509 US at 36-37. The risk of the hazard is amplified by Plaintiff's comorbidities including COPD, advanced age, bullous emphysema, smoking/alcohol/drug use history, all of which make him extremely susceptible to severe damage or death were he to contract COVID-19. Defendant's witnesses acknowledge the institutional failure to ensure proper mask wearing by AICs and staff. Moreover, despite this dangerous environment, Defendant failed to maintain consistent screening of Plaintiff, a medically vulnerable AIC who is high-risk for serious illness or death from COVID-19. The court finds these failures violate contemporary standards of decency to expose a person so vulnerable to risks so great.

As to the subjective factor of deliberate indifference, the court considers "the prison authorities' current attitudes and conduct" as well as the adoption of institutional policies to address the environmental hazard and evidence on how the institution is administering the policies. *Helling*, 509 US at 36-37.

While Defendant has introduced extensive evidence of evolving policies and procedures to prevent and manage COVID-19 in SRCI, there is extensive and reliable evidence – from the mouths of defense witnesses no less – to document the chronic institutional problem of mask noncompliance by AICs and staff at SRCI. The evidence before the court documents a pattern of mask noncompliance in the context of an institutional setting that SRCI's CMO described as a large-scale nursing home, where the residents have no control over the behaviors of the staff who monitor them. Moreover, AS Bell acknowledged that the AICs had reason to fear retaliation if they were to report staff for mask violations. Defendant introduced a policy for disciplining staff who fail to mask properly, but little evidence as to enforcement.

Applying the preponderance of the evidence standard, the court finds this subjective component a very close call. Nonetheless, this court finds that Plaintiff failed to prove that Defendant turned a blind eye and deaf ear to the COVID-19 problem in a manner indicative of a total unconcern for Plaintiff's welfare. Plaintiff's Claim One is DENIED.

B. Claim Two: Cruel And Unusual Punishment For Failure To Adequately Treat Plaintiff's Serious Medical Issue: COPD

Based on the findings set forth above, Plaintiff has proven by a preponderance of the evidence that he suffers from a serious medical condition in the form of COPD and that Defendant has failed to adequately treat the seriousness of the plaintiff's COPD particularly in the context of the COVID-19 pandemic. *Billings*, 323 Or at 180. Plaintiff has therefore met his burden on the objective component of the Cruel and Unusual Punishment claim.

As to the second, subjective, component, Plaintiff has also proven by a preponderance of the evidence that Defendant has been deliberately indifferent in responding to Plaintiff's COPD in the context of the current pandemic and Plaintiff's refusal to take the COVID-19 vaccine. *Billings*, 323 Or at 180. Defendant failed to modify treatment in the face of evidence of pulmonary decompensation in the medical records, failed to monitor Plaintiff's oxygen saturation, failed to engage in consistent monitoring of him as a vulnerable AIC, and provided confusing direction on the Albuterol inhaler. Consideration of this conduct as a whole results in a conclusion that Defendant is aware of a substantial risk to Plaintiff from his COPD, particularly during this pandemic, and failed to take reasonable measures to abate the risk. Plaintiff's Second Claim is GRANTED.

C. Claim Three: Unnecessary Rigor Cruel And Unusual Punishment For Failure To Provide Preventative and Management Measures To Combat COVID-19 At SRCI

To prevail on this claim, Plaintiff must prove by a preponderance of the evidence that Defendant's policies and practices are abusive and not justified by necessity. The court concludes that Plaintiff has met this burden as to the failure of Defendant to ensure mask wearing at SRCI and the risk that failure unnecessarily poses to Plaintiff.

As discussed above, despite the evidence before the court regarding mask noncompliance at SRCI and the threat it poses to the AICs, including Plaintiff, the court denied Plaintiff's Claim One based on the high burden of proof as to the subjective intent of Defendant. Viewing the same claim under the framework of

an Unnecessary Rigor Clause yields a different result. The court finds that the mask-compliance aspect of Defendant's management of the COVID-19 pandemic in SRCI creates an unjustifiable risk.

Based on AS Bell and Dr. Gulick's testimony, it is apparent that certain SRCI staff view mask wearing as an issue of politics rather than one related to health and welfare during a pandemic. Mask failures by staff are particularly troubling considering the very nature of their jobs: to oversee a large, congregate environment that Dr. Gulick referred to as basically a large-scale nursing home filled with medically vulnerable AICs. Equally relevant, these AICs do not choose to reside there, nor do they select their corrections officers. While the AICs are required to serve sentences legally imposed by the courts as punishment, execution of those sentences may not subject AICs to unjustifiable risk of serious illness or death.

Every time a staff person enters SRCI, particularly if s/he believes that COVID-19 is a hoax and therefore does not engage in adequate preventative measures, and if that person fails to properly wear a mask, that person introduces a risk of death or severe disability to the medically vulnerable AICs housed there. As recognized by AS Bell: "COVID-19 prevention policies…must be implemented at the institutional level to be effective." Def. Ex. 101 ¶79. SRCI cannot throw up its hands in the face of chronic mask noncompliance and simultaneously fail to explore other options such as rapid testing of staff before entry. To do so is to subject Plaintiff to unnecessary health hazards.

The court appreciates Dr. Gulick's testimony about the effect of false positives and continuation of Tier 4 status at SRCI. But the problem with Dr. Gulick's approach is that SRCI has been on Tier 4 status since July 2020 due to positive test results *absent mass testing*. The current plan has proven ineffective. Doing the same thing over and over and expecting a different result is unreasonable, irrational and unjustifiable.

The court shares Dr. Gulick's goal that SRCI soon emerge from the COVID-19 crisis and allow staff and AICs to go back to their normal routines with decreased monitoring, in-person visitation, and increased programming. The SRCI practice of symptom monitoring of staff and AICs has failed. A more aggressive approach is required.

Although Dr. Gulick testified that staff cannot be required to test for COVID-19, the Employment Equal Opportunity Commission states:

> The ADA requires that any mandatory medical test of employees be "job related and consistent with business necessity." Applying this standard to the current circumstances of the COVID-19 pandemic, employers may take screening steps to determine if employees entering the workplace have COVID-19 because an individual with the virus will pose a direct threat to the health of others. Therefore an employer may choose to administer COVID-19 testing to employees before initially permitting them to enter the workplace and/or periodically to determine if their presence in the workplace poses a direct threat to others. The ADA does not interfere with employers following recommendations by the CDC or other public health authorities regarding whether, when, and for whom testing or other screening is appropriate. Testing administered by employers consistent with current CDC guidance will meet the ADA's "business necessity" standard.[6]

[6] https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws (last visited 03/23/2021).

Testing of SRCI staff is consistent with Oregon's approach to protecting the state's most vulnerable citizens residing in other communal settings: "Oregon requires staff in all nursing, assisted living and residential care facilities to undergo routine COVID-19 testing as of November 1, 2020."[7] *See also* Oregon DHS, *Updated Routine Staff Testing Guidance for community-based care providers* (Jan. 8, 2021): "Oregon's strategy for testing of COVID-19 in staff and residents continues to be an essential part of overall care and safety of long-Term Care residents."[8] The State of California requires corrections employees to consent to testing before entering a correctional institution.[9]

Particularly considering the unenviable place in which SRCI finds itself regarding staff and AIC views about the seriousness of the virus, the reasonableness of preventative measures, and the safety of the vaccine, Defendant must take a more proactive approach. Accordingly, Plaintiff's Claim Three is GRANTED IN PART in that Defendant's enforcement of masking creates an unjustifiable risk of a serious health hazard to Plaintiff. Other allegations raised under section 13 of failure to manage and prevent COVID-19 at SRCI are DENIED.

VII. Conclusion

The court ORDERS the following:

1. Plaintiff's Claim One is DENIED without prejudice.
2. Plaintiff's Claim Two is GRANTED. Defendant is directed to provide Plaintiff an urgent consultation with a pulmonologist for formal spirometry and optimization of Plaintiff's COPD therapy.
3. Plaintiff's Claim Three is GRANTED as to failures in SRCI's mask policy enforcement. Defendant is directed to consider the above findings and prepare a proposal to the court to address steps Defendant is taking to reduce unnecessary risks to medically vulnerable AICs like Plaintiff. The proposal is to include the following:
    a. Documentation as to how SRCI is enforcing the masking policy, including proof of specific enforcement;
    b. Consideration of a plan to engage in mass COVID-19 testing at SRCI, particularly rapid testing of staff prior to entry.
4. Defendant and his agents are enjoined from retaliating against Plaintiff for requesting medical services or for reporting violations of mask requirements.
5. Defendant and his agents are enjoined from retaliating against Plaintiff for seeking redress from this court.
6. Defendant is to pay any filing fee paid by Plaintiff.
7. The court will retain jurisdiction over this case to ensure compliance.

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[7] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3447.pdf (last visited 03/23/2021).
[8] https://content.govdelivery.com/attachments/ORDHS/2021/01/08/file_attachments/1643063/CBC%20routine%20testing%20frequencies_01.2021.pdf (last visited 03/23/2021).
[9] https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/12/Mandatory-Employee-Testing-and-Non-Compliance-Accountability-12-21-20.pdf (last visited 03/23/2021). *See also* https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html (last visited 3/23/2021).

8. The parties are to confer and suggest through the clerk of the court a proposed date in approximately 30 days for a Status Check on the requirements of this Order.

9. Plaintiff is directed to prepare a proper form of Judgment for entry into the record granting relief consistent with this court's opinion.

DATED this 24th of March, 2021.

Signed: 3/24/2021 10:33 AM

Circuit Court Judge Amy M. Baggio