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

Case No: 20CV24540

DONALD SKELTON
Plaintiff

v.

BRAD CAIN, Superintendent, Snake River Correctional Institution
Defendant

OPINION AND ORDER ON PLAINTIFF SKELTON'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. W. Edward Neusteter appeared on behalf of Plaintiff Donald Skelton; Assistant Attorney General Yufeng Luo appeared on behalf of Defendant Brad Cain; Plaintiff Skelton appeared by video from Snake River Correctional Institution.

After carefully considering Plaintiff Skelton's two claims in the context of the pleadings, the evidence submitted by both sides, and the arguments of both parties, the court concludes that Plaintiff has proven by a preponderance of the evidence that Defendant acted with deliberate indifference to Plaintiff's serious medical needs as described below. Accordingly, the court shall enter an Order partially granting relief and retaining jurisdiction over this matter to ensure compliance with the court's Order.

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. After this court's Opinion & Order on Defendant Cain's motion to dismiss raised issues related to the way Plaintiff stated his claims in the Replication, on February 8, 2021, Plaintiff sought permission to file an Amended Replication. Defendant objected in part to the request. On February 19, 2021, the court granted in part Plaintiff's request to file an Amended Replication.

After certain claims settled, two claims set forth in his Amended Replication remain for the court to decide:

> *Claim One*, "Cruel and Unusual Punishment in Failure to Provide Adequate Treatment and Diagnosis of Plaintiff's Serious Medical Conditions," to wit, Plaintiff's reactive airway disease and related breathing difficulties. As to this claim, Plaintiff alleges that particularly in light of the impact of his August 2020 COVID-19 infection, Defendant has failed to provide adequate medical care for this serious breathing condition. Plaintiff asserts this failure "violates the Eighth Amendment to the United States Constitution and Article I, Sections 13, 16 and 23 of the Oregon Constitution." Amended Replication, ¶22.
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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 hypertension and heart-related conditions. As to this claim, Plaintiff alleges that for many months Defendant has failed to provide adequate medical care for these serious health conditions. Plaintiff asserts this failure "violates the

Eighth Amendment to the United States Constitution and Article I, Sections 13, 16 and 23 of the Oregon Constitution." Amended Replication, ¶25.

II. Initial Legal Question: Nature Of Plaintiff's Claims

As an initial matter, the court must resolve the dispute between the parties as to whether Plaintiff raised his two claims under only the Cruel and Unusual Punishment prohibitions of the state and federal constitutions (Oregon Constitution Article I, section 16; U.S. Const., 8th Am.), or if Plaintiff's reference to the Unnecessary Rigor Clause in his Amended Replication paragraphs 22 and 25 was sufficient to raise the medical claims under that provision as well. It is undisputed that Plaintiff's Amended Replication Claims One and Two did not reference the Unnecessary Rigor Clause in either the title of the claim nor in the text of the claim itself. Plaintiff's only reference to the Unnecessary Rigor Clause was by virtue of the citation to Oregon Constitution Article I, section 13.

This question is particularly important *if* (1) the court finds that Plaintiff fails to meet his burden of proof as to his claims clearly brought under the Cruel and Unusual Punishment provisions of state and federal constitutional law *and* (2) the court agrees with Plaintiff as a matter of law that Unnecessary Rigor Clause claims under Article I, section 13, involve a different – and less onerous standard – than Cruel and Unusual Punishment Claims.

Because the court finds Plaintiff met his burden of proof to establish his serious medical condition claims under the Cruel and Unusual Punishment Clauses, the court concludes resolution of this separate legal issue as to whether Plaintiff properly pled the claims under Unnecessary Rigor Clause is of no great import. However, for purposes of resolving this initial legal dispute, the court finds that Plaintiff's claims, read in the context of the original Replication as well as in the context of the other claims pled, but settled, in the Amended Replication, lead to an inevitable conclusion that Plaintiff's First and Second Claims are properly pled as allegations of violation of the Cruel and Unusual Punishment Clauses alone. This is true even considering the claims liberally as required. *Bedell v. Schiedler*, 307 Or 562, 566-67, 770 P2d 909 (1989); *see also* ORCP 12.

Relevant to the court's conclusion, Plaintiff's Amended Replication included claims (later settled) that raised specific arguments under the Unnecessary Rigor Clause. *See, e.g.*, Amended Replication Claim Four: "Unnecessary Rigor in Defendant's Failure to Provide Preventative and Management Measures." All four of Plaintiff's claims in the Amended Replication included the same laundry list of citations to authority: "the Eighth Amendment to the United States Constitution and Article I, Sections 13, 16 and 23 of the Oregon Constitution;" however, the title and description of each claim made plain the specific provision of law under which Plaintiff sought relief. As held in *Bedell*: "A plaintiff claiming a violation of constitutional rights must allege facts showing that such violations affect him or her individually." 307 Or at 566. Plaintiff's Amended Replication, construed liberally, but read fairly, results in a conclusion that Plaintiff's two remaining claims present Cruel and Unusual Punishment claims alone. The court therefore need not engage in an analysis of whether claims brought under the Unnecessary Rigor Clause involve a different standard from those under the Cruel and Unusual Punishment provisions of state and federal constitutions.

III. 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 adult in custody (AIC) to further imprisonment or restraint not justified under the original sentence and (2) that the AOC 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, 592 P2d 584 (1978). Plaintiff's case involves the latter type of claim in that Plaintiff alleges Defendant's failure to adequately care for his serious medical issues constitutes Cruel and Unusual Punishment under state and federal constitutions and that immediate judicial intervention is required to remedy the inadequate medical care.

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 (1996).

B. 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."). These 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* [*v. Gamble*, 429 US 97, 105–06 (1976)] so stating with regard to Eighth Amendment); *Sanchez v. Vild*, 891 F2d 240, 242 (9th Cir 1989).

Billings, 323 Or at 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) (emphasis added).

IV. Brief Overview Of Evidence Before The Court

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

Regarding Plaintiff Skelton, the court finds that while he does have an interest in the outcome of this litigation, he testified credibly.

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 the 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. 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 six exhibits: Exhibits 01-03 are excerpts from Plaintiff's Medical Records at SRCI. Plaintiff's Exhibit 04 is a redacted request for admissions. Plaintiff's Exhibit 05 is the Declaration of John Smith, an investigator for Plaintiff. Plaintiff's Exhibit 06 is the Centers for Disease Control (CDC) July 17, 2020, Morbidity and Mortality Weekly Report: *Symptom Profiles of a Convenience Sample of Patients with COVID-19 – United States, January-April 2020*.

Defendant presented only one witness: SRCI's Chief Medical Officer 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 testimony as well as the strength of his medical conclusions about an appropriate course of treatment in light of Dr. Baskerville's testimony, evidence from the CDC (Pl. Ex. 06), and when his testimony as to policies and practices was contradicted by Plaintiff's medical records at SRCI.

Defendant introduced three exhibits: Defendant's Exhibit 101 is Dr. Gulick's Declaration; Defendant's Exhibit 102 is an updated set of Plaintiff's medical records at SRCI, and Defendant's Exhibit 103 is a 16-page set of medical records for Plaintiff that were missing from Defendant's Exhibit 102.

V. Analysis Of The Claims In Plaintiff's Case

Plaintiff's claims relate to two medical conditions: reactive airway disease/breathing difficulties and hypertension/heart disease/fluttering. The record is clear that both conditions satisfy the "serious medical condition" element as either condition, left untreated, could result in death. In addition, the existence of COVID-19 and its impact on persons with compromised pulmonary systems and hypertension make the

treatment of Plaintiff's issues all the more serious. Defendant recognizes through Dr. Gulick's testimony that Plaintiff is a medically vulnerable person. The question before the court focuses more on the second component of Plaintiff's Cruel and Unusual Punishment Claims: whether Plaintiff has proven by a preponderance of the evidence that Defendant has been deliberately indifferent to one or both of Plaintiff's conditions. While there is no pending claim as to Defendant's overall management of COVID-19 in SRCI, the court finds, consistent with Dr. Baskerville's testimony that Plaintiff's underlying serious medical conditions make him more susceptible to severe illness were he to again be infected by COVID-19, that evidence related to the existence of the deadly virus is relevant to the risk that Plaintiff's underlying medical conditions pose if they are insufficiently treated by Defendant.

A. Findings Of Fact

Plaintiff is an AIC at Snake River Correctional Institution (SRCI) in Malheur County, Oregon. SRCI is the largest prison in Oregon, with a total of 3,000 inmate beds available at various security levels. Pl. Ex. 05 ¶6.a. Dr. Gluck, the Chief Medical Officer (CMO) at SRCI testified that his institution is the only Department of Corrections Institution that has 24 hour-a-day, seven day-a-week medical care. He testified that SRCI is functioning as a transfer site for AICs at other institutions who are infected with COVID-19 and require round-the-clock medical care short of full hospitalization.

As of December 8, 2020, 463 AICs at SRCI had tested positive for COVID-19. Pl. Ex. 05 ¶6.a.i. As such, approximately 15.4% of the AIC population at SRCI has contracted COVID-19. *Id*. Dr. Gulick testified that eleven SRCI AICs have died from the disease. Two other AICs who were transferred from other institutions died from the virus at SRCI as well.

Eleven deaths out of 463 COVID-19-infected AICs at SRCI reveals a death rate of 2.37%. Nationwide, COVID-19 is reported as deadly for 1.8% of those infected. *See generally* CDC Covid Data Tracker, *available at* https://covid.cdc.gov/covid-data-tracker/#datatracker-home (last visited 03/23/2021) (29,613,017 cases; 539,038 deaths). Thus, the death rate at SRCI is significantly higher than the overall mortality rate in the United States. This is not surprising considering the evidence in this case. Dr. Gulick testified that SRCI houses a very large number of medically vulnerable AICs and likened the institution to a large-scale nursing home. The risk to those medically vulnerable AICs is amplified by the dense, communal living required in a prison setting.

1. Plaintiff's Serious Medical Conditions

Consistent with the medical records and the testimony of Dr. Baskerville and Dr. Gulick, Plaintiff suffers from reactive airway disease (RAD), or asthma. RAD, left untreated, can result in death resulting from an inability to breathe. According to Dr. Baskerville, Plaintiff's significant pulmonary history, including RAD and a history of smoking and environmental exposures, make the threat of COVID-19 infection particularly deadly, especially if those conditions are insufficiently treated. In contrast, Dr. Gulick testified that Plaintiff's RAD is well controlled and further that asthma poses additional risks to "very few" persons who contract COVID-19.

In addition to RAD, Plaintiff suffers from Hypertension/Heart Disease. According to Plaintiff's medical records at SRCI, he was diagnosed with hypertension in December of 2016. Def. Ex. 102 at 1. His medical intake records note a history of high blood pressure for which he had taken medication, but that his high blood pressure was under control without medication at the time he entered SRCI. Def. Ex. 102 at 49. Plaintiff has also begun experiencing heart fluttering since September 2020. Dr. Baskerville

testified that Plaintiff's heart issues can cause a stroke, the "silent killer," which can come on without warning and may cause permanent disability or death.

Plaintiff is high-risk for severe infection by COVID-19. In addition to the health conditions described above, he has additional risk factors such as the fact that he is Native American, 55 years-old, has a body mass index of 31, and smoked a pack of cigarettes per day for ten years. He was also an auto-industry employee, an environment Dr. Baskerville testified creates environmental hardship for the lungs. *See also* Def. Ex. 101 at ¶44 ("AIC Skelton was identified by ODOC as particularly vulnerable" to COVID-19).

2. Defendant's Treatment Of Plaintiff's Serious Medical Conditions

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

Plaintiff suffered from asthma upon admission to SRCI in October 2015. Def. Ex. 102 at 49. At the time of admission, Plaintiff's reported asthma was limited: "uses inhaler when working out." *Id*. Plaintiff focuses on two issues that Plaintiff asserts prove that Defendant has been recklessly indifferent to Plaintiff's serious medical issue, RAD, while at SRCI. First, Plaintiff asserts that the refill limits on albuterol inhalers fall below the standard of care and constitute deliberate indifference, particularly in an environment highly at-risk for COVID-19 infection and when a pre-existing condition of RAD, according to Plaintiff, creates a higher risk for a more devastating impact of a COVID-19 infection. Second, Plaintiff asserts that Defendant has been deliberately indifferent regarding the improper medical care for Plaintiff's ongoing breathing problems suffered since he became infected with COVID-19 by (or before) August 2020.

a. Albuterol Prescription Refills

Plaintiff's excerpted medical records include "Medication Administration Record" paperwork dating back to January 2019. Def. Ex. 102 at 131. Those records demonstrate that SRCI had prescribed Plaintiff an albuterol inhaler since at least November 20, 2018 (per the prescription date on the entry). Def. Ex. 102 at 131. Both doctors testified that albuterol inhalers are considered "rescue inhalers" for use in times of breathing crisis.

In the earliest of the Medication Administration Records admitted to the court, a November 20, 2018, prescription for albuterol directs Plaintiff to "INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED" and goes on to state: "MUST LAST 90 DAYS." Def. Ex. 102 at 131. Plaintiff did not refill his albuterol prescription during that initial prescription authorization period but restarted albuterol through a new prescription in September 2019. Def. Ex. 102 at 121-30. In October 2019, the records reflect that the direction as to how long the prescription must last changed from 90 days: "MUST LAST 120 DAYS." Def. Ex. 102 at 120.

Dr. Baskerville testified that such limits on albuterol inhalers "make no sense whatsoever." As discussed by Dr. Baskerville, an albuterol inhaler contains 200 puffs. Were a person to administer two puffs, four times per day, the inhaler would last 25 days, not the 90 or 120 days required by the prescription.

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. Gulick further testified that Plaintiff had not requested additional refills of his albuterol inhaler beyond the "MUST LAST" limitations. He explained that if an AIC made requests to refill more often than permitted under the terms of the prescription, then the person's case would be reviewed by the Therapeutic Level of Care (TLC) Committee for consideration of an exception to the refill frequency or to determine whether other treatment was necessary.

Dr. Gulick testified that if an AIC has a medical emergency, he can request help by reporting the emergency to staff. An AIC may also request an appointment through "sick call." Lastly, an AIC may submit a "kyte," in intra-institutional communication. Per SRCI policy, if the kyte is for a medical need, a nurse will respond within one day. Depending on the nature of the kyte request, it may result in spontaneous scheduling because of the AIC's underlying conditions.

While there are some records that reflect a response within the policy to which Dr. Gluck testified (Def. Ex. 102 at 149-151; 146 &78), Plaintiff's records also reflect multiple incidents in which Plaintiff submitted a request for medical assistance to which a nurse took more than one day to respond. For example:

- On April 14, 2020, Plaintiff submits a written request for health and safety information applicable during a pandemic. *Staff responded nine days later on* April 23, 2020, at which time they denied his request for information. Def. Ex. 102 at 148. (Dr. Gulick testified that the delay in response to this question was not concerning as he did not consider this a medical request.)

- On July 1, 2020, Plaintiff submits a written request for a COVID-19 test because he is experiencing symptoms of loss of taste and smell. *Staff responded six days later on* July 7, 2020. Def. Ex. 102 at 145.

- On July 2, 2020, Plaintiff submits a second written request for a COVID-19 test because he is experiencing symptoms of loss of taste/metallic taste in his mouth, periodic warm flashes, disorientation, and nausea. *Staff responded three days later* on July 5, 2020. Def. Ex. 102 at 147.

- On January 9, 2021, Plaintiff submitted a request for the results of his stress echocardiogram and reported "sharp pain that feel like there cutting through my head (Brain). This has never happen before and they are periodically not all the time." *Staff responded five days later,* on January 14, 2021, that he was scheduled for a chart review. Def. Ex. 102 at 25.

In addition, Dr. Gulick's own declaration reviews medical records dating back farther than those included as Def. Ex. 102. In that review, Dr. Gulick includes a number of health-related requests made by Plaintiff that took over a day for response by Defendant. For example:

- On March 31, 2018, Plaintiff requested a medical report for allergies; he saw a nurse on April 2, 2018. Def. Ex. 101 at ¶24.

- On May 4, 2018, Plaintiff requested a renewal of his inhaler "because his breathing was short again"; Defendant responded on May 8, 2018, that he was scheduled for a chart review. Def. Ex. 101 at ¶25.

Therefore, while Dr. Gulick testified that AICs receive a response within one day of medical-type requests, Plaintiff's medical records demonstrate that is not always true. This reality makes the requirement that an AIC seek special authorization for a refill within 120 days of greater importance. This evidence also raises concerns over the reliability of Dr. Gulick's testimony about institutional operations in the face of documentary evidence to the contrary.

Defendant argues that the records reflect that Plaintiff did not request frequent refills of his albuterol inhaler and therefore, the "MUST LAST" direction on the prescription is no of great consequence. The submitted medical records related to issuance of prescriptions are missing months and overall not a model of clarity, but they do provide evidence as to how often Plaintiff obtained a refill:

Inhaler Issued (*time since last*)	Def Ex 102 @	Date Rx	Refill Hx	Direction on Inhaler
1 (*unknown*)	131	11/20/2018-2/17/2019		INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED (MUST LAST 90 DAYS)
	130	"	N/A 02/2019	"
	129	"	N/A 03/2019	"
	128	"	N/A 04/2019	"
	127	"	N/A 05/2019	"
	126	"	N/A 06/2019	"
	125	"	N/A 07/2019	"
	123-24	"	N/A 08/2019	"
2 (*10 mo*)	121-22	9/4/2019-12/02/2019	**Restarted** 09/2019	INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED (MUST LAST 90 DAYS)
3?[1] (*2 mo*)	120	"	N/A 10/2019	INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED (MUST LAST 120 DAYS).
	119	"	N/A 11/2019	"

[1] The record reflects a new prescription with the "MUST LAST 120 DAYS" language; it is not clear whether this revised direction was given in the context of issuance of a new inhaler to Plaintiff, or if the prescription language was revised without reference to a new inhaler.

Inhaler Issued (*time since last*)	Def Ex 102 @	Date Rx	Refill Hx	Direction on Inhaler
4?[2] (*2 mo*)	117	**Rx extended** to 5/31/2020	12/2019	"
	116	"	N/A 01/2020	"
	115	"	N/A 02/2020	"
5? (~4 mo)	114	"	**REFILL** 3/26/2020	"
	113	"	N/A 04/2020	"
	112	"	N/A 05/2020	"
	111	NO ALBUTEROL Rx LISTED (expired 05/2020)		"
6?[3] (*3 mo*)	109	06/30/2020-12/26/2020	**REFILL** requested via Kyte 6/29/2020	INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED (MUST LAST 120 DAYS)
Medication administration records missing from Def. Ex. 102 from August 2020 through November 2020*				
	22	"	N/A 11/2020	
	21	"	N/A 12/2020	
7?[4] (*7 mo,*)	8, 20	01/27/2020-07/26/2021	**REFILL** 1/20/2021	INHALE TWO PUFFS DEEP INTO THE LUNGS 4 TIMES DAILY IF NEEDED (MUST LAST 120 DAYS)

[2] This record is similarly unclear as to whether the prescription was merely extended, or if it was extended in connection with issuance of a new inhaler.

[3] The Medication Administration Record does not clearly document a refill of Albuterol in June 2020 (Def. Ex. 102 at 111) but when read in connection with Plaintiff's kyte on this date (Def. Ex. 102 at 146), as well as the new prescription effective dates for the July 2020 record (Def. Ex. 102 at 109), a new inhaler was clearly issued.

[4] The submitted records reflect a seven-month lag between prescriptions, ***but see above *****, noting missing medication records for August, September and October.

Plaintiff's medical records are not sufficiently clear to draw any firm conclusions about the frequency of his refills of Albuterol. There was testimony and argument offered by Defendant that Plaintiff was not seeking refills frequently enough for the "MUST LAST" direction to be of consequence; however, the court is not certain of that based on the information outlined above as well as based on Plaintiff's testimony that he was rationing use of his albuterol because of the "MUST LAST" instruction.

Dr. Gulick testified that the "MUST LAST" direction is intended for the provider, not the AIC. If so, that notation should not be included on the AIC's prescription information. The language is likely to result in rationing effect by AICs, who may already expect to wait for days for a response to their medical requests. Indeed, Plaintiff testified that he rationed use of albuterol due to the "MUST LAST" instruction. Moreover, this practice is particularly unreasonable as imposed on Plaintiff, an AIC with a significant pulmonary history and other underlying health conditions such as hypertension and obesity, in the midst of a deadly pandemic, involving a virus that targets the lungs, and that is documented to be particularly dangerous for people who have Plaintiff's co-morbidities. Were this to be Plaintiff's only argument that Defendant's medical care violates Plaintiff's rights, it would be insufficient. However, this finding is considered alongside Plaintiff's other pulmonary treatment complaint: that Defendant has provided insufficient care and monitoring of his breathing issues after his COVID-19 infection.

b. Plaintiff Contracts COVID-19

As noted in a different context above, on July 1, 2020, Plaintiff submitted a written request for a COVID-19 test after he began experiencing symptoms. Def. Ex. 102 at 145. Plaintiff made a second request for testing on July 2, 2020, when he reported loss of taste/metallic taste, periodic warm flashes, disorientation, and nausea. Def. Ex. 102 at 147. A nurse responded three days later, on July 5, 2020: "As long as you are not having a fever you don't meet criteria for testing." Plaintiff was seen by medical staff on July 7, 2020 and reported he was feeling better. Def. Ex. 102 at 77. Plaintiff was not tested at that time. *See also* Def. Ex. 101 at ¶¶30-31.

On August 13, 2020, Plaintiff again complained of respiratory symptoms and fever. Def. Ex. 101 at ¶32; Def. Ex. 102 at 77. Medical staff visited Plaintiff at his cell and confirmed his subjective report of fever and cough. Def. Ex. 102 at 77. Plaintiff was moved from his cell to the Intensive Management Unit-Echo (IMU-E) or "the hole" as it is known colloquially in the institution. IMU was traditionally used for behavioral management issues, but SRCI was using the IMU to house AICs infected, or thought to be infected, by COVID-19. Plaintiff testified that he and other inmates were left in total isolation in IMU-E, with no way to call for help. Medical staff visited once per day to conduct temperature and oxygen saturation checks and to document symptoms. Plaintiff testified that his cell in IMU-E was cleaned once during the two weeks he was held in there. He was allowed to shower only three times per week. AICs were given mental health medications at night.

Plaintiff was tested for COVID-19 after the transfer. His test came back positive on August 16, 2020. Def. Ex. 102 at 96.

Dr. Gulick testified that staff used a "COVID Flow Sheet" to chart symptoms for AICs in IMU or in other locked down housing units because it was impractical to expect staff to transport the AICs' entire charts with them as they documented AICs' conditions. According to Dr. Gulick, so long as the AICs remained stable, they remained housed in the IMU and were never transported to the infirmary.

Plaintiff testified that he remained in IMU-E from August 13th through August 26th. Plaintiff testified that he was told by medical staff in IMU-E to use his inhaler if he could not breathe. He was also directed to use his inhaler *before* staff measured his oxygen saturation levels pursuant to their daily symptom checks documented in the COVID Flow Sheets.

Dr. Gulick testified that while Plaintiff was infected with COVID-19 he remained in IMU-E and never saw a doctor. The doctor testified that he defines "severe COVID" as 93% oxygen saturation accompanied by shortness of breath. Dr. Gulick initially testified that Plaintiff was asymptomatic when he had COVID-19, but he later amended that testimony to explain that he meant that Plaintiff never suffered reductions in oxygen saturation. He further testified that he himself did not see patients who were not suffering from desaturation.

Upon questioning as to how Dr. Gulick could know that Plaintiff did not suffer reductions in oxygen saturation while in IMU-E, Dr. Gulick recognized that Plaintiff's medical records were missing the COVID Flow Sheets for his time in IMU-E and that these COVID Flow Sheets were the only document that would have tracked Plaintiff's symptoms during that time.[5] Dr. Gulick directed staff to look for the missing records. They were located after Dr. Gulick's testimony and the 16-pages of COVID Flow Sheet for Plaintiff, covering the time period of July 2020 through January 2021, was received as Defendant's Exhibit 103.

c. Plaintiff's COVID Flow Sheets

Again, focusing on Dr. Gulick's testimony that the seriousness of a COVID-19 infection was in his opinion driven by oxygen saturation, the court turns its analysis to Plaintiff's COVID Flow Sheets. Def. Ex. 103. The form includes fields to track the following:

Day # After Exposure	Date	Time	Temperature / Blood Pressure / Oxygen Saturation	SYMPTOMS: Cough, SOB/difficulty breathing, chills, muscle pain, headache, sore throat, new loss smell, diarrhea, none

Def. Ex. 103. The COVID Flow Sheets include screening of Plaintiff for potential COVID-19 symptoms from July 2020 through January 2021. As noted above, Plaintiff was transferred to IMU-E on August 13, 2020. On that date, the chart notes that Plaintiff had a fever of 101º, chills, and headache. Def. Ex. 103 at 12. Notably to the court, while Dr. Gulick testified of the importance of oxygen saturation levels, particularly if they fell below 93% and shortness of breath, Plaintiff twice during his weeks in IMU-E suffered oxygen saturation levels of 92%, on August 17 and August 20. Def. Ex. 103 at 13. Again, the court considers this evidence in the context of Plaintiff's testimony that he was directed by medical staff to use his inhaler *before* staff measured his oxygen levels. As such, these measurements – 92% oxygen saturation, numbers which Dr. Baskerville testified were "concerning" and reflected "marginal saturation" – did not represent a baseline of Plaintiff's oxygen levels.[6] And yet, Plaintiff never saw a doctor and remained housed in isolation, without anyone to call should he need help, throughout his placement in IMU-E while ill.

[5] Dr. Gulick's willingness to opine about Plaintiff's symptoms while in IMU-E when the necessary records on which to base that opinion were missing is relevant to the reliability of his opinion.

[6] Dr. Baskerville also testified that oxygen saturation below 92% required the patient to be placed on oxygen. Dr. Gulick testified that whether a person with a 92% saturation rate required oxygen would depend on the person's other underlying conditions.

Also relevant is Plaintiff's testimony that his symptoms continued while in IMU-E for three to five days, after which they dissipated. Plaintiff testified that labored breathing was his worst symptom and that he could not catch his breath. This testimony conflicts with Plaintiff's COVID Flow Sheet for his time in IMU-E which reflects Plaintiff had no symptoms other than on August 14. Def. Ex. 103 at 13.

In light of the conflict of Plaintiff's testimony and the COVID Flow Sheets, the court reviewed the records carefully. One Flow Sheet claims to document August 6-21, but in oddly numbered rows in that August 17-21 appear at the top, followed by August 6-16 coming after them. Def. Ex. 103 at 12. This Flow Seet does not specify a "Housing Unit" at the top; this presumably means that this, and all of the other Flow Sheets other than two, reflect data collected while Plaintiff was in his regular housing unit, which Plaintiff testified had been 1B1, cell 7A. Two pages out of the set of records list "Housing Unit" as "IME19." Def. Ex. 103 at 13-14. These two pages of records appear to record Plaintiff's symptoms while in IMU-E because they cover the time period of August 14-24. These are the only COVID Flow Sheets that include entries of oxygen saturation levels. Def. Ex. 103 at 13-14.

With regard to the reliability of these Flow Sheets in that they conflict with Plaintiff's testimony about his symptoms while in IMU-E, the court makes the following observations. The oddly numbered Flow Sheet that appears to chart Plaintiff's symptoms while he was housed in his normal unit, 1B1, is not only odd in its numbering of entries (August 17-21 appearing before August 6-16), but odd in an additional way. This document purports to reflect Plaintiff's condition on August 16, 2020, including that he had a temperature of 97.6 º and no COVID-19 symptoms. Def. Ex. 103 at 12 (last row). This entry is puzzling.

In fact, on August 16, 2020, Plaintiff was located not in his regular 1B1 unit, in cell 7A. He had been moved to IMU-E. The Flow Sheet entries on August 14 and 15 on this page are consistent with that interpretation in that on August 14, the Flow Sheet entry for Plaintiff lists "gone" and on August 15, the entry is blank. Def. Ex. 103 at 12. The Flow Sheet for Plaintiff in IMU-E for August 16, 2020, reflects that his temperature was 98.2 º and that he suffered no other symptoms. These odd and apparently inconsistent entries in the Covid Flow Sheets go to the reliability of the Flow Sheets introduced as evidence by Defendant.

In addition, the court notes that the Flow Sheet for Plaintiff on July 2, 2020, Housing Unit "1B107A" reports that his temperature was 97.2º and that he experienced no COVID symptoms. Contrast this record with Plaintiff's kytes from July 1[7] and July 2, 2020, in which he asked for a COVID test because he was experiencing warm flashes, loss of taste, nausea, and disorientation. Def. Ex. 102 at 145 & 147. In light of these conflicts, the court finds Plaintiff's testimony about his breathing difficulties while in IMU-E more credible than the COVID Flow Sheets reflecting symptom reporting to the contrary.

d. Plaintiff's Breathing Issues Post-COVID-19 Infection

Dr. Gulick testified that Plaintiff has not complained of breathing difficulties since he recovered from COVID-19 in August. This is not accurate. Counsel for Defendant reminded Dr. Gulick of some complaints by Plaintiff after he supposedly recovered; the court identified additional complaints by Plaintiff. Plaintiff's records document that he has complained repeatedly about difficulty breathing after his COVID-19 infection. He complained of ongoing COVID-19 symptoms, to include breathing problems, cough and congestion, on September 18, 2020 (Def. Ex. 102 at 33), October 5, 2020 (*id*. at 41), October 8, 2020 (Def. Ex. 103 at 8); October 13, 2020 (Def. Ex. 102 at 14; Def. Ex. 103 at 8), October 16,

[7] There appears to be no Flow Sheet entry for Plaintiff for July 1, 2020. *See* Def. Ex. 102 & 103.

2020 (Def. Ex. 103 at 8), October 28, 2020 (*id*. at 14 & Def. Ex. 103 at 7), December 2, 2020 (Def. Ex. 102 at 27), January 20, 2021 (*id*. at 24); January 21, 2021 (Def. Ex. 102 at 12) and January 22, 2021 (Def. Ex. 102 at 12).

Plaintiff testified that he was not tested for COVID-19 before he was moved from IMU-E back to his 1B1 housing unit. Once there, Plaintiff testified that he continued to suffer breathing problems as well as stomach upset, disorientation, body aches and other flu-like symptoms that Plaintiff described were like the flu, but different. He spoke of an ongoing issue with breathing and the need to use his inhaler more often.[8] He said that recurrence of symptoms came frequently and out of the blue. Plaintiff testified that his health has improved from his time in the IMU-E, but symptoms continue such as low energy, occasional breathing problems, chest pains, sporadic flu-like symptoms, fatigue, stomach cramps, and joint pain. He has also begun experiencing heart fluttering, addressed more below.

Plaintiff also testified that when he reported his ongoing symptoms to medical staff that he was made to feel that he was abusing sick call. He testified that a nurse told him that "this was COVID" and that there was nothing more to do. These statements by staff to Plaintiff affect his thinking as to the availability of treatment for his ongoing breathing difficulties and are relevant to the court regarding how often Plaintiff sought help and the efficacy of that help to Plaintiff.

Dr. Baskerville testified to Plaintiff's ongoing symptoms as he saw documented in Plaintiff's records and based on his interviews with Plaintiff. As described by Dr. Baskerville, Plaintiff is still subjectively symptomatic and has remained so since August 2020. Dr. Baskerville described Plaintiff's health as consistent with what Dr. Baskerville termed Post-COVID Syndrome. He testified that pulmonary decompensation and dysfunction were seen across a large number of COVID-19 patients and that when persons exhibit these symptoms, the best practice is to actively treat symptoms and send the person to an expert pulmonologist for a pulmonary function test. He testified that while assessing the most effective treatment may require experimentation with medication and therapies, aggressively addressing these ongoing symptoms is crucial out of a concern that Plaintiff may contract COVID-19 a second time. Dr. Baskerville described the threat of a "double hit," which he explained was when a patient has an injured lung from a previous COVID-19 infection and that patient is again infected. To avoid this risk, Dr. Baskerville testified, it was important to optimize pulmonary functioning. Dr. Baskerville testified that this approach was based on his daily experience treating these types of patients and working with pulmonologists doing the same. Dr. Baskerville testified that these preventative strategies were particularly important in an incarceration setting where the prevalence of COVID-19 is disproportionately high due to the communal living situation.

Dr. Gulick relies on the results of Plaintiff's 2019 spirometry test, 2021 peak flow breathing test[9], and chest x-rays from 2017 and 2021 (Def. Ex. 102 at 17) in support of his opinion that Plaintiff suffers no breathing issues that require treatment beyond the current course. Plaintiff testified that he was told to take both of his breathing medications before medical staff administered the peak flow test.[10]

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[8] Frequency of Plaintiff's albuterol inhaler requests is addressed below.

[9] Dr. Gulick ordered a peak flow test for Plaintiff on February 11, 2021, eight days before Dr. Gulick testified. Plaintiff scored a 91, which Dr. Gulick reported was in the normal range. Dr. Gulick ordered a chest x-ray on January 27, 2021, in response to a report from Plaintiff that he was having trouble breathing. Dr. Gulick said this x-ray appeared normal.

[10] Plaintiff testified that he took both his fluticasone and used his albuterol inhaler prior to taking the peak test. Plaintiff testified that while staff had not directed him this time to medicate immediately before taking the test, that

Dr. Gulick testified that he believed Plaintiff was receiving appropriate care for his breathing issues. He testified that Plaintiff's chest imaging and his performance on the January 2021 peak breathing test confirmed that his breathing issues were being properly treated at SRCI. He testified that he did not believe referral to a pulmonary specialist was appropriate. He stated that he believed that continued monitoring of Plaintiff's oxygen saturation and additional peak flow tests were sufficient to care for Plaintiff's RAD and other breathing issues.

Dr. Baskerville testified that the 2021 peak flow testing utilized an inappropriate approach because for a peak test to have value, one must first establish a baseline by testing an unmedicated AIC and then have the AIC take his medications and retest to know the efficacy of the medication. He testified that the chest x-rays gave a helpful snapshot in time as to lung condition, but more information was needed to properly care for Plaintiff's breathing issues.

(ii) Defendant's Treatment Of Plaintiff's Hypertension/Heart Disease/Fluttering

Plaintiff complains of overlapping heart-related issues: hypertension or high blood pressure, heart disease, and heart fluttering.

a. Plaintiff's Blood Pressure Monitoring

When Plaintiff arrived at SRCI in 2015, his medical intake states that he had high blood pressure in the past, but "states is under control now." Def. Ex. 102 at 49. Dr. Gulick stated in his declaration that ODOC is monitoring AIC Skelton's blood pressure. His blood pressure has been checked multiple times from 2016 to present." Def. Ex. 101 at ¶6.

The parties agree that Plaintiff's high blood pressure is a serious and deadly medical issue. Healthy blood pressure measurements involve readings of less than 140 over less than 80.

Plaintiff's blood pressure has been recorded by medical staff over the past year as consistently well above safe levels. Plaintiff's medical records reflect the following readings, including **in bold** those that are beyond the healthy range of 140/80:

Date	Blood Pressure Measurement	Citation in Medical Records
3/19/2016	**173/97**	Def. Ex. 102 at 51
3/26/2016	**154/92**	Def. Ex. 102 at 51
4/9/2016	**152/81**	Def. Ex. 102 at 51
4/23/2016	**150/86**	Def. Ex. 102 at 51
7/23/2016	**146/96; 152/96; 154/90**	Def. Ex. 102 at 134, 137
8/1/2016	**152/88; 142/82**	Def. Ex. 102 at 54

they had advised him to do so before previous tests and therefore, Plaintiff thought that was proper. Dr. Baskerville testified to the importance of testing without use of albuterol to establish a baseline, and then to test after use of albuterol to understand the effects of the medication on Plaintiff's breathing.

Date	Blood Pressure Measurement	Citation in Medical Records
12/06/2016	**156/96**	Def. Ex. 102 at 53
06/15/2017	**146/86**	Def. Ex. 102 at 53
12/27/2017	**154/92**	Def. Ex. 102 at 53
4/4/2018	134/**85**	Def. Ex. 102 at 91
7/9/2018	**150**/70	Def. Ex. 102 at 52
8/29/2018	135/77	Def. Ex. 102 at 90
12/17/2018	122/70	Def. Ex. 102 at 89
4/1/2019	129/**83**	Def. Ex. 102 at 52
7/31/2019	**146/88**	Def. Ex. 102 at 85
8/31/2019	**158/85**	Def. Ex. 102 at 83
9/2/2019	**156/84**	Def. Ex. 102 at 82
9/11/2019	132/76	Def. Ex. 102 at 81
9/21/2019	**152**/78	Def. Ex. 102 at 82
9/23/2019	**159/94**	Def. Ex. 102 at 81
9/26/2019	**145**/79	Def. Ex. 102 at 52
11/16/2019	138/**87**	Def. Ex. 102 at 80
6/30/2020	**145/85**	Def. Ex. 102 at 77
7/7/2020	138/**88**	Def. Ex. 102 at 77
8/21/2020	129/**95**	Def. Ex. 103 at 13[11]
8/24/2020	**143**/75	Def. Ex. 103 at 14
10/12/2020	**164/98**	Def. Ex. 102 at 14
10/28/2020	**178/80**	Def. Ex. 102 at 14
12/04/2020	**171/96**	Def. Ex. 102 at 14
12/16/2020	**150/80**	Def. Ex. 102 at 7

[11] Although the COVID Flow Sheets direct staff to measure blood pressure (see Def. Ex. 103), Plaintiff's blood pressure was documented only twice in all of his Flow Sheets. Def. Ex. 103 at 13 & 14.

Date	Blood Pressure Measurement	Citation in Medical Records
12/18/2020	**163/104**	Def. Ex. 102 at 18 (at rest measure from stress echocardiogram)
1/21/2021	**190/98**	Def. Ex. 102 at 12
1/22/2021	**143/87**	Def. Ex. 102 at 12

Of importance to the court is the fact that Plaintiff has had a history of high blood pressure for almost five years. Of particular note is that while the test results reflected above illustrate the seriousness and long-term nature of Plaintiff's high blood pressure, in the vast majority of medical appointment records, medical staff did not note in his record that they measured Plaintiff's blood pressure. *See generally*, Def. Ex. 102. Dr. Gulick attested in his declaration that ODOC has checked Plaintiff's blood pressure "multiple times" from 2016 to present. Def. Ex. 101 at ¶6. While there are "multiple" readings documented above, SRCI medical staff have failed to do anything about Plaintiff's condition that can lead to stroke, causing permanent disability or death.

According to Plaintiff's medication records, he had been prescribed 100mg Losartan on June 19, 2019. Def. Ex. 102 at 125. He was prescribed 12.5mg hydrocholorothiazide once daily on August 26, 2019, and appears to have continued that medication at that dosage level to the present. Def. Ex. 102 at 122 (Aug. 2019), 120 (Oct. 2019), 119 (Nov. 2019), 117 (Dec. 2019), 116 (Jan. 2020), 114 (Mar. 2020), 102 (Apr. 2020), 111 (Jun. 2020), 109 (Jul. 2020), 10 (Oct. 2020), 22 (Nov. 2020).

This record demonstrates that Defendant left Plaintiff on the same medication from at least August 2019 until December 2020, despite the consistently very high readings starting in October 2020. And to reiterate again, when Plaintiff did see medical staff for any reason, they often did not measure and record Plaintiff's blood pressure, despite the documented history of high numbers. *See generally* Def. Ex. 102.

Medical staff added an additional medication of 50mg of Losartan on December 16, 2020, to address the high blood pressure. Def. Ex. 102 at 20. Despite the additional medication, as documented above, Plaintiff's blood pressure continued to be very high. In fact, both doctors testified that Plaintiff's numbers in December 2020 and January 2021 were out of control. Dr. Gulick testified that he doubled Plaintiff's Losartan to 100mg on February 8, 2021, two-weeks prior to the evidentiary hearing.

Regarding ongoing monitoring, Dr. Gulick testified that while SRCI previously offered blood pressure clinics where AICs could have their blood pressure tested, those clinics are currently extremely limited due to COVID-19 and wholly unavailable to any unit under lockdown. Dr. Gulick testified that some AICs are on mandatory blood pressure monitoring, but that he did not know if Plaintiff was. There is no evidence in Plaintiff's medical records that he is slated for mandatory monitoring. Dr. Gulick testified that Plaintiff could request blood pressure testing by going to sick call. Dr. Gulick testified that he believed that the increased Losartan in combination with the hydrocholorothiazide was sufficient to treat Plaintiff's high blood pressure. Dr. Baskerville testified that the increase of Losartan was good news, but that doubling medication without proper monitoring was dangerous. He testified that it was necessary to monitor blood pressure closely in the face of such a big increase since blood pressure that is too low is also dangerous.

b. Heart Flutter

In addition to high blood pressure, subsequent to his COVID-19 infection in August 2020, Plaintiff began experiencing heart flutters. Def. Ex. 101 at ¶36. The first report of this experience is on September 17, 2020. *Id.*; Def. Ex. 102 at 43. He complained of heart flutters again on September 18, 2020 (Def. Ex. 102 at 33). The TLC approved administration of a stress echocardiogram on September 22, 2020; Plaintiff was notified on September 30, 2020, of the approval. (Def. Ex. 102 at 36, 44).

As per DOC policy, Plaintiff was tested for COVID-19 on December 16, 2020, before being transported off-site for the echocardiogram; the result was negative. Def. Ex. 102 at 16. The stress echocardiogram took place on December 18, 2020, approximately three months after the TLC approved the test. Def. Ex. 102 at 18. What appears to be a notification of Plaintiff dated December 22, 2020, of the normal result appears in Plaintiff's records (Def. Ex. 102 at 19); however, as of January 9, 2021, Plaintiff was still unaware of the result because he sent a kyte inquiring into the results and complaining of other, ongoing symptoms (Def. Ex. 102 at 25).

Plaintiff made additional complaints about heart flutters on December 2, 2020 (Def. Ex. 102 at 27) and December 4, 2020 (Def. Ex. 102 at 14).

Four months after the test was ordered, on January 20, 2021, medical staff informed Plaintiff that the stress echocardiogram was normal.

Dr. Baskerville testified that long term heart issues, including fluttering, are another of the Post-Covid Syndrome symptoms. While Albuterol use can cause heart fluttering, Dr. Baskerville noted in his testimony that Plaintiff had used Albuterol for years and reported no heart fluttering until September 2020.

B. Conclusion On The Facts

The above findings make plain a record that Plaintiff has not received adequate medical care for his breathing and heart issues. In assessing this evidence against the applicable legal framework, the court must assess whether the evidence reflects an honest difference in medical opinion, or whether this case presents substantively different opinion based on the doctors' background, training, experience, specialties, and reasonableness of their opinions such that one opinion is more reliable than the other.

VI. Weighing The Evidence

Throughout its factfinding, the court made observations regarding the reliability of testimony and medical opinion in specific circumstances as described above. 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.

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.

1. Fever As A Symptom Of COVID-19

In terms of diagnosing symptoms of COVID-19 and assessing the seriousness of a COVID-19 infection, Dr. Gulick testified three times 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. He testified that almost every COVID-19 patient he has treated had a fever. Dr. Baskerville's testimony is consistent with CDC guidance documented in Pl. Ex. 06, 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 (Pl. Ex. 06 at 001-002). *See also id*. at 001 (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.").

In addition, Dr. Gulick's testimony that fever is not a symptom indicative of COVID-19 is contrary to the Plaintiff's medical records. When Plaintiff complained of other COVID-19 symptoms such as lack of taste and nausea and asked to be tested, medical staff responded: "As long as you are not having a fever you don't meet criteria for testing." Def. Ex. 102 at 147. Dr. Gulick's belief is also contrary to the COVID Flow Sheets themselves, which direct staff to track "TEMP/BP/SAO2" as well as whether a person has "Fever/Chills". *See generally*, Def. Ex. 103.

2. 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 AICs to be tested for COVID-19 except in connection to necessary off-site transports. He said that because AICs did not want to be placed in IMU-E, 15-20% of AICs refuse to be tested and 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, programming is cancelled, and visitation is limited to mandatory visits only. 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. 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, even if the ultimate decisions about testing are made elsewhere in ODOC.

The CDC's report, "Mass Testing for SARS-CoV-2 in 16 Prisons and Jails – Six Jurisdictions, United States, April-May 2020"[12] 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

[12] The CDC report on mass testing in incarceration settings is available online at https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm (last visited 03/23/2021).

unique challenges to 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 directly contrary to Dr. Gulick's opinion on the efficacy of mass testing. *See also* CDC, *Testing in Correctional & Detention Facilities* (Mar. 17, 2021).[13]

3. 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.

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 and the latest studies on prevention, symptoms and treatment. He also displayed an in-depth understanding of the latest scientific understanding of what has been termed Post-Covid Syndrome.

Dr. Gulick has 17-years of experience providing medical care to AICs in an institutional setting. He treats patients outside SRCI at his clinic, but Dr. Gulick did not testify about caring for COVID-19 patients in that context. Dr. Gulick recognized that the care he has directly provided 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. Dr. Gulick does not work regularly with pulmonologists or other experts in the ER or ICU settings. Dr. Gulick had heard of Post-Covid Syndrome but had not been trained in it.

B. Change In Treatment Prior To Hearing

Just prior to the evidentiary hearing, Dr. Gulick doubled Plaintiff's blood pressure medication and ordered a zio patch that provides 24-hour heart monitoring. Dr. Gulick testified that the device was placed on Plaintiff on February 21, 2021, the day before this court's evidentiary hearing. He explained that the device will monitor Plaintiff's heart for the specified time and then the results will be sent to a telemetry specialist for study. Dr. Gulick will receive the results in approximately two weeks and testified his next course of action will depend on the results. Dr. Baskerville explained that while the zio patch will provide data necessary to better understand Plaintiff's heart flutter, the zio patch is a telemetry device and in no way a medication, nor does it address Plaintiff's hypertension.

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

The increased medication (increased February 8, 2021) and the application of the zio patch (begun February 21, 2021) are no doubt improvements in his health care for Plaintiff's hypertension/heart issues. Both doctors testified that the change in medication was likely the cause of the blood pressure decrease between January 21, 2021 and January 22, 2021. It is not lost on this court, however, that Defendant made these changes on the eve of an evidentiary hearing/trial. The court finds that such measures were necessary long before February 22, 2021, and that it is unfortunate if Plaintiff received the care he deserves only because he filed suit. This is relevant to credibility and reliability of medical opinion.

VII. Decisions On The Claims

A. Claim One: RAD/Breathing Difficulties

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

As to the first, objective, component, Plaintiff has proven by a preponderance of the evidence that he suffers from a serious medical condition and that Defendant has failed to adequately treat the seriousness of the Plaintiff's serious medical condition. *Billings*, 323 Or at 180. Plaintiff has proven that he suffers from RAD/asthma and related breathing difficulties. Plaintiff has further proven that that condition, inadequately treated and particularly in the context of an AIC who is suffering from lung damage from a COVID-19 infection in August 2020, poses additional risks at SRCI where COVID-19 infections continue.

As to the second, subjective, component, Plaintiff has proven by a preponderance of the evidence that Defendant has been deliberately indifferent in responding to Plaintiff's RAD and related breathing difficulty. *Billings*, 323 Or at 180. Plaintiff has proven more than a mere difference of opinion between equally qualified experts. Plaintiff has proven Defendant has been deliberately indifferent to his serious medical needs in the form of indifference manifested by medical staff's response to Plaintiff's breathing problems. As noted in *Farmer*, 511 US at 847: 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." This court concludes Defendant has done just that by failing to take reasonable measures to abate Plaintiff's RAD/related breathing issues, likely worsened by his August 2020 COVID-19 infection.

B. Claim Two: Hypertension/Heart Disease/Fluttering

As to the first, objective component, Plaintiff has proven by a preponderance of the evidence that he suffers from a serious medical condition in the form of hypertension and other heart-related conditions. Plaintiff has also proven by a preponderance of the evidence that Defendant has failed to adequately treat these conditions. *Billings*, 323 Or at 180.

As to the second, subjective, component, Plaintiff has proven by a preponderance of the evidence that Defendant has been deliberately indifferent in responding to Plaintiff's hypertension and heart related conditions, such as fluttering. *Billings*, 323 Or at 180. Plaintiff has proven more than an honest difference in medical opinion. Defendant has been deliberately indifferent as manifested by medical staff's response to Plaintiff's blood pressure and heart fluttering. Plaintiff has proven Defendant knew about Plaintiff's serious and deadly hypertension for months and disregarded that risk by failing to take reasonable measures to abate it. *See Farmer*, 511 US at 847. The changes in treatment on the eve of trial are also relevant.

Accordingly, the court will adopt Dr. Baskerville's Recommendations as to each of the two serious medical conditions.

VIII. Constitutionally Adequate Care

A. Additional Treatment Required For RAD & Related Breathing Issues, Likely Post-COVID Syndrome

Dr. Baskerville recommended that Plaintiff (1) be given a pulmonary function test; (2) see an expert on Post-COVID syndrome to improve his lung functioning; and (3) have his albuterol prescription altered to remove "MUST LAST" language so as to remove the possibility of rationing or lack of access in case of emergency. The court agrees that, particularly in light of the record that demonstrates a delay by Defendant in responding to Plaintiff's requests for medical care, and a practice of isolating AICs who feel ill, that Plaintiff must have unrestricted access to life-saving Albuterol. As noted by Dr. Baskerville, these provisions of care are critical to reduce the potential lethality of a second COVID-19 infection. A change in the labeling will not affect the interests Dr. Gulick identified in the hearing. He testified repeatedly that the direction was to staff to be aware of the frequency of refills of albuterol out of concerns that AICs were giving their albuterol inhalers to other AICs who did not have a valid prescription. The court understands and appreciates Dr. Gulick's desire to limit albuterol use to those who have a valid prescription, but frequency monitoring may be achieved on the staff end without issuing what are reasonably read as limiting instructions to AICs. This is particularly important for Plaintiff, who suffers from RAD and has a documented history of breathing difficulty since his COVID-19 experience in August 2020. The court orders Defendant to comply with all three of Dr. Baskerville's recommendations.

B. Additional Treatment Required For Hypertension/Heart Disease and Related Fluttering

Dr. Baskerville agrees with Dr. Gulick that an increase of Losartan to 100mg daily was appropriate based on Plaintiff's blood pressure measurements in December 2020 and January 2021. He stated that the current treatment plan is missing regular blood pressure monitoring. Dr. Gulick testified that SRCI offers mandatory blood pressure monitoring but did not know if Plaintiff was on the list of AICs receiving it. The records submitted by Defendant suggest blood pressure monitoring is inconsistent. Dr. Baskerville testified that regular monitoring is crucial when blood pressure medication is doubled. This court agrees with Dr. Baskerville's recommendation and will require SRCI to place Plaintiff on mandatory blood pressure monitoring, if he is not already, while the medical staff continues to adjust his blood pressure medications. The court also directs Defendant to timely disclose the results of the zio patch results to Plaintiff and his counsel in order to allow timely communication of the results and the planned course of treatment.

IX. Conclusion

For the reasons set forth above, Plaintiff's Claims One and Two are GRANTED.

The court ORDERS the following:

1. Defendant is to immediately implement the recommendations referenced above in order to provide adequate medical care;

2. Defendant and his agents are enjoined from retaliating against Plaintiff for requesting medical services;

3. Defendant and his agents are enjoined from retaliating against Plaintiff for seeking redress from this court;

4. Defendant is to pay any filing fee paid by Plaintiff;

5. The court will retain jurisdiction over this case to ensure compliance;

6. The parties are to confer and suggest a date through the clerk of the court, approximately one month from the date of the Order, for the court to hold a Status Conference at which Defendant will update the court on progress in complying with this Order. The court will expect updates as to:

    a. Plaintiff's RAD/breathing problems:

        i. Administration to Plaintiff of a pulmonary function test;

        ii. Referral of Plaintiff to an expert on Post-COVID syndrome in order to consult and receive guidance as to how to improve Plaintiff's lung functioning;

        iii. The deletion of the "MUST LAST" direction on Plaintiff's prescription for albuterol; and

    b. Plaintiff's hypertension/related heart issues:

        i. Efforts to continue to adjust medication to control Plaintiff's hypertension;

        ii. Placement of Plaintiff on mandatory blood pressure monitoring until his medications are successful at controlling his serious medical condition;

        iii. Updated information on the results of the zio patch and planned courses of care in regard to the zio patch data so that Plaintiff can request a second opinion and offer evidence as to the sufficiency of the planned course of treatment for the heart flutter.

7. The court will schedule additional Status Hearings as necessary. Once the court is satisfied that Defendant has complied with this order, the court will terminate ongoing jurisdiction. Until that time, the court will retain jurisdiction over this matter.

8. 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 ~~23rd~~ 24th of March, 2021.

Circuit Court Judge Amy M. Baggio

Signed: 3/24/2021 10:26 AM